RULES OF

Department of Mental Health

Division 30—Certification Standards

Chapter 3—Substance Use Disorder Prevention and Treatment Programs

Title **Page**

9 CSR 30-3.010 Definitions (Rescinded October 30, 2001) 5

9 CSR 30-3.020 Procedures to Obtain Certification (Rescinded October 30, 2001) 5

9 CSR 30-3.022 Transition to Enhanced Standards of Care (Rescinded July 30, 2018) 5

9 CSR 30-3.030 Governing Authority (Rescinded October 30, 2001) 5

9 CSR 30-3.032 Certification of Substance Use Disorder Prevention and Treatment Programs 5

9 CSR 30-3.040 Client Rights (Rescinded October 30, 2001) 5

9 CSR 30-3.050 Planning and Evaluation (Rescinded October 30, 2001) 5

9 CSR 30-3.060 Environment (Rescinded October 30, 2001) 6

9 CSR 30-3.070 Fiscal Management (Rescinded October 30, 2001) 6

9 CSR 30-3.080 Personnel (Rescinded October 30, 2001) 6

9 CSR 30-3.100 General Requirements for Substance Use Disorder Treatment Programs 6

9 CSR 30-3.110 Service Definitions, Staff Qualifications, and Documentation Requirements for Substance Use Disorder Treatment Programs 8

9 CSR 30-3.120 Detoxification 12

9 CSR 30-3.130 Outpatient Treatment 13

9 CSR 30-3.132 Opioid Treatment Programs 15

9 CSR 30-3.134 Gambling Disorder Treatment 20

9 CSR 30-3.140 Residential Treatment 21

9 CSR 30-3.150 Comprehensive Substance Treatment and Rehabilitation (CSTAR) 22

9 CSR 30-3.151 Eligibility Determination, Assessment, and Treatment Planning in Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs 23

9 CSR 30-3.152 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Utilizing the American Society of Addiction Medicine (ASAM) Criteria 26

9 CSR 30-3.155 Staff Requirements for Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs 37

9 CSR 30-3.157 Community Support in Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs. 39

9 CSR 30-3.160 Institutional Treatment Centers 40

9 CSR 30-3.190 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for Women and Children 47

9 CSR 30-3.192 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for Adolescents 50

9 CSR 30-3.195 Outpatient Substance Use Disorder Treatment Programs. 52

9 CSR 30-3.200 Research (Rescinded October 30, 2001) 53

9 CSR 30-3.201 Substance Awareness Traffic Offender Programs 53

9 CSR 30-3.202 SATOP Administration and Service Documentation. 54

9 CSR 30-3.204 SATOP Personnel 56

9 CSR 30-3.206 SATOP Structure 57

9 CSR 30-3.208 SATOP Supplemental Fee 61

9 CSR 30-3.210 Clients' Records (Rescinded October 30, 2001) 62

9 CSR 30-3.220 Referral Procedures (Rescinded October 30, 2001) 62

9 CSR 30-3.230 Required Educational Assessment and Community Treatment Program (REACT). 62

9 CSR 30-3.240 Medication (Rescinded October 30, 2001). 64

9 CSR 30-3.250 Dietary Services (Rescinded October 30, 2001) 64

9 CSR 30-3.300 Prevention Programs. 64

9 CSR 30-3.310 Recovery Support Programs 67

9 CSR 30-3.400 Social Setting Detoxification (Rescinded October 30, 2001) 71

9 CSR 30-3.410 Modified Medical Detoxification (Rescinded October 30, 2001) 71

9 CSR 30-3.420 Medical Detoxification Services (Rescinded October 30, 2001) 71

9 CSR 30-3.500 Residential Programs (Rescinded October 30, 2001). 71

9 CSR 30-3.510 Adolescent Program (Rescinded October 30, 2001) 72

9 CSR 30-3.600 Outpatient Programs (Rescinded October 30, 2001). 72

9 CSR 30-3.610 Methadone Treatment (Moved to 9 CSR 30-3.132). 72

9 CSR 30-3.611 Compulsive Gambling Treatment (Moved to 9 CSR 30-3.134). 72

9 CSR 30-3.620 Information and Referral Program (Rescinded October 30, 2001). 72

9 CSR 30-3.621 Central Intake Program (Rescinded October 30, 2001). 72

9 CSR 30-3.630 Prevention Programs (Moved to 9 CSR 30-3.300) 72

9 CSR 30-3.700 Substance Abuse Traffic Offender Programs (Moved to 9 CSR 30-3.201) 72

9 CSR 30-3.710 Definitions (Rescinded October 30, 2001) 72

9 CSR 30-3.720 Procedures to Obtain Certification (Rescinded October 30, 2001) 72

9 CSR 30-3.730 Administration (Moved to 9 CSR 30-3.202) 72

9 CSR 30-3.740 Environment (Rescinded October 30, 2001) 72

9 CSR 30-3.750 Personnel (Moved to 9 CSR 30-3.204). 72

9 CSR 30-3.760 Program Structure (Moved to 9 CSR 30-3.206) 72

9 CSR 30-3.770 Client Records (Rescinded October 30, 2001). 72

9 CSR 30-3.780 Curriculum and Training (Rescinded October 30, 2001) 72

9 CSR 30-3.790 Supplemental Fee (Moved to 9 CSR 30-3.208) 73

9 CSR 30-3.800 Required Educational Assessment and Community Treatment Program (Moved to 9 CSR 30-3.230) 73

9 CSR 30-3.810 Definitions (Rescinded October 30, 2001) 73

9 CSR 30-3.820 Procedures to Obtain Certification (Rescinded October 30, 2001). 73

9 CSR 30-3.830 Comprehensive Substance Treatment and Rehabilitation Program Description (Rescinded October 30, 2001) 73

9 CSR 30-3.840 Treatment and Rehabilitation Process (Rescinded October 30, 2001). 73

9 CSR 30-3.850 Service Provision (Rescinded October 30, 2001) 73

9 CSR 30-3.851 Specialized Program for Women and Children (Rescinded October 30, 2001) 73

9 CSR 30-3.852 Specialized Program for Adolescents (Rescinded October 30, 2001) 73

9 CSR 30-3.853 Adolescent Residential Support (Rescinded October 30, 2001) 73

9 CSR 30-3.860 Quality Assurance (Rescinded October 30, 2001) 73

9 CSR 30-3.870 Behavior Management (Rescinded October 30, 2001) 73

9 CSR 30-3.880 Client Records (Rescinded October 30, 2001) 73

9 CSR 30-3.890 Personnel, Staff Qualifications, Responsibilities and Training (Rescinded October 30, 2001) 73

9 CSR 30-3.900 Client Rights (Rescinded October 30, 2001) 74

9 CSR 30-3.910 Research (Rescinded October 30, 2001) 74

9 CSR 30-3.920 Governing Authority and Program Administration (Rescinded October 30, 2001) 74

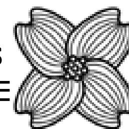
9 CSR 30-3.930 Fiscal Management (Rescinded October 30, 2001) 74

9 CSR 30-3.940 Environment, Safety and Sanitation (Rescinded October 30, 2001) 74

9 CSR 30-3.950 Accessibility (Rescinded October 30, 2001) 74

9 CSR 30-3.960 Dietary Services (Rescinded October 30, 2001) 74

9 CSR 30-3.970 Medication Management (Rescinded October 30, 2001) 74



TITLE 9 — DEPARTMENT OF MENTAL HEALTH
Division 30 — Certification Standards
Chapter 3 — Substance Use Disorder Prevention and Treatment Programs

9 CSR 30-3.010 Definitions
(Rescinded October 30, 2001)

AUTHORITY: sections 313.842, 630.050 and 630.655, RSMo 1994. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed July 15, 1987, effective July 1, 1988. Amended: Filed Jan. 19, 1988, effective July 1, 1988. Emergency amendment filed Oct. 4, 1988, effective Oct. 14, 1988, expired Jan. 14, 1989. Amended: Filed Oct. 4, 1988, effective Jan. 14, 1989. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Amended: Filed Oct. 13, 1995, effective April 30, 1996. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.020 Procedures to Obtain Certification
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 1994. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed May 6, 1985, effective Sept. 1, 1985. Amended: Filed Jan. 19, 1988, effective July 1, 1988. Amended: Filed Aug. 14, 1995, effective Feb. 25, 1996. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.022 Transition to Enhanced Standards of Care
(Rescinded July 30, 2018)

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed Jan. 12, 2018, effective July 30, 2018.

9 CSR 30-3.030 Governing Authority
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.032 Certification of Substance Use Disorder Prevention and Treatment Programs

PURPOSE: This rule identifies the types of substance use disorder prevention and treatment programs and services eligible for certification from the department and the applicable requirements.

(1) Types of Programs and Services. Certification from the department is available for the following types of programs and services:

(A) Comprehensive Substance Treatment and Rehabilitation (CSTAR), including specialized programs for adolescents, women and children, adult general population, and opioid use disorders;

(B) Gambling disorder treatment;

(C) Institutional treatment center;

(D) Opioid treatment;

(E) Outpatient treatment;

(F) Prevention;

(G) Recovery support;

(H) Required Educational Assessment and Community Treatment (REACT);

(I) Residential treatment;

(J) Substance Awareness Traffic Offender Program (SATOP); and

(K) Withdrawal management.

(2) Applicable Program Regulations. The organization must comply with the regulations applicable to each program and/or service for which certification is being sought.

(3) Other Regulations. In addition to the regulations for specific programs and services as specified in 9 CSR 30-3, the organization must comply with other applicable regulations as follows:

(A) 9 CSR 10-7.010 to 9 CSR 10-7.140, Core Rules for Psychiatric and Substance Use Disorder Treatment Programs;

(B) 9 CSR 10-5.190 Background Screening Requirements;

(C) 9 CSR 10-5.200 Report of Complaints of Abuse, Neglect, and Misuse of Funds/Property;

(D) 9 CSR 10-5.206 Report of Events; and

(E) 9 CSR 10-5.220 Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(4) Approval of Programs and Sites. The department must authorize and approve each proposed program/service and site prior to the delivery of services.

(A) Organizations requesting certification must comply with 9 CSR 10-7.130, Procedures to Obtain Certification, by submitting a fully completed application to the department.

(B) Notice of any change in program location, service array, or administration must be submitted to the department for approval prior to the change to ensure the program meets all applicable requirements, which may include an on-site review of the physical environment and safety practices.

(C) All opioid treatment programs shall meet the program and/or site approval requirements of this rule, as well as the requirements specified under 9 CSR 30-3.132.

AUTHORITY: sections 302.540, 630.050, 630.655, and 631.102, RSMo 2016. 45 CFR parts 160 and 164, the Health Insurance Portability and Accountability Act of 1996. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 8, 2002, effective Sept. 30, 2002. Emergency amendment filed April 1, 2003, effective April 14, 2003, expired Oct. 14, 2003. Amended: Filed April 1, 2003, effective Oct. 30, 2003. Amended: Filed May 28, 2021, effective Dec. 30, 2021.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.102, RSMo 1997.*

9 CSR 30-3.040 Client Rights
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.110–630.125, 630.200 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.050 Planning and Evaluation
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.060 Environment
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed Dec. 13, 1983, effective April 12, 1984. Rescinded and readopted: Filed June 2, 1988, effective Nov. 1, 1988. Rescinded: Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.070 Fiscal Management
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.455 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.080 Personnel
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.200 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed July 15, 1987, effective July 1, 1988. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.100 General Requirements for Substance Use Disorder Treatment Programs

PURPOSE: This rule describes general requirements applicable to all certified/deemed certified substance use disorder treatment programs as well as specific requirements that pertain to organizations that are funded by and/or have a contractual relationship with the department for the provision of services.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Screening and Assessment. All individuals shall be screened and assessed as specified in 9 CSR 10-7.030 Service Delivery Process and Documentation, and in accordance with program-specific requirements included in these regulations.

(2) Diagnosis. Eligibility for services shall include a diagnosis of a substance use disorder by a licensed diagnostician in accordance with the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)*, 2013, incorporated by reference and made a part of this rule as published by the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. This rule does not incorporate any subsequent amendments or additions to this publication.

(A) The following mental health professionals are approved to render diagnoses in accordance with the *DSM-5*:

1. Physicians/Psychiatrists;
2. Psychologists (licensed or provisionally licensed);
3. Advanced Practice Registered Nurses;
4. Professional Counselors (licensed or provisionally licensed);
5. Marital and Family Therapists (licensed or provisionally licensed);
6. Licensed Clinical Social Workers;
7. Licensed Master Social Workers who are under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker. LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis.

(B) Signatures can be obtained by a face-to-face meeting with a licensed diagnostician or a face-to-face meeting with a master's level Qualified Addiction Professional (QAP) or a Qualified Mental Health Professional (QMHP) followed by sign off by a licensed diagnostician. Signature stamps shall not be used.

(C) The diagnosis is not considered complete until the diagnostician's signature is obtained. The licensed diagnostician is accountable for the stated diagnoses.

(D) A licensed supervisor must sign off on assessments and diagnoses completed by provisionally licensed providers.

(3) Treatment Plan. All individuals shall participate in the development of an individual treatment plan and regular plan reviews and updates as specified in 9 CSR 10-7.030 Service Delivery Process and Documentation, and in accordance with program-specific requirements included in these regulations.

(4) Services to Family Members. Family therapy and family conference shall be available to family members of persons participating in substance use disorder treatment.

(A) Family members shall be routinely informed of available services and the program shall demonstrate the ability to effectively engage family members in the recovery process.

(B) A separate record for a family member is not required if group rehabilitative support is the only service provided by a program that is funded by/contracted with the department. Documentation of group rehabilitative support sessions and the participating family member(s) shall be maintained.

(5) Peer Support and Social Networks. Services shall be designed and organized to engage individuals and their family members/natural supports in peer support services, social networks, and resources in the community.

(6) Services to Women. An organization that lacks certification to provide women and children's CSTAR services must meet the following requirements in order to provide services to women:

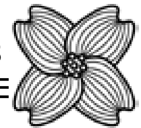
(A) Offer gender-specific groups which address therapeutic issues relevant to women;

(B) Have staff with experience and training in the delivery of services for women with substance use disorders, including co-occurring disorders and trauma-related services and supports;

(C) Women who are pregnant shall be referred to a women and children's CSTAR program unless it is documented in the clinical record the program can meet the individual's treatment needs, or the program cannot immediately make arrangements for admission to a women and children's CSTAR program.

1. If temporary admission to the program is necessary, arrangements for transfer to a women and children's CSTAR program shall be completed as soon as possible, with efforts documented in the clinical record; and

(D) If the program is unable to refer a woman who is pregnant to a women and children's CSTAR program or immediately assess and admit her to provide interim services, staff shall



contact designated department staff to make arrangements for immediate admission to treatment with another provider.

(7) Services to Adolescents. An organization that lacks certification to provide adolescent CSTAR services must meet the following requirements in order to provide services to adolescents:

(A) Offer groups specifically for adolescents; and

(B) Have staff with experience and training in the provision of services for adolescents with substance use disorders.

(8) Program Schedule. A current schedule of groups and other structured program activities shall be maintained.

(A) Each person shall actively participate in program activities, with individualized scheduling and services based on his/her treatment goals and needs and physical and behavioral health status.

(9) Priority Populations. Individuals who will be receiving department-funded/contracted services shall be appropriately screened at the point of first contact to determine if a crisis situation exists and whether they meet eligibility criteria as a priority population.

(A) The following populations shall receive priority assessment and admission to appropriate services:

1. Women who are pregnant and inject drugs;

2. Women who are pregnant;

3. Individuals who have injected drugs in the past thirty (30) days;

4. Civil involuntary commitments — ninety-six (96) hour commitments must be admitted to withdrawal management services, and thirty (30) day commitments must be admitted to withdrawal management services or residential treatment;

5. Individuals determined to be high risk who are referred by the Department of Corrections' institutions and Division of Probation and Parole via the designated referral form and protocol;

6. Applicants for and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via electronic referral and protocol;

7. Children/youth and families served through the Children's System of Care; and

8. Other populations specified by the department.

A. Women who are pregnant and individuals who are involuntarily committed must receive immediate admission.

B. High-risk referrals from correctional institutions and probation and parole shall be assessed and admitted to appropriate services within five (5) business days of initial contact or scheduled release date.

C. Other priority populations shall be assessed and admitted to appropriate services within seventy-two (72) hours of initial contact.

(10) Referrals and Interim Services. If an individual who will be receiving department-funded/contracted services has been determined to have injected drugs within the past thirty (30) days, and he/she cannot be assessed and admitted to the program within forty-eight (48) hours of receiving such a request, staff shall —

(A) Refer the individual to an alternative substance use disorder treatment program that has sufficient capacity to admit him/her within forty-eight (48) hours; or

(B) Provide interim substance use services within forty-eight (48) hours of the initial request and admit him/her to treatment within one hundred twenty (120) days of the initial request.

(C) Interim services shall be provided until the individual is enrolled in an episode of care. Interim services are intended to maintain engagement and help the individual recognize the harmful consequences of substance use, reduce the adverse health effects of substance use, and reduce the likelihood of detrimental or unlawful behavior.

1. An assessment is not required for individuals receiving interim services.

2. Interim services may be delivered on an individual or group basis.

3. Documentation must be included in the individual record for those who miss a scheduled session or refuse interim services, including efforts to reengage.

4. Interim services must include, but are not limited to:

A. Counseling and education about HIV, tuberculosis (TB), and hepatitis;

B. Counseling and education about the risks of sharing needles;

C. Counseling and education about the risks of transmission of infectious diseases to sexual partners and infants and measures to ensure such transmission does not occur;

D. Referral for HIV, TB, or hepatitis treatment services, if necessary;

E. Group rehabilitative support focusing on reducing the adverse health effects of substance use or other aspects of treatment and recovery; and

F. Referral to recovery support programs or self-help (mutual support) groups that offer social, emotional, and informational support for individuals seeking treatment and educational materials that will increase understanding about addiction and recovery, including other local resources available.

5. Interim services may include services such as motivational interviewing to establish a therapeutic partnership and support engagement in treatment when the program has the capacity to admit the individual into an appropriate episode of care.

(11) Waiting Lists. The department may require organizations that receive federal block grant funds to maintain a waiting list for specific populations to meet block grant reporting requirements. When a waiting list is required, the organization shall —

(A) Document the individual's date of placement on the list, including identified needs;

(B) Implement a process for maintaining contact with individuals who meet criteria as a priority population and are awaiting admission to treatment;

(C) Maintain the list through ongoing review and updates;

(D) Identify procedures for referring individuals who are in crisis or are a priority population to necessary care or interim services;

(E) Document all contacts with individuals on the waiting list; and

(F) Respond to long-term waiting lists through strategic or community-based planning, involvement of support services, and referral to available services/supports.

(12) Discharge. Each individual's length of engagement in services shall be based on his/her needs and progress in achieving treatment goals.

(A) Criteria to consider in determining successful completion and discharge from treatment includes, but is not limited to, the individual's ability to —

1. Recognize and understand his/her substance use disorder and its resulting impact on family members/natural supports, impairments on health and social functioning, and other societal consequences;

2. Demonstrate absence of an immediate or a recurring crisis that poses a substantial risk for a return to use of substances;

3. Stabilize emotional problems, when applicable, such as not experiencing serious psychiatric symptoms and taking medication as prescribed;

4. Demonstrate independent living skills;

5. Implement a plan to prevent return to use of substances; and

6. Develop family and/or social networks which support recovery/resiliency and a continuing recovery plan.

(B) Discharges prior to an individual accomplishing his/her treatment goals shall be documented in the individual record, including the rationale for discharge.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. ** Rescinded and readopted: Filed May 28, 2021, effective Dec. 30, 2021.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

***Pursuant to Executive Order 21-07, 9 CSR 30-3.100, paragraph (6)(A)2. was suspended from April 23, 2020 through August 31, 2021.*

9 CSR 30-3.110 Service Definitions, Staff Qualifications, and Documentation Requirements for Substance Use Disorder Treatment Programs

PURPOSE: This rule defines and describes services, staff qualifications, and documentation requirements for certified/ deemed certified substance use disorder treatment programs.

(1) Service Definitions and Staff Qualifications. Services shall be provided as defined in this rule, in accordance with the organization's certification and contractual status with the department.

(A) Case management—links the individual and family members with needed services and supports. Key service functions include, but are not limited to:

1. Arranging for or referring individuals/family members to appropriate services/supports and resources;

2. Communicating with referral sources and coordinating services with other entities including, but not limited to, physical and behavioral healthcare providers, the criminal justice system, and social service agencies; and

3. Assisting individuals in resolving a crisis situation.

4. Services shall be provided by—

A. A qualified addiction professional (QAP);

B. An associate addiction counselor (AAC); or

C. A staff person with a bachelor's degree in social work, psychology, nursing, or a closely related field from an accredited college or university. Equivalent experience may be substituted on the basis of one (1) year for each year of required educational training.

(B) Collateral dependent counseling (individual and group)—face-to-face, goal-oriented therapeutic interaction with an individual, or a group of individuals, to address dysfunctional behaviors and life patterns associated with being a family member of an individual who has a substance use disorder and is currently participating in treatment. Group sessions shall not exceed twelve (12) family members, which may involve multiple individuals engaged in treatment.

1. This service shall only be provided to family members of the individual in treatment when the services are for the direct benefit of the individual in accordance with his/her needs and goals identified in the treatment plan, and for assisting in the individual's recovery.

2. The individual being served in treatment shall not participate in collateral dependent counseling sessions.

3. Key service functions include, but are not limited to:

A. Exploration of substance use disorders and its impact on the family member's functioning;

B. Development of coping skills and personal responsibility for changing one's own dysfunctional patterns in relationships;

C. Examination of attitudes, feelings, and long-term consequences of living with a person with a substance use disorder;

D. Identification and consideration of alternatives and structured problem-solving;

E. Productive and functional decision-making; and

F. Development of motivation and action by group members through peer support, structured confrontation, and constructive feedback.

4. Counseling for family members age five (5) and younger shall only be provided when the child is shown to have the requisite social and verbal skills to participate in and benefit from the service.

5. This service shall be provided by a Marital and Family Therapist or QAP practicing within his/her current competence.

6. Group services for children under age twelve (12) shall be provided by a graduate of an accredited college or university with a bachelor's degree in counseling, psychology, social work, or closely related field.

(C) Communicable disease counseling—assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and help them achieve optimal functioning and desired personal potential. Topics may include, but are not limited to, disclosing human immunodeficiency virus (HIV), sexually transmitted infections (STI), tuberculosis (TB) status, and/or substance use to family members/natural supports, addressing stigma in accessing services, maximizing healthcare service interactions, reducing substance use and avoiding overdose, and addressing anxiety, anger, and depressive episodes.

1. The program shall have a working relationship with the local health department, a physician, or other qualified healthcare practitioner to provide individuals with necessary testing for HIV, TB, STIs, and hepatitis.

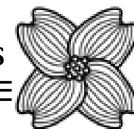
2. Prior to an individual being tested for HIV, counseling shall be provided by a staff person who is knowledgeable about communicable diseases including HIV, STIs, and TB through training and/or previous employment experience.

3. The program shall make referrals and cooperate with appropriate entities to ensure coordinated treatment is provided for individuals with positive test results.

4. Post-test counseling may be provided for individuals who test positive for HIV or TB. Program staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the Department of Health and Senior Services.

5. Program staff shall arrange and coordinate post-test follow-up for individuals who test positive for a STI or hepatitis.

6. This service shall be provided by a licensed mental health professional, QAP, or AAC who is knowledgeable about



communicable diseases including HIV, STIs, and TB through training and/or previous employment experience. Knowledge shall include, but is not limited to, awareness of risks, disease management/treatment and resources for care, confidentiality requirements, and therapeutically assisting individuals in understanding and appropriately responding to test results.

(D) Community support—as specified in 9 CSR 30-3.157;

(E) Crisis prevention and intervention—face-to-face emergency or telephone intervention available twenty-four (24) hours per day, on an unscheduled basis, to assist individuals in resolving a crisis and providing support and assistance to promote a return to routine, adaptive functioning.

1. Minimum service functions shall include, but are not limited to:

A. Interacting with the identified individual and his or her family members/natural supports, legal guardian, or a combination of these;

B. Specifying factors that led to the individual's crisis state, when known;

C. Identifying maladaptive reactions exhibited by the individual;

D. Evaluating potential for rapid regression;

E. Attempting to resolve the crisis; and

F. Referring the individual for treatment in an alternative setting when indicated.

2. Documentation must include—

A. A description of the precipitating event(s)/situation when known;

B. A description of the individual's mental status;

C. The intervention(s) initiated to resolve the individual's crisis state;

D. The individual's response to the intervention(s);

E. The individual's disposition; and

F. Planned follow-up by staff.

3. Services must be provided by a qualified mental health professional (QMHP) or QAP. Non-licensed or non-credentialed staff providing this service must have immediate, twenty-four (24) hour telephone access to consultation with a licensed physician/psychiatrist, licensed physician assistant, licensed assistant physician, or advanced practice registered nurse (APRN).

(F) Day treatment—combines group rehabilitative support with medically necessary services that are structured and therapeutic and focus on providing opportunities for individuals to apply and practice healthy skills, decision-making, and appropriate expression of thoughts and feelings.

1. Day treatment shall be provided in a group setting.

2. Services shall be designed to assist individuals with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with a substance use disorder. Services are intended to restore individuals to being active and productive members of their family, community, and/or culture to the fullest extent possible.

3. Key service functions include, but are not limited to:

A. Promoting an understanding of the relevance of the nature, course, and treatment of substance use disorders to assist individuals in understanding their individual recovery needs and how they can restore functionality;

B. Assisting in the development and implementation of lifestyle changes needed to cope with the side effects of addiction, use of prescribed psychotropic medications, and/or promote recovery from the disabilities, negative symptoms, and/or functional delays associated with a substance use disorder; and

C. Assisting with the restoration of skills and use of resources to address symptoms that interfere with activities of daily living and community integration.

4. Services shall be provided by a team consisting of Group Rehabilitation Support Specialists and Day Treatment Technicians.

(G) Drug testing—conducted to determine and detect an individual's use of alcohol or other drugs and/or monitor compliance with a prescribed medication regimen as a necessary support and adjunct to treatment.

1. Drug testing may be of greater importance for individuals—

A. With known or suspected diversion of medication for substance use disorders;

B. Who present in person to the program with symptoms and signs of intoxication or withdrawal;

C. With a self-reported or otherwise identified overdose; and

D. With significantly unstable opioid and/or other substance use disorders.

2. Test results shall be discussed with persons served in order to intervene with substance use behavior, including updates to the treatment plan based on test results.

3. Test results and actions taken shall be documented in the individual record, including the category or type of test (on-site or laboratory), the number of panels, types of drugs tested for, and the test results.

4. Drug testing may be performed on-site or sent to a laboratory. A laboratory which analyzes specimens must meet all applicable state and federal laws and regulations.

5. Written policies and procedures regarding the collection and handling of specimens shall be implemented. Urine or other specimens shall be collected in a manner that communicates respect for persons served, while taking reasonable steps to prevent falsification of samples.

6. The program shall implement written policies and procedures outlining the interpretation of results and actions to be taken when the presence of alcohol or other drugs has been determined.

(H) Family conference—intervention that enlists the assistance of the individual's support system through meeting with family members, referral sources, and other natural supports about the individual's treatment plan, continuing recovery plan, and discharge plan. The service must include the individual served and be for his/her direct benefit in accordance with needs and goals identified in the treatment plan and to assist in his/her recovery.

1. Key service functions include, but are not limited to:

A. Communicating about issues in the individual's home that are barriers to achieving his/her treatment goals;

B. Identifying relapse triggers and establishing a continuing recovery plan;

C. Assessing the need for family therapy or other referrals to support the family system; and

D. Participating in continuing recovery and discharge planning conferences.

2. Services shall be provided by a QAP or AAC.

3. Documentation must indicate the relationship of the family members and/or other participants to the individual in treatment.

(I) Family therapy—face-to-face counseling or family-based therapeutic interventions (such as role playing or educational discussions) for the individual served and/or one (1) or more of his/her family members/natural supports. Services must be for the direct benefit of the individual served in accordance with his/her treatment needs and goals and to assist in their

recovery.

1. Services shall address and resolve patterns of dysfunctional communication and interactions that have become persistent over time, particularly as they relate to alcohol and/or other drug use.

2. Services may be offered to members of a single family or members of multiple families dealing with similar issues.

3. Services may be provided in an office setting or the individual's home, depending on those involved.

4. Key service functions include, but are not limited to:

A. Utilizing generally accepted principles of family therapy to influence family interaction patterns;

B. Examining family interaction styles, confronting patterns of dysfunctional behavior, and strengthening communication patterns that promote healthy family function;

C. Facilitating family participation in family self-help recovery groups;

D. Developing and applying skills and strategies for improving family functioning; and

E. Promoting healthy family interactions independent of formal helping systems.

5. Documentation must indicate the relationship of the family members/natural supports to the individual engaged in treatment.

6. In any calendar month, for fifty percent (50%) of family therapy sessions, the individual engaged in treatment must be present, in addition to one (1) or more of his/her family members/natural supports. Family members younger than age twelve (12) can be counted as one (1) of the required family members when the child is shown to have the requisite social and verbal skills to participate in and benefit from the service.

7. Services shall be provided by a professional who—

A. Is licensed or provisionally licensed in Missouri as a marital and family therapist; or

B. Has a degree in marriage and family therapy, psychology, social work, or counseling and—

(I) Has at least one (1) year of supervised experience in family therapy and has specialized training in family therapy; or

(II) Receives close supervision from a professional who meets the requirements of subparagraph (1)(I)7.A. and B. of this rule; or

C. A QAP who receives close supervision from an individual who meets the requirements of subparagraphs (1)(I)7.A. and B. of this rule.

(J) Group counseling—face-to-face, goal-oriented therapeutic interaction between a counselor and two (2) or more individuals based on needs and goals specified in their treatment plans. Services shall be designed to promote individual functioning and recovery through personal disclosure and interpersonal interaction among group members.

1. This service can include trauma-related symptoms and co-occurring behavioral health and substance use disorders.

2. Evidence-based practices, such as motivational interviewing and cognitive behavioral therapy, shall be utilized by appropriately trained staff.

3. Some scheduled group sessions may not be applicable to or appropriate for all individuals, therefore, participation shall be on a designated or selective basis. Examples of designated or selective groups include, but are not limited to, parenting skills, budgeting, anger management, domestic violence, co-occurring disorders, life skills, and trauma.

4. Key service functions include, but are not limited to:

A. Facilitating individual disclosure of addiction-related issues which permits generalization of the issues to the larger group;

B. Promoting recognition of addictive thinking and behaviors and teaching strategies that support non-use of alcohol and/or other drugs that interfere with the individual's functioning;

C. Preparing individuals to cope with physical, cognitive, and emotional symptoms of craving alcohol and/or other drugs;

D. Encouraging and modeling productive and positive interpersonal communication; and

E. Developing motivation and action by group members through peer influence, structured confrontation, and constructive feedback.

5. Services shall be provided by a QAP, QMHP, AAC, or an intern/practicum student as specified in 9 CSR 10-7.110(5).

6. The usual and customary group size is twelve (12) individuals. The size of group counseling sessions shall not exceed an average of twelve (12) individuals during a calendar month, per facilitator, per group.

7. A group log or documentation in the individual record (paper or electronic format) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual's in and out time, and the signature and title of the staff member providing the service. Signature stamps shall not be used.

(K) Group rehabilitative support—facilitated group discussions based on individual needs and treatment plan goals to promote an understanding of the relevance of the nature, course, and treatment of substance use disorders to assist individuals in understanding their recovery needs and how they can restore functionality.

1. Key service functions include, but are not limited to:

A. Classroom style didactic lecture to present information about a topic and its relationship to substance use;

B. Presentation of audio-visual materials that are educational in nature with required follow-up discussion. Instructional aids shall be incorporated into education sessions to enhance understanding and promote discussion and interaction among individuals. Aids may include, but are not limited to, DVDs or other electronic media, worksheets, and informational handouts and shall not comprise more than twenty percent (20%) of group rehabilitative support sessions;

C. Promotion of discussion and questions about the topic presented to the individuals in attendance; and

D. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning.

2. The program shall develop a schedule and curriculum for delivery of group rehabilitative support that addresses topics and issues relevant to the individuals served. Individuals shall attend group sessions that are relevant to their needs and goals based on the assessment and interventions recommended in their individual treatment plan.

3. Services shall be provided by a group rehabilitation support specialist who is present throughout the session and—

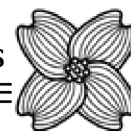
A. Is suited by education, background, or experience to present the information being discussed;

B. Demonstrates competency and skill in facilitating group discussions; and

C. Has knowledge of the topic(s) being taught.

4. Group size shall not exceed an average of thirty (30) individuals during a calendar month, per facilitator, per group session.

5. A group log or documentation in the individual record (paper or electronic format) shall be maintained for each



session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual's in and out time, and the signature and title of the staff member providing the service. Signature stamps shall not be used.

(L) Individual counseling—face-to-face, structured, and goal-oriented therapeutic counseling designed to resolve issues related to the use of alcohol and/or other drugs that interfere with the individual's functioning.

1. Evidence-based interventions including, but not limited to, motivational interviewing, cognitive behavioral therapy, and trauma-informed care shall be utilized, when appropriate.

2. Key service functions shall include, but are not limited to:

A. Exploration of an identified problem and its impact on the individual's functioning;

B. Examination of attitudes, feelings, and behaviors that promote recovery and improved functioning;

C. Identification and consideration of alternatives and structured problem-solving;

D. Discussion of skills to aid in making positive decisions; and

E. Application of information presented in the program to the individual's life situation to promote recovery and improved functioning.

3. Services shall be provided by a QAP, QMHP, AAC, or an intern/practicum student as specified in 9 CSR 10-7.110(5).

(M) Individual counseling, co-occurring disorders—individual, face-to-face, structured and goal-oriented therapeutic interaction between an individual and a counselor designed to identify and resolve issues related to substance use and co-occurring mental illness functioning.

1. This service must be provided by—

A. A licensed or provisionally licensed qualified mental health professional (QMHP);

B. An individual holding the Co-Occurring Disorders Professional or Co-Occurring Disorders Professional/Diplomate credential from the Missouri Credentialing Board;

C. A non-licensed QMHP who meets the co-occurring counselor competency requirements established by the department; or

D. A QAP who meets the co-occurring counselor competency requirements established by the department.

(N) Individual counseling, trauma—individual, face-to-face counseling provided to the individual in accordance with his/her treatment plan to resolve issues related to psychological trauma in the context of a substance use disorder. Personal safety and empowerment of the individual must be addressed.

1. This service must be provided by a—

A. Licensed or provisionally licensed mental health professional; or

B. Professional licensed by the Missouri Division of Professional Registration who is practicing within their current competence.

2. Qualified staff must have specialized training on trauma and trauma-informed care and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.

(O) Medication services—goal-oriented interaction to assess the appropriateness of medications in an individual's treatment, periodic evaluation/reevaluation of the efficacy of prescribed medications, and ongoing management of a medication regimen within the context of the individual's treatment plan.

1. Key service functions include, but are not limited to:

A. Assessment of the individual's presenting condition;

B. Mental status exam;

C. Review of symptoms and screening for medication side effects;

D. Review of functioning;

E. Assessment of the individual's ability to self-administer medications;

F. Education regarding the effects of medication and its relationship to the individual's substance use disorder and/or mental illness; and

G. Prescription of medication(s), when indicated.

2. Services shall be provided by a licensed physician, or licensed psychiatrist, or licensed physician assistant, licensed assistant physician, or APRN who is in a collaborating practice agreement with a licensed physician.

(P) Medication services support—medical and other consultative services for the purpose of monitoring and managing an individual's health needs while taking medications.

1. Services must be provided by a registered nurse (RN) or licensed practical nurse (LPN).

(Q) Peer and family support—coordinated services within the context of a comprehensive, individualized treatment plan that includes specific individualized goals. Services are person-centered and promote the individual's ownership of his/her treatment plan.

1. Services may be provided to the individual's family/natural supports when the services are for the direct benefit of the individual served in accordance with his/her needs and goals identified in the treatment plan and to assist in the individual's recovery.

2. Key service functions include, but are not limited to:

A. Planning in a person-centered manner to promote the development of self-advocacy skills;

B. Empowering the individual to take a proactive role in developing, updating, and implementing his/her person-centered treatment plan;

C. Providing crisis support;

D. Assisting the individual and his/her family and other natural supports in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the treatment plan, so the individual remains in the least restrictive setting, achieves recovery and resiliency goals, self-advocates for quality physical and behavioral health services, and has access to strength-based behavioral health and physical health services in the community;

E. Assisting individuals and their family members/natural supports in identifying strengths and personal/family resources to aid recovery, promote resilience, and recognize their capacity for recovery/resilience;

F. Serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health of a child/youth with a substance use and/or co-occurring disorder; and

G. Providing information and support to the parent(s)/caregiver(s) of a child who has a serious emotional disorder so they have a better understanding of the child's needs, the importance of his/her voice in the development and implementation of the individual treatment plan, the roles of the various service/support providers and the importance of the team approach, and assisting in the exploration of options to be considered as part of treatment.

3. Services shall be provided by a certified peer specialist or family support provider.

(R) Withdrawal management/detoxification, as defined in 9 CSR 30-3.120.

(2) Ratio of Qualified Addiction Professionals. A majority of the program's staff who provide individual and group counseling shall be Qualified Addiction Professionals (QAP).

(3) Supervision of Associate Counselors. If an AAC provides individual or group counseling, he/she shall meet the requirements of the Missouri Credentialing Board or the appropriate board of professional registration within the Department of Commerce and Insurance. All counselor functions performed by an AAC shall be performed pursuant to the supervisor's authority, oversight, guidance, and full professional responsibility.

(A) The supervisor shall review and countersign documentation in individual records made by the AAC.

(B) Documentation which must be countersigned includes the initial treatment plan, treatment plan updates, and discharge summaries.

(C) A training plan must be in place for each AAC and be available for review by department staff or other authorized representatives.

(4) Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a QAP who has—

(A) A degree from an accredited college in an approved field of study; or

(B) Four (4) or more years of employment experience in the treatment and rehabilitation of persons with substance use disorders.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Sept. 25, 2002, effective May 30, 2003. Rescinded and readopted: Filed May 28, 2021, effective Dec. 30, 2021.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.120 Detoxification

PURPOSE: This rule describes the goals, eligibility and discharge criteria, levels of care, and performance indicators for detoxification programs.

(1) Goals. Detoxification is the process of withdrawing a person from alcohol, other drugs or both in a safe, humane, and effective manner. The goals of detoxification services are to help persons become—

(A) Alcohol and drug-free in a safe manner without suffering severe physical consequences of withdrawal. Medical services shall be provided or arranged, when clinically indicated; and

(B) Involved in continuing treatment. Each person shall be oriented to treatment resources and recovery concepts and shall be assisted in making arrangements for continuing treatment.

(2) Screening. Upon initial contact, a person shall be screened by a trained staff member and assigned to a level of care based on the signs and symptoms of intoxication, impairment or withdrawal, as well as factors related to health and safety.

(A) A screening protocol approved by a physician shall be used to evaluate the person's physical and mental condition and to guide the level of care decision. The department may require, at its option, the use of a standardized screening protocol for those services funded by the department or provided through a service network authorized by the department.

(B) The assigned level of care shall have the ability to effectively address the person's physical and mental condition.

(3) Eligibility Criteria. In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for oneself;

(B) Lacks a supportive, safe place to go and demonstrates a likelihood of continued use of alcohol or other drugs if free to do so;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

(4) Certified Levels of Care. A person shall be assigned to one (1) of the following levels of detoxification service in accordance with the screening protocol and admission criteria. An agency may offer and be certified for one (1) or more of the following levels of detoxification service:

(A) Social Setting Detoxification. This level of care is offered by trained staff in a residential setting with services and admission available twenty-four (24) hours per day, seven (7) days per week.

1. Medical personnel are not available on-site to prescribe, dispense or administer medications or to diagnosis and treat health problems.

2. A person, who is admitted to social setting detoxification with medication for an established physical or mental health condition, may continue to self-administer his or her medication;

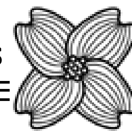
(B) Modified Medical Detoxification. This level of care is offered by medical staff in a non-hospital setting with services and admission available twenty-four (24) hours per day, seven (7) days per week.

1. Routine medical services are provided, and medications are used, when clinically indicated, to alleviate symptoms of intoxication, impairment or withdrawal.

2. A registered or licensed nurse is on duty at all times. Licensed nursing staff receive clinical supervision by a registered nurse.

3. There is on call at all times a physician or an advanced practice nurse licensed and authorized to title and practice as an advanced practice nurse pursuant to section 335.016, RSMo and who is engaged in a written collaborative practice arrangement as defined by law.

(C) Medical Detoxification. This level of care is offered by medical staff in a licensed hospital with services and admission available twenty-four (24) hours per day, seven (7) days per week. Emergency and non-emergency medical services are provided, and medications are used, when clinically indicated, to alleviate symptoms of impairment or withdrawal.



(5) Safety and Supervision. All detoxification services shall be provided in a humane manner and shall ensure the safety and well-being of persons served.

(A) There shall be monitoring and assessment of the person's physical and emotional status during the detoxification process.

1. Vital signs shall be taken on a regular basis, with the frequency determined by client need based on a standardized assessment instrument.

2. Blood alcohol concentration may be monitored upon admission and thereafter as indicated. Further testing of urine or blood may be conducted by qualified personnel.

(B) Staff coverage in residential settings shall ensure the continuous supervision and safety of clients.

1. Two (2) staff members shall be on-site at all times, and additional staff may be required, as warranted by the size of the program and the responsibilities and duties of staff members.

2. Staff providing direct supervision and monitoring of clients shall demonstrate competency in recognizing symptoms of intoxication, impairment and withdrawal; monitoring vital signs; and understanding basic principles and resources for substance abuse treatment.

3. Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

(6) Continuing Treatment. Detoxification services shall actively encourage each person to address substance abuse issues and to make arrangements for continuing treatment. There shall be documentation of services delivered and arrangements for continuing treatment. A comprehensive assessment and master treatment plan are not required during detoxification.

(A) Information and education shall be given to each person regarding substance abuse issues.

(B) Individual and group sessions shall be provided, and each person shall be expected to participate in these sessions, to the extent warranted by their physical and mental status.

(C) Each person shall be encouraged to make plans for continuing treatment.

1. Staff shall assist in making referrals and other arrangements, as needed.

2. Any client refusal of treatment services or referrals shall be documented.

(D) A qualified substance abuse professional shall be available and involved in providing individual and group sessions and making arrangements for continuing treatment.

(7) Discharge Criteria. A person shall be successfully discharged or transferred from the detoxification service when they are physically and mentally able to function without the supervision, monitoring and support of this service.

(8) The program handles applications for civil detention of intoxicated persons in accordance with sections 631.115, 631.120 and 631.125, RSMo 2000 unless a waiver is granted in writing by the department.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.130 Outpatient Treatment

PURPOSE: This rule describes the levels of outpatient care that may be certified and the goals, eligibility criteria, and available services. Discharge criteria and performance indicators for outpatient programs are also identified.

(1) Available Services. An array of services shall be available on an outpatient basis to persons with substance abuse problems and their family members. The program shall provide all services and comply with the functions required under 9 CSR 30-3.110.

(2) Certified Levels of Care. Outpatient services shall be organized and certified according to levels of care. Each of the levels of care shall vary in the intensity and duration of services offered.

(A) The levels of care may include—

1. Community-based primary treatment. This level of care is the most structured, intensive, and short-term service delivery option with services offered on a frequent, almost daily basis;

2. Intensive outpatient rehabilitation. This level of care provides intermediate structure, intensity and duration of treatment and rehabilitation, with services offered on multiple occasions per week;

3. Supported recovery. This level of care provides treatment and rehabilitation on a regularly scheduled basis, with services offered on approximately a weekly basis unless other scheduling is clinically indicated.

(B) All outpatient services and levels of care offered by an organization shall be certified in accordance with this rule. An organization shall be certified as providing one of the following methods of outpatient service delivery:

1. Supported recovery;

2. Intensive outpatient rehabilitation and supported recovery; or

3. Community-based primary treatment, intensive outpatient rehabilitation and supported recovery.

(C) Outpatient services shall be provided in a coordinated manner responsive to each person's needs, progress and outcomes.

1. The organization shall ensure that individuals can access an appropriate level of care.

A. If all three (3) outpatient levels of care are not offered, the organization shall demonstrate that it effectively helps persons to access other levels of care that may be available in the local geographic area, as needed.

B. The organization must demonstrate that it effectively helps persons to access detoxification and residential treatment services, as needed.

2. An organization with multiple service sites shall not be required to offer its certified levels of care at every site, if it can demonstrate that an individual has reasonable access to its levels of care through coordinated service delivery.

3. A light meal shall be served at a site to those individuals who receive services for a period of more than four (4) consecutive hours. Additional meals shall be provided, if warranted by the program's hours of operation.

(3) Individualized Treatment Options. The levels of care shall be used in a manner that provides individualized treatment options and offers service intensity in accordance with the needs, progress and outcomes of each person served.

(A) A person may enter treatment at any level of care in accordance with eligibility criteria.

(B) A person can move from one level of care to another over time in accordance with symptoms, progress, outcomes and other clinical factors.

1. The duration of each level of care shall be time-limited and tailored to the individual's needs.

2. A person may be transferred to a more intensive level of care if there is a continuing inability to make progress toward treatment and rehabilitation goals.

(4) Community-Based Primary Treatment. This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on—

1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and

2. Need for frequent, almost daily services and supervision.

(B) Expected outcomes for primary treatment are to—

1. Interrupt a significant pattern of substance abuse;

2. Achieve a period of abstinence;

3. Enhance motivation for recovery; and

4. Stabilize emotional and behavioral functioning.

(C) The program shall offer an intensive array of services each week.

1. Each person shall participate in at least twenty-five (25) hours of service per week, unless contraindicated by the individual's medical, emotional, legal, and/or family circumstances, and unless residential support is provided.

2. Where residential support is provided, each person shall be offered additional structured therapeutic activities in accordance with residential treatment standards.

3. Each person shall participate in at least one (1) hour per week of individual counseling. Additional individual counseling shall be provided, in accordance with the individual's needs.

4. For community-based primary treatment that is funded by the department or provided through a service network authorized by the department, day treatment may be specified as the applicable service for this level of care.

(5) Intensive Outpatient Rehabilitation. This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on—

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;

2. Absence of crisis that cannot be resolved by community support services;

3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and

4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(B) Expected outcomes for intensive outpatient rehabilitation are to—

1. Establish and/or maintain sobriety;

2. Improve emotional and behavioral functioning; and

3. Develop recovery supports in the family and community.

(C) The program shall offer at least ten (10) hours of service per week.

1. Each person shall be expected to participate in at least ten (10) hours of service per week, unless contraindicated by the individual's medical, emotional, legal, and/or family circumstances.

2. Each person shall participate in at least one (1) hour per week of individual counseling.

(6) Supported Recovery. This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on—

1. Lack of need for structured or intensive treatment;

2. Presence of adequate resources to support oneself in the community;

3. Absence of crisis that cannot be resolved by community support services;

4. Willingness to participate in the program, keep appointments, participate in self-help, etc.;

5. Evidence of a desire to maintain a drug-free lifestyle;

6. Involvement in the community, such as family, church, employer, etc.; and

7. Presence of recovery supports in the family and/or community.

(B) Expected outcomes for supported recovery are to—

1. Maintain sobriety and minimize the risk of relapse;

2. Improve family and social relationships;

3. Promote vocational/educational functioning; and

4. Further develop recovery supports in the community.

(C) The program shall offer at least three (3) hours of service per week. Each person shall be expected to participate in any combination of services determined to be clinically necessary.

(7) Continued Services. The treatment episode or level of care shall be reviewed for the appropriateness of continued services if the person presents repeated relapse incidents, a pattern of noncompliance or poor attendance, threats or aggression toward staff or other clients, or failure to comply with basic program rules.

(8) Discharge Criteria. Each person's length of stay in outpatient services shall be individualized, based on the person's needs and progress in achieving treatment goals.

(A) An individual should be considered for successful completion and discharge from outpatient services upon—

1. Recognizing and understanding his/her substance abuse problem and its impacts;

2. Achieving a continuous period of sobriety;

3. Absence of immediate or recurring crisis that poses a substantial risk of relapse;

4. Stabilizing emotional problems, when applicable (for example, not experiencing serious psychiatric symptoms, taking psychotropic medication as prescribed, etc.);

5. Demonstrating independent living skills;

6. Implementing a relapse prevention plan; and

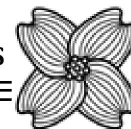
7. Developing family and/or social networks which support recovery and a continuing recovery plan.

(B) A person may be discharged from outpatient services before accomplishing these goals if—

1. Commitment to continuing services is not demonstrated by the client; or

2. No further progress is imminent or likely to occur.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed July 29,*



2002, effective March 30, 2003.

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.132 Opioid Treatment Programs

PURPOSE: This rule describes the specific functions, policies, and practices required for certified opioid treatment programs.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Certification Requirements. Prior to delivering services, the organization must be certified as an opioid treatment program (OTP) by the department.

(A) The program shall comply with applicable federal, state, and local laws and regulations, including those under the jurisdiction of the U.S. Food and Drug Administration (FDA), U.S. Drug Enforcement Administration (DEA), Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (HHS/SAMHSA), and the Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (DHSS/BNDD).

(B) The organization shall comply with 9 CSR 10-5 General Program Procedures, 9 CSR 10-7 Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, and 9 CSR 30-3 Substance Use Disorder Prevention and Treatment Programs, as applicable.

(2) Medication Administration, Dispensing, and Use. OTPs shall only utilize medications approved by the FDA for the treatment of opioid use disorder.

(A) Opioid agonist, partial agonist, and antagonist treatment medications shall be administered and dispensed by a practitioner licensed in Missouri and registered under the appropriate state and federal laws to administer or dispense opioid drugs.

(B) Written policies and procedures shall be maintained to ensure the following dosage form and initial dosing requirements are met:

1. Methadone is prescribed by a qualified prescriber, administered and dispensed only in oral form, and formulated in a manner to reduce its potential for parenteral abuse;

2. For newly admitted individuals, the initial dose of methadone does not exceed thirty (30) milligrams and the total dose for the first day does not exceed forty (40) milligrams, unless the program physician documents in the individual record that forty (40) milligrams did not suppress opioid abstinence symptoms; and

3. Each opioid agonist medication is administered and dispensed in accordance with its approved product labeling. Dosing and administration decisions shall be made by a qualified prescriber familiar with the most up-to-date product labeling. These procedures must ensure any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the individual record.

(C) If a prescription drug monitoring program (PDMP) is available, the program physician and other staff, as permitted, shall register and utilize the PDMP in accordance with federal, state, and local regulations. Policies and procedures shall be maintained regarding use of the PDMP information for diversion control planning.

(D) Individuals admitted to an OTP may be provided with naloxone or, if insured, a prescription for naloxone.

(3) Program Administration. The OTP shall have a program sponsor and a medical director.

(A) The program sponsor shall be responsible for the general establishment, certification, accreditation, and operation of the program, ensuring it is in continuous compliance with all federal, state, and local laws and regulations related to the use of opioid agonist and partial agonist treatment medications in the treatment of opioid use disorder.

(B) The medical director must be a physician licensed in Missouri and is responsible for overseeing all medical services provided by the OTP, performing them directly or by delegating specific responsibilities to an authorized program physician and healthcare professionals functioning under his/her direct supervision. The medical director shall ensure all medical, psychiatric, nursing, pharmacy, toxicology, and other services offered by the OTP are conducted in compliance with federal, state, and local regulations at all times. Other responsibilities of the medical director include, but are not limited to:

1. Ensuring individuals meet admission criteria and receive the required physical examination(s) and laboratory testing;

2. Prescribing methadone and other FDA-approved medications with the individual's input, ensuring the prescribed dosage of medication is appropriate to his/her needs;

3. Reviewing and signing each individual's initial treatment plan and reviewing and updating the plan based on his/her needs; and

4. Coordinating care and consulting with each individual's clinical treatment team on a regular basis.

(4) Service Delivery Requirements. A range of treatment and rehabilitation services shall be provided to address the therapeutic needs of persons served. All medications approved by the FDA for treatment of opioid use disorder shall be available to meet individual needs.

(A) At a minimum, the following services as defined in 9 CSR 30-3.110 or as specified in another regulation, must be available to all individuals based on needs and treatment goals:

1. Communicable disease counseling;
2. Community support;
3. Continuing recovery and discharge planning, as defined in 9 CSR 10-7.030(8);
4. Crisis prevention and intervention;
5. Drug testing;
6. Family conference;
7. Family therapy;
8. Group counseling, including trauma and co-occurring disorders;
9. Group rehabilitative support;
10. Individual counseling, including trauma and co-occurring disorders;
11. Medication services;
12. Medication services support; and
13. Medical evaluations, as specified in this rule.

(B) The services must be available at the OTP's primary location or through a documented collaborative referral

arrangement with another qualified service provider. Services shall be offered at least six (6) days per week. Medical and psychosocial services shall be available during the early morning and/or evening to ensure individuals have access to services.

(C) All medical services shall be offered and occur simultaneously with clinical therapy, education, development of positive social supports, and ongoing treatment and rehabilitation for substance use disorders and related life problems.

(D) OTPs shall directly provide, or make available through referral to adequate and reasonably accessible community resources, other support services including, but not limited to, rehabilitation, education, and employment for individuals who request such services or have been determined by program staff to be in need of these services.

(E) Information and education shall be provided in areas such as community resources, substance use disorders, and behavioral health disorders.

(F) Services may be provided via telehealth to enhance accessibility for individuals served.

(5) Admission Criteria. Individuals shall be admitted to maintenance treatment by qualified staff who use accepted medical criteria, such as those listed in the *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)*, 2013, to determine the person is currently addicted to an opioid drug and he/she became addicted at least one (1) year before admission for treatment. The *DSM-5* is hereby incorporated by reference and made a part of this rule, as published by the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington VA 22209-3901. This rule does not incorporate any subsequent amendments or additions to this publication.

(A) The program physician shall ensure each individual voluntarily chooses maintenance treatment, all relevant facts concerning the use of the opioid drug are clearly and adequately explained to him/her, and each individual provides informed, written consent to treatment.

(B) Documentation in the individual record must indicate clinical signs and symptoms of opioid use disorder.

(C) Decisions regarding the most appropriate medication shall be individualized, based on personal needs and goals, throughout the individual's engagement in treatment.

(D) If clinically appropriate, the program physician may waive the requirement of a one- (1-) year history of addiction for—

1. Women who are pregnant;

2. Individuals released from a correctional facility with a documented history of opioid use disorder, within six (6) months after release; and

3. Individuals who have been previously treated, up to two (2) years after discharge.

(E) Individuals under the age of eighteen (18) are required to have had two (2) documented unsuccessful attempts at short-term medical withdrawal (detoxification) or drug-free treatment within a twelve- (12-) month period to be eligible for methadone maintenance treatment.

1. Individuals under the age of eighteen (18) shall not be admitted to maintenance treatment unless a parent/guardian or responsible adult designated by the relevant state authority consents in writing to such treatment. This requirement is applicable to methadone and does not pertain to buprenorphine.

(6) Admission for Priority Populations. OTPs that have a contract with the department shall ensure priority admission for—

(A) Women who are pregnant and use intravenous drugs;

(B) Women who are pregnant or postpartum, up to one (1) year after delivery;

(C) Individuals who use intravenous drugs;

(D) Women who have children and are at risk of losing custody or are attempting to regain custody;

(E) Individuals who test positive for the human immunodeficiency virus (HIV);

(F) Individuals determined to be high risk and are referred for treatment by Department of Corrections' institutions and the Division of Probation and Parole via the designated referral form and protocol, as well as individuals referred from federal correctional institutions;

(G) Individuals who are applying for or receiving Temporary Assistance for Needy Families (TANF) and are referred for treatment by the Department of Social Services, Family Support Division, via the designated electronic referral process and protocol.

1. Women who are pregnant shall receive immediate admission.

2. High-risk referrals from correctional institutions and probation and parole shall be assessed and admitted within five (5) working days of initial contact or scheduled release date, including weekends and holidays.

3. If the OTP is unable to assess and admit an individual who uses intravenous drugs within forty-eight (48) hours of receiving such a request, interim services shall be available in accordance with department contract requirements;

(H) Interim maintenance treatment, as defined in section (16) of this rule, shall be available for individuals who are eligible for treatment but cannot be immediately admitted to the OTP where services are being sought or through referral arrangements with another OTP; and

(I) Individuals seeking treatment who are participants in the MO HealthNet program and do not meet priority population criteria shall be given an appointment in a timely manner and shall not be placed on a wait list.

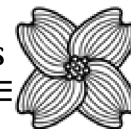
(7) Admission Protocol. Prior to admission, staff shall verify and document the individual seeking services is not currently enrolled in another opioid treatment program utilizing a central registry, if available, or other client enrollment/admission database, such as the department's Customer Information, Management, Outcomes, and Reporting (CIMOR) system, for verification purposes.

(A) An individual currently enrolled in an OTP shall not be permitted to obtain treatment in any other OTP except in exceptional circumstances.

1. If the medical director or program physician of the OTP where the individual is currently enrolled determines exceptional circumstances exist, the individual may be granted permission to seek treatment at another OTP. Justification for the exceptional circumstances must be included in the individual record at both program locations.

(B) Each individual shall undergo a complete and fully documented physical evaluation prior to admission by a program physician, primary care physician, or authorized healthcare professional working under the supervision of a program physician. The full physical examination, including the results of serology and other tests, must be completed within fourteen (14) days following admission.

1. Women should have a pregnancy test as deemed clinically appropriate.



(C) Screening shall determine the risk of undiagnosed conditions such as hepatitis C, HIV, sexually transmitted infections, cardiopulmonary disease, and sleep apnea to determine if further diagnostic testing such as laboratory analysis, a cardiogram, or others are needed.

1. Positive screening results or disease risks should have a care coordination plan that is seen through to completion, regardless of whether this is accomplished via services provided directly by the OTP or through referral to another provider.

(D) A complete medical history, physical examination, and laboratory testing shall not be required for an individual who has had such medical evaluation within the prior thirty (30) days. The program shall have documentation of the medical evaluation and any significant findings in the individual record.

(8) Pregnant and Postpartum Women. Written policies and procedures shall be maintained and implemented to address the needs of women who are pregnant and postpartum. Prenatal care and other gender-specific services for women who are pregnant must be provided by the OTP or by referral to an appropriate healthcare provider.

(A) For pregnant women who are receiving methadone or buprenorphine, the program shall have written policies and procedures in place to ensure—

1. The initial dose of medication for a newly admitted woman who is pregnant, and the subsequent induction and maintenance dosing strategy, reflect the same effective dosing protocols used for all other individuals;

2. The methadone dose is carefully monitored, especially during the third (3rd) trimester when pregnancy induces changes such as the rate at which methadone is metabolized or eliminated from the system, potentially necessitating either an increased or a split dose; and

3. Women who become pregnant during treatment are maintained at their pre-pregnancy dosage, if effective, and are managed with the same dosing principles used with women who are not pregnant.

(B) Women who are pregnant are eligible to receive ongoing maintenance treatment up to one (1) year postpartum, including evaluation of their current dose to determine if an adjustment is needed during the postpartum period. Women shall be offered education about signs and symptoms of oversedation which may occur after delivery.

(C) Medically supervised withdrawal after pregnancy shall occur as clinically indicated and documented, or is requested by the individual.

(D) When a planned discharge occurs, OTP staff shall document the contact information of the physician or other authorized healthcare professional to whom the individual has been referred, including the reason for discharge.

(E) Mothers shall be educated about neonatal abstinence syndrome, its symptoms, potential effects on their infant, and need for treatment if it occurs.

(9) Safety and Health. The program shall implement written policies, procedures, and practices which ensure access to services and address the safety and health of individuals served. The provider shall—

(A) Ensure continued opioid treatment for individuals in the event of an emergency, pandemic, or natural disaster by cooperating with other OTPs, including those in surrounding states, to develop and maintain medication dosing arrangements;

(B) Utilize a central registry, if available, or other client enrollment/admission system such as the department's CIMOR system, to coordinate services;

(C) Ensure treatment to persons regardless of serostatus, HIV-related conditions, tuberculosis (TB), or hepatitis C;

(D) Provide information and education to individuals on prevention and transmission of HIV-related conditions;

(E) Provide or arrange HIV testing and pre- and post-test counseling for individuals;

(F) Provide or arrange testing for TB, hepatitis C, and sexually transmitted infections upon admission and at least annually thereafter;

(G) Provide medical evaluations to individuals upon admission and at least annually thereafter, including cardiac risk assessment;

(H) Utilize infection control procedures in accordance with federal, state, and local regulations; and

(I) Arrange medical care for women during pregnancy, if necessary, and document the arrangements made and action taken by the individual.

(10) Staff Training. All direct service staff and medical staff shall complete four (4) clock hours of training relevant to service delivery in an opioid treatment setting during a two- (2-) year period. This training applies to the required thirty-six (36) clock hours of training during a two- (2-) year period specified in 9 CSR 10-7.110(2)(F)1.

(11) Testing and Screening for Drug Use. The program shall use drug testing as a clinical tool for purposes such as diagnosis and treatment planning.

(A) Each individual shall have an initial toxicology test as part of the admission process. At a minimum, admission samples shall be analyzed for opiates, methadone, marijuana, cocaine, barbiturates, benzodiazepines, buprenorphine, amphetamines, fentanyl, and alcohol.

(B) If there is a history of misuse of prescription opioid analgesics, an expanded toxicology panel that includes these opioids shall be administered. Additional testing shall be based on individual needs and local drug use patterns and trends.

(C) Random drug testing of each individual in maintenance treatment shall be conducted at least eight (8) times during a twelve- (12-) month period.

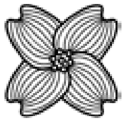
(D) Individuals engaged in long-term detoxification treatment (medical withdrawal) shall receive an initial drug test and a monthly random test.

(E) Individuals engaged in short-term detoxification treatment (medical withdrawal) shall have at least one (1) initial drug test.

(12) Unsupervised Approved Use (Take-Home) of Medication. The medical director shall ensure policies and procedures for approval of take-home methadone do not create barriers to individuals in maintenance treatment. The dispensing restrictions set forth in this section of this rule do not apply to buprenorphine and buprenorphine products.

(A) Any individual in comprehensive maintenance treatment may receive a single take-home dose of methadone for a day the program is closed for business, including Sundays and state and federal holidays.

(B) Decisions on dispensing methadone to individuals for unsupervised use, beyond that set forth in this rule, shall be determined by the medical director. In determining which individuals may be approved for unsupervised use, the medical director shall consider the following:



1. Absence of recent misuse of drugs (opioid or non-narcotic), including alcohol;

2. Regularity of program attendance;

3. Absence of serious behavioral issues at the program;

4. Absence of known recent involvement in the justice system, such as drug dealing;

5. Stability of the individual's home environment and social relationships;

6. Length of time in comprehensive maintenance treatment;

7. Assurance that take-home medication can be safely stored within the individual's home; and

8. Whether the rehabilitative benefit the individual derives from decreasing the frequency of program attendance outweighs the potential risks of diversion.

(C) Determinations for unsupervised use of methadone and the basis for such determinations, consistent with the criteria outlined in paragraphs (12)(B)1. to 8. of this rule, shall be documented in the individual record.

(D) Take-home doses dispensed to individuals beyond that specified in subsection (12)(A) of this rule, shall be subject to the following:

1. During the first ninety (90) days of treatment, the take-home supply is limited to one (1) dose each week and the individual must ingest all other doses under appropriate supervision at the program;

2. In the second ninety (90) days of treatment, the take-home supply is limited to two (2) doses per week;

3. In the third ninety (90) days of treatment, the take-home supply is limited to three (3) doses per week;

4. In the remaining months of the first year of treatment, the individual is limited to a maximum six- (6-) day supply of take-home medication;

5. After one (1) year of continuous treatment, the individual may receive a maximum two- (2-) week supply of take-home medication; and

6. After two (2) years of continuous treatment, the individual may receive a maximum one- (1-) month supply of take-home medication and he/she must make monthly visits to the program.

(E) Individuals in short-term detoxification treatment or interim maintenance treatment shall not receive methadone for unsupervised or take-home use.

(F) OTPs must implement written procedures to identify theft or diversion of take-home medications, including labeling containers with the OTP's name, address, and telephone number. Programs must also ensure take-home supplies are packaged in a manner designed to reduce the risk of accidental ingestion, including use of child-proof containers.

(G) Program staff shall educate individuals about safe transportation and storage of methadone, as well as emergency procedures in case of accidental ingestion.

(H) Individuals approved for take-home doses of methadone must have a lock box for safe transportation and home storage.

(I) OTPs shall implement written policies and procedures that address the responsibilities of individuals who are approved for take-home doses of methadone, including methods to assure appropriate use and storage of the medication.

(J) Staff shall regularly monitor each individual's use of take-home medication to ensure security of the medication and prevent diversion. When determined necessary, the medical director and staff may review an individual's unsupervised use and may deny or rescind take-home privileges. Such action shall be documented in the individual record, including the rationale for denial or rescission of unsupervised use.

(K) The time in treatment requirements outlined in paragraphs (12)(D)1. to 6. of this rule are minimum reference points after which an individual may be considered for take-home medication privileges. The time references do not mean an individual in treatment for a particular time has a specific right for approval of take-home medication.

(L) Any deviation from the regulations for unsupervised use of methadone as specified in this rule requires prior approval from the state opioid treatment authority (SOTA), or his/her designee, and/or SAMHSA.

1. The Exception Request and Record of Justification form SMA-168 must be submitted to the SOTA/designee and/or SAMHSA as specified in section (24) of this rule. Justification for an exception may include, but is not limited to, transportation hardships, employment, vacation, medical or family emergencies, or other unexpected circumstances.

(13) Guest Medication. Individuals who travel, but do not meet the criteria for take-home medication as specified in section (12) of this rule, should be considered for guest medication in accordance with the 2020 *Guidelines for Guest Medications* hereby incorporated by reference and made a part of this rule, as published by the American Association for the Treatment of Opioid Dependence, 225 Varick St., Suite 402, New York, NY 10014, (212) 566-5555. This rule does not incorporate any subsequent amendments or additions to this publication.

(A) Guest medication provides a mechanism for individuals to travel from their home program for business, pleasure, or family emergencies. It also provides an option for individuals who need to travel for a period of time that exceeds the amount of eligible take-home doses to do so within regulatory requirements.

(B) Individuals shall be on a stable dose of methadone and not be scheduled for a dose increase or decrease during guest medication.

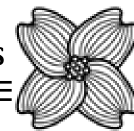
(C) Individuals approved for guest medication must be medically and psychiatrically stable.

(14) Continuity of Care. The program shall implement written policies and procedures to address continuity of care for individuals who are unable to participate in regularly scheduled visits for observed ingestion of medication due to illness, pregnancy, participation in residential treatment, incarceration, lack of transportation, or other situations.

(A) A chain-of-custody process shall be implemented to document the transportation, delivery, administration, and observation of medication when an individual is unable to report to the program as required.

(15) Diversion Control. OTPs shall maintain and implement a written diversion control plan as part of its performance improvement process. The plan shall contain specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use. Medical and administrative staff of the program shall be assigned to implement the diversion control measures and functions described in the diversion control plan.

(16) Interim Maintenance Treatment. The program sponsor of a public or private OTP may place an individual who is eligible for admission to comprehensive maintenance treatment into interim maintenance treatment, if he/she cannot be placed in a public or nonprofit private comprehensive OTP within a reasonable geographic area within fourteen (14) days of the individual's application for admission to comprehensive



maintenance treatment.

(A) An initial and at least two (2) other urine screens shall be taken from an individual engaged in interim treatment during the maximum one hundred twenty (120) days permitted for such treatment.

(B) The OTP shall maintain and implement written policies and procedures for transferring individuals from interim maintenance to comprehensive maintenance treatment.

1. The transfer criteria shall include, at a minimum, a preference for admitting women who are pregnant into interim maintenance treatment and criteria for transferring individuals from interim maintenance to comprehensive maintenance treatment.

(C) Interim maintenance treatment shall be provided in a manner consistent with all applicable federal and state laws, including sections 1923, 1927(a), and 1976 of the Public Health Service Act (21 U.S.C. 300x-23, 300x-27(a), and 300y-11).

(D) The program shall notify the SOTA when an individual begins interim maintenance treatment, when he/she leaves interim maintenance treatment, and before the date of mandatory transfer to comprehensive maintenance treatment, documenting all notifications in the individual record.

(E) SAMHSA may revoke the interim maintenance authorization for a program that fails to comply with the provisions of this section of this rule.

(F) SAMHSA will consider revoking the interim maintenance authorization of a program if the state in which the program operates is not in compliance with the provisions of 42 CFR section 8.11(g).

(G) All requirements for comprehensive maintenance treatment apply to interim maintenance treatment with the following exceptions:

1. The opioid agonist treatment medication is required to be administered daily under observation;

2. Unsupervised (take-home) use is not allowed;

3. An initial treatment plan and periodic treatment plan reviews are not required;

4. A primary counselor is not required to be assigned to the individual;

5. Interim maintenance treatment shall not be provided for longer than one hundred twenty (120) days in any twelve- (12-) month period; and

6. The rehabilitative, educational, and other counseling services specified in section (4) of this rule are not required to be provided to the individual.

(17) Medically Supervised Withdrawal. The program shall maintain and implement written policies and procedures to ensure individuals are admitted to short- or long-term detoxification treatment (as defined in 42 CFR section 8.2.) by qualified staff, such as the program physician, who determines such treatment is appropriate by applying established diagnostic criteria. Medically supervised withdrawal may be voluntary or involuntary, as specified in sections (18) and (20) of this rule.

(A) The individual's treatment plan and continuing recovery plan shall include a strategy to transition to another form of medication, if needed. Review of the risks and benefits of withdrawal from maintenance therapy shall be provided, and informed written consent shall be obtained from individuals who voluntarily choose this treatment option.

(B) Individuals shall be educated about the risks of a recurrence of symptoms and potential for fatal overdose following medically supervised withdrawal, and be offered relapse prevention services that includes counseling, naloxone, and opioid antagonist therapy.

(C) OTPs shall offer a variety of supportive options as part of the transition from opioid agonist therapy, such as increased counseling sessions prior to discharge, and individuals shall be encouraged to attend a twelve- (12-) step or other mutual-help program sensitive to the needs of individuals receiving treatment with medication.

(D) Individuals with two (2) or more unsuccessful detoxification episodes within a twelve- (12-) month period must be assessed by the program physician for other forms of treatment. A program shall not admit an individual for more than two (2) detoxification episodes in one (1) year.

(18) Voluntary Medically Supervised Withdrawal. Voluntary medically supervised withdrawal may be initiated by the person served or the program physician in collaboration with the individual as part of individualized treatment planning.

(A) As deemed clinically appropriate, women shall have a pregnancy test and the results reviewed prior to initiation of medically supervised withdrawal.

(B) For women who are pregnant, the physician shall not initiate withdrawal before fourteen (14) weeks or after thirty-two (32) weeks of pregnancy.

(C) If an individual experiences intolerable withdrawal symptoms or actual or potential return to use, the physician shall consider stopping the withdrawal process and restoring the individual to a previously effective dose. In collaboration with the individual served, the physician shall determine if an additional period of maintenance is necessary before further medically supervised withdrawal is attempted.

(D) Regardless of whether medically supervised withdrawal is conducted with or against medical advice (AMA), careful review of the risks and benefits of withdrawal from maintenance treatment must be provided to the individual and informed written consent obtained from those who choose to initiate medically supervised withdrawal.

(19) Withdrawal Against Medical Advice (AMA). Individuals who request voluntary medically supervised withdrawal from medication treatment AMA of the physician or program staff, may receive it. Individuals have the right to leave treatment when they choose to do so.

(A) The same services that are available to individuals engaged in voluntary medically supervised withdrawal shall be offered to individuals choosing medically supervised withdrawal AMA.

(B) The program must fully document the issue(s) that caused the individual to seek discharge, steps taken to avoid discharge, and the circumstances of readmission, as applicable.

(C) In the case of a woman who is pregnant, the program must keep the physician or agency providing prenatal care informed, consistent with the privacy standards of 42 CFR section 2.

(20) Involuntary Withdrawal from Treatment (Administrative Withdrawal). Individuals shall be retained in treatment for as long as they can benefit from it and express a desire to continue treatment. Administrative withdrawal is typically involuntary and shall be used only when all other therapeutic options have been exhausted by program staff. OTPs may refer or transfer individuals to a suitable alterative treatment program, as clinically indicated.

(A) Missing scheduled appointments and/or continued drug use shall not be the sole reason for initiating involuntary withdrawal for an individual being served.

(B) If involuntary withdrawal is initiated for an individual, the program shall follow the criteria included in the January, 2015 *Federal Guidelines for Opioid Treatment Programs* incorporated by reference and made a part of this rule as published by SAMHSA, Center for Substance Abuse Treatment, 1 Choke Cherry Rd., Rockville, MD 20857, (877) 726-4727, publication number (SMA) PEP15-FEDGUIDEOTP. This rule does not incorporate any subsequent amendments or additions to this publication.

(21) Medication Storage and Security. The program shall ensure the security of its medication supply and shall account for all medications kept on site at all times.

(A) The program shall meet the requirements of the DEA and BNDD.

(B) The program shall maintain an acceptable security system, and the system shall be checked on a quarterly basis to ensure continued safe operation.

(C) The program shall physically separate the narcotic storage and dispensing area from other parts of the facility used by individuals.

(D) The program shall implement written policies and procedures to ensure positive identification of all individuals before any medication is administered. Verification shall include a minimum of two (2) forms of identification.

(E) The program shall implement written policies and procedures for recording each individual's medication intake and maintaining a daily medication inventory.

(22) Medication Units. Certified OTPs may establish medication units that are authorized to dispense opioid agonist treatment medications for observed ingestion. Services provided at the medication unit must comply with 42 CFR section 8.12.

(A) Prior to establishing a medication unit, the OTP must notify and receive prior approval from the SOTA/designee and SAMHSA by submitting form SMA-162. The required documents include, but are not limited to:

1. A description of how the medication unit will receive its medication supply;

2. An affirmative statement that the medication unit is limited to administering and dispensing the narcotic treatment drug and collecting samples for drug testing or analysis;

3. An affirmative statement that the program sponsor agrees to retain responsibility for individual treatment and care;

4. A diagram and description of the facility to be used as a medication unit;

5. Total number of individuals to be served by the primary OTP and medication unit;

6. Total number of individuals that will be served only at the medication unit;

7. A justification for the need to establish a medication unit; and

8. The name and address of any other active medication unit(s) attached to the primary OTP.

(B) A DEA inspection and approval must be obtained prior to opening a medication unit. A medication unit must have a separate and unique DEA registration.

(C) The OTP must comply with the provisions of 21 CFR part 1300 prior to establishing a medication unit.

(D) Medication units are not required to be free-standing entities and may be located at a hospital or community pharmacy, for example.

(E) The certified OTP shall be responsible for all operations of an approved medication unit.

(23) Mobile Units. A mobile unit, for the purpose of dispensing opioid agonist treatment medications to individuals for observed ingestion, may be established if approval is granted by the DEA allowing such units to be considered a coincidental activity of the registered OTP. OTPs shall follow all federal, state, and local regulations regarding the operation of a mobile unit.

(24) Exception Requests and Records of Justification. Any deviation from these regulations requires prior approval from the SOTA/designee and/or SAMHSA. Requests must be submitted on the Exception Request and Record of Justification form (SMA-168), SAMHSA, 5600 Fishers Ln., Rockville, MD 20857, (240) 276-2710.

(A) OTPs shall follow department requirements for submitting form SMA-168 to the SOTA/designee and or/SAMHSA. Failure to submit the completed form and obtain prior approval from the SOTA/designee and/or SAMHSA constitutes a regulatory violation which may jeopardize the OTP's accreditation and certification status.

(B) SAMHSA and the SOTA/designee must be notified of any change to the OTP sponsor or medical director within three (3) weeks of the change by submitting SAMHSA form SMA-162 in accordance with established procedures.

AUTHORITY: sections 630.655 and 631.102, RSMo 2016. This rule originally filed as 9 CSR 30-3.610. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded and readopted: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed July 29, 1997, effective Jan. 30, 1998. Moved to 9 CSR 30-3.132 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed March 8, 2002, effective Sept. 30, 2002. Amended: Filed July 1, 2003, effective Dec. 30, 2003. Emergency amendment filed Nov. 8, 2004, effective Nov. 18, 2004, expired May 16, 2004. Amended: Filed Nov. 8, 2004, effective April 30, 2005. Amended: Filed Feb. 1, 2005, effective July 30, 2005. Rescinded and readopted: Filed May 28, 2021, effective Dec. 30, 2021.*

**Original authority: 630.655, RSMo 1980, and 631.102, RSMo 1997.*

9 CSR 30-3.134 Gambling Disorder Treatment

PURPOSE: This rule describes the specific service delivery requirements for gambling disorder treatment.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

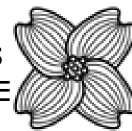
(1) Service Functions. The key functions of gambling disorder treatment and rehabilitation services shall include—

(A) Utilizing evidence-based treatment principles to promote positive changes in gambling behavior and lifestyle;

(B) Exploring the gambling behavior and its impact on self, marriages, partnerships, and families;

(C) Helping the person to better understand his/her needs and how to constructively meet them;

(D) Teaching effective methods to deal with urges to gamble to include use of medication assisted treatment as indicated;



(E) Enhancing motivation and creative problem-solving for the individual and his/her family and other natural supports;

(F) Addressing financial problems incurred as a result of the gambling behavior with appropriate referrals, as needed; and

(G) Determining suicide risk and the presence of co-occurring behavioral health factors to determine the need for ancillary treatment services.

(2) Treatment Goals and Performance Outcomes. Indicators of a positive treatment outcome include the reduction or cessation of gambling behavior, as well as improvements and/or involvement in family and other natural support relationships, leisure and social activities, educational/vocational functioning, legal status, psychological functioning, and financial situation.

(3) Eligibility Criteria. Eligibility for gambling disorder treatment shall be based on criteria for persistent and recurrent problematic gambling behavior as defined in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, 800 Maine Avenue S.W., Suite 900, Washington, DC 20024, www.psychiatry.org and does not include any later amendments or additions. There must be documentation in the individual record of the specific behaviors and circumstances demonstrating how the person meets treatment criteria. The department may require the use of designated instruments for the admission and eligibility determination processes for individuals receiving services funded by the department. The referenced guide does not include any later amendments or additions.

(4) Available Services. Gambling disorder treatment services shall be offered on an individual, family, and group basis in an outpatient setting. Available services include individual counseling, group rehabilitative support and counseling, family therapy, and collateral relationship counseling.

(A) Each individual shall be oriented to and encouraged to participate in mutual support groups, if available.

(B) Family members and other natural supports of persons with a gambling disorder shall be encouraged to participate in treatment. Such participation does not include counseling sessions for family members and other natural supports on an ongoing basis to resolve other personal problems or other behavioral health disorders.

(C) The treatment provider shall arrange other services and make referrals to address other problems the individual or the family may have such as financial problems, substance use, or other behavioral health disorders.

(5) Clinical Review and Data Reporting. Services are subject to clinical review by the department in accordance with 9 CSR 10-7.030. Providers shall comply with data reporting requirements established by the department for individuals whose services are funded by the department.

(6) Certified Gambling Disorder Counselor. A certified gambling disorder counselor demonstrates substantial knowledge and skill in the treatment of individuals with persistent and recurrent problematic gambling behavior by having completed a designated training program sponsored or approved by the Missouri Credentialing Board, and being either—

(A) A counselor, clinical social worker, psychologist, or physician licensed in Missouri by the Division of Professional Registration; or

(B) Possess a qualifying certified level credential as designated by the Missouri Credentialing Board.

(7) Credentialing of Gambling Disorder Counselors. The Missouri Credentialing Board designates the credential of a gambling disorder counselor to individuals who meet the qualifications specified in this rule. This credential is a requirement for providing gambling disorder counseling services eligible for funding by the department.

(A) A person may request an application for the Gambling Disorder Counselor credential from the Missouri Credentialing Board, 428 E. Capitol Avenue, 2nd Floor, Jefferson City, MO 65101, (573) 616-2300, www.missouricb.com.

(B) The credential is issued for a period of time coinciding with the period of licensure or certification otherwise required of the applicant, up to a maximum period of two (2) years.

(C) The credential may be renewed upon further application and verification that the counselor continues to meet all qualifications. For renewal, the applicant must have received during the past two (2) years at least fourteen (14) hours of training sponsored or approved by the Missouri Credentialing Board that is directly related to the treatment of gambling disorders.

(D) Credentialed counselors shall adhere to the code of ethics for their profession in providing services for individuals with gambling disorders.

1. Any complaint or grievance received by the department regarding a counselor providing services to individuals for a gambling disorder shall be forwarded to the applicable licensure or certification body.

2. Any sanction arising from a code of ethics violation shall be deemed as applying equally to the gambling disorder credential.

AUTHORITY: sections 313.842, 630.050, and 630.655, RSMo 2016. This rule originally filed as 9 CSR 30-3.611. Original rule filed Oct. 13, 1995, effective April 30, 1996. Amended: Filed Jan. 10, 1997, effective Aug. 30, 1997. Moved to 9 CSR 30-3.134 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 20, 2018, effective Nov. 30, 2018. Amended: Filed June 29, 2023, effective Jan. 30, 2024.*

**Original authority: 313.842, RSMo 1991, amended 1996, 2000; 630.050, RSMo 1980, amended 1993, 1995, 2008; and 630.655, RSMo 1980.*

9 CSR 30-3.140 Residential Treatment

PURPOSE: This rule describes the goals, eligibility and discharge criteria, available services, and performance indicators for residential treatment.

(1) Treatment Goals. Residential treatment shall offer an intensive set of services in a structured alcohol- and drug-free setting. Services shall be organized and directed toward the primary goals of—

(A) Stabilizing a crisis situation, where applicable;

(B) Interrupting a pattern of extensive or severe substance abuse;

(C) Restoring physical, mental and emotional functioning;

(D) Promoting the individual's recognition of a substance abuse problem and its effects on his/her life;

(E) Developing recovery skills, including an action plan for continuing sobriety and recovery; and

(F) Promoting the individual's support systems and community reintegration.

(2) Eligibility Criteria. In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following—

1. Recent patterns of extensive or severe substance abuse;
2. Inability to establish a period of sobriety without continuous supervision and structure;
3. Presence of significant resistance or denial of an identified substance abuse problem; or
4. Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person—

1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or
2. Presents imminent risk of serious consequences associated with substance abuse.

(3) Safety and Supervision. The residential setting shall ensure the safety and well-being of persons served.

(A) Staff coverage shall ensure the continuous supervision and safety of clients.

1. There shall be an adequate number of paid staff on duty (awake and dressed) at all times. At least two (2) staff shall be on duty, unless otherwise stipulated in these rules or authorized in writing by the department through the exceptions process. Additional staff shall be required, if warranted by the size of the program and the responsibilities and duties of the staff members.
2. Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

(B) The program shall immediately and effectively address any untoward or critical incident including, but not limited to, any incident of alcohol or drug use by a client on its premises.

(4) Intensive Services with Individualized Scheduling. Services shall be responsive to the needs of persons served.

(A) There shall be a current schedule of program activities that offers a minimum of fifty (50) hours of structured, therapeutic activity per week.

1. Therapeutic activities shall be provided seven (7) days per week.
2. Group education and group counseling must constitute at least twenty (20) of the required hours of therapeutic activity per week.

(B) At least one (1) hour of individual counseling per week shall be provided to each client. Additional individual counseling shall be provided, in accordance with the individual's needs.

(5) Discharge Criteria. Each client's length of stay in residential treatment shall be individualized, based on the person's needs and progress in achieving treatment goals.

(A) To qualify for successful completion and discharge from residential treatment, the person should—

1. Demonstrate a recognition and understanding of his/her substance abuse problem and its impacts;
2. Achieve an initial period of sobriety and accept the need for continued care;
3. Develop a plan for continuing sobriety and recovery; and
4. Take initial steps to mobilize supports in the community for continuing recovery.

(B) A person may be discharged before accomplishing these goals if maximum benefit has been achieved and—

1. No further progress is imminent or likely to occur;
2. Clinically appropriate therapeutic efforts have been made by staff; and
3. Commitment to continuing care and recovery is not demonstrated by the client.

(6) The program handles applications for continued civil detention in accordance with sections 631.140, 631.145 and 631.150, RSMo 2000.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed April 15, 2002, effective Nov. 30, 2002.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.150 Comprehensive Substance Treatment and Rehabilitation (CSTAR)

PURPOSE: This rule establishes requirements for service delivery as a Comprehensive Substance Treatment and Rehabilitation (CSTAR) program.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Program Requirements. In order to be certified by the department to provide CSTAR services, the organization must—

(A) Comply with 9 CSR 10-7, 9 CSR 10-5, and 9 CSR 30-3, as applicable;

(B) Be accredited to provide substance use disorder treatment services by Commission on Accreditation of Rehabilitation Facilities (CARF) International, The Joint Commission, Council on Accreditation, or other entity recognized by the department;

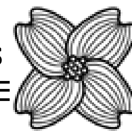
(C) Have the capacity to collect, analyze, and report outcome and other data related to the population served to the department in accordance with established protocol;

(D) Incorporate evidence-based, best, and promising practices into its service array.

1. At a minimum, the organization shall employ or have a formal contract with the following:

A. Licensed and credentialed professionals with expertise and specialized training in the treatment of trauma-related disorders;

B. Licensed and credentialed professionals with



expertise and specialized training in the treatment of co-occurring disorders (substance use and mental illness);

C. Licensed prescribers to provide FDA-approved medications which can be provided in an outpatient setting for the treatment of opioid use and other substance use disorders (methadone must be provided by a certified opioid treatment program). Long-term medications shall be offered and prescribed, as medically appropriate;

D. Certified Peer Specialists who have completed department-approved training and credentialing;

E. Clinical staff who have completed department-approved training on smoking cessation;

F. Clinical staff who have completed department-approved training on suicide prevention; and

(E) Have clinical staff who are trained and qualified to utilize *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 2013, hereby incorporated by reference and made a part of this rule, published by and available from The American Society of Addiction Medicine, 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication.

(2) Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements when the department determines they are applicable:

(A) Services offered on a residential basis shall comply with requirements for residential treatment; and

(B) Requirements as a specialized program for adolescents or as a specialized program for women and children shall be met, where applicable.

(3) Medicaid Eligibility. An organization must be certified as a CSTAR program to qualify for Medicaid reimbursement for delivery of substance use disorder treatment services to eligible persons.

(A) A CSTAR program shall comply with applicable state and federal Medicaid requirements.

(B) If there is a change in the Medicaid eligibility or financial status of a person served, the individual shall not be prematurely discharged from the CSTAR program or otherwise denied CSTAR services. The program shall—

1. Continue to provide all necessary and appropriate services until the individual meets treatment plan goals and criteria for discharge; or

2. Transition the individual to another provider and document in the individual's record there is continuity of clinically appropriate treatment services.

(C) A CSTAR program acknowledges and accepts that not all required services may be reimbursed by Medicaid.

(4) Temporary Waiver. Upon the effective date of this rule, the department will grant a one- (1-) year waiver from the requirements specified in subsections (1)(B) and (1)(E) of this rule to programs that have a current and valid CSTAR contract with the department and continue to meet certification and contract requirements.

(A) Waivers shall be temporary and time limited.

1. The initial waiver period of one (1) year may be renewed or extended by the department annually thereafter.

2. The total period of waiver shall not exceed three (3) years unless otherwise determined by the department.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 25, 2021, effective Sept. 30, 2021. Amended: Filed Aug. 7, 2023, effective Feb. 29, 2024.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.151 Eligibility Determination, Assessment, and Treatment Planning in Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs

PURPOSE: This rule specifies the eligibility determination, assessment, treatment planning, and documentation requirements for Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Consent to Treatment. Each individual served or a parent/guardian must provide informed, written consent to treatment.

(A) A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record.

(B) Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.

(2) Eligibility Determination. Eligibility determination may be completed to expedite the admission process for individuals seeking services. Eligibility determination requires a diagnosis and placement in a level of care.

(A) A diagnosis shall be rendered in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)*, 2022, hereby incorporated by reference and made a part of this rule, published by and available from the American Psychiatric Association, 800 Maine Avenue SW, Suite 900, Washington, DC 20024, (202) 559-3900. This rule does not incorporate any subsequent amendments or additions to this publication.

(B) The following licensed or provisionally licensed mental health professionals (LMHP) are approved to render diagnoses. Professionals possessing the credentials listed below are expected to provide services within their scope of practice in the area(s) in which they are adequately trained and should not practice beyond their individual level of competence:

1. Physician (including psychiatrist);
2. Physician assistant;
3. Assistant physician;
4. Resident physician (including psychiatrist);
5. Advanced practice registered nurse (APRN);
6. Psychologist;
7. Professional counselor;
8. Marital and family therapist; and
9. Licensed clinical social worker.

(C) Individuals shall be placed in a level of care utilizing *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 2013, hereby incorporated

by reference and made a part of this rule, developed by and available from the American Society of Addiction Medicine, Inc., 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication.

(D) Eligibility determination shall be completed by qualified staff as follows:

1. An LMHP conducts a diagnostic assessment, including dated signature; or

2. A qualified addiction professional (QAP) or qualified mental health professional (QMHP) assists in obtaining information from the individual to complete the eligibility determination with finalization by an LMHP for completion of the diagnosis and clinical summary, including dated signature.

(E) Documentation of eligibility determination, with inclusion of *The ASAM Criteria* (abbreviated) as referenced in subsection (2)(C) of this rule, must include the following:

1. Presenting problem and referral source;

2. Brief history of previous substance use disorder/psychiatric treatment, including type of admission;

3. Current medications;

4. Current substance use supporting the diagnosis;

5. Current mental health symptoms;

6. Current medical conditions;

7. Diagnoses, including substance use, mental disorders, medical conditions, and notation for psychosocial and contextual factors;

8. Functional assessment using a department-approved instrument, if required;

9. Identification of urgent needs including suicide risk, personal safety, and risk to others;

10. Initial treatment recommendations;

11. Initial treatment goals to meet immediate needs within the first forty-five (45) days of service; and

12. Dated signature(s), title(s), and credential(s) of staff determining eligibility.

(3) Comprehensive Assessment. A comprehensive assessment shall be completed for each individual as follows:

(A) On the date of admission or within seven (7) days of the date of CSTAR eligibility determination, if completed, for individuals admitted to a residential level of care; or

(B) On the date of admission or within thirty (30) days of the date of CSTAR eligibility determination, if completed, for individuals admitted to an outpatient level of care;

(C) If a diagnosis was rendered through eligibility determination, other trained staff may assist in collecting assessment information from the individual with finalization by a QAP or QMHP, including development of treatment recommendations;

(D) If a diagnosis is rendered during the assessment process, finalization by an LMHP is required for completion of the diagnosis and clinical summary;

(E) *The ASAM Criteria* as referenced in subsection (2)(C) of this rule shall be utilized in completing the comprehensive assessment. Documentation of the comprehensive assessment shall include but is not limited to the following:

1. Basic information (demographics, age, language spoken);

2. Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause them to seek services;

3. Risk assessment for determining emergency, urgent, or routine need for services (suicide, safety, risk to others);

4. Trauma history (experienced and/or witnessed abuse, neglect, violence, sexual assault);

5. Substance use treatment history and current use including alcohol, tobacco, and/or other drugs. For children/youth, prenatal exposure to alcohol, tobacco, or other substances;

6. Mental status;

7. Mental health treatment history;

8. Medication information including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications;

9. Physical health summary (health screen, current primary care, vision and dental, date of last examinations, current medical concerns, body mass index, tobacco use status, and exercise level. Immunizations for children/youth and medical concerns expressed by family members that may impact the child/youth;

10. Assessed needs based on functioning (challenges, problems in daily living, barriers, and obstacles);

11. Risk-taking behaviors, including child/youth risk behavior(s);

12. Living situation including living accommodations (where and with whom), financial situation, guardianship, need for assistive technology, and parental/guardian custodial status for children/youth;

13. Family, including cultural identity, current and past family life experiences. For family functioning/dynamics, relationships, current issues/concerns impacting children/youth;

14. Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech, hearing and language, emotional, behavioral, intellectual functioning, and self-care abilities;

15. Spiritual beliefs/religious orientation;

16. Sexuality, including current sexual activity, safe sex practices, and sexual orientation;

17. Need for and availability of social, community, and natural supports/resources such as friends, pets, meaningful activities, leisure/recreation interests, self-help groups, resources from other agencies, interactions with peers including child/youth and family;

18. Legal involvement history;

19. Legal status such as guardianship, representative payee, conservatorship, and probation/parole;

20. Education, including intellectual functioning, literacy level, learning impairments, attendance, and achievement;

21. Employment, including current work status, work history, interest in working, and work skills;

22. Status as a current or former member of the U.S. Armed Forces;

23. Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders and psychological/social adjustment to disabilities and/or disorders;

24. Diagnosis(es);

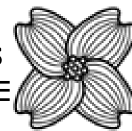
25. Individual's expression of service preferences;

26. Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities, and barriers; and

27. Dated signature(s), title(s), and credential(s) of staff completing the comprehensive assessment; and

(F) The date of the LMHP's signature on the eligibility determination or assessment, if eligibility determination is not completed, is the effective date of program eligibility, and is the date on which billing for CSTAR services may begin.

(4) Assessment Updates. Assessment updates shall be



completed as clinically indicated by the treatment team and as specified in *The ASAM Criteria*, as referenced in subsection (2)(C) of this rule, to facilitate transition between levels and placement in the appropriate level of care.

(A) At a minimum, reassessment in outpatient levels of care shall take place every twelve (12) months.

(B) Documentation for assessment updates shall include—

1. A narrative summary of the individual's risk ratings in each of the six (6) ASAM dimensions;

2. The recommended level of care; and

3. Any recommended changes to the treatment plan based on the reassessment.

(C) Reassessment should not be conducted when an individual is intoxicated or experiencing withdrawal symptoms.

(5) Initial Treatment Plan. A treatment plan shall be developed for each individual admitted to CSTAR within forty-five (45) days of the date of admission with completion of a comprehensive assessment or eligibility determination with requirements met.

(A) The treatment plan shall be developed collaboratively with the individual and/or parent/guardian and members of the treatment team with input from family members/natural supports, as appropriate.

(B) Documentation for completion of the initial treatment plan must include, at a minimum—

1. Identifying information;

2. Goals as expressed by the individual served and family members/natural supports, as appropriate, that are measurable, achievable, time-specific with start date, strength/skill based, and include supports/resources needed to meet goals and potential barriers to achieving goals;

3. Specific treatment objectives, including a start date, that are understandable to the individual served, sufficiently specific to assess progress, responsive to the disability or concern, and reflective of age, development, culture, and ethnicity;

4. Specific interventions and services including action steps, modalities, and services to be utilized, duration and frequency of interventions, who is responsible for the intervention, and action steps of the individual served and family members/natural supports, as appropriate;

5. Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CSTAR program to be addressed through referral/services with another organization;

6. Transfer, treatment, and discharge planning beginning at the point of admission and includes but is not limited to criteria for service conclusion, how the individual served and/or parent/guardian and treatment team will know treatment goals have been accomplished; and

7. Dated signature of the QAP or QMHP completing the plan with finalization by an LMHP. The LMHP's dated signature certifies that treatment is needed and services are appropriate as described in the treatment plan and does not recertify the diagnosis. The individual must also sign the plan unless there is a current signed consent to treatment included in the individual record.

(6) Treatment Plan Updates. Treatment plans shall be updated each time an individual is reassessed as specified in section (4) of this rule. A functional assessment may be utilized as the treatment plan update.

(A) At a minimum, treatment plans shall be reviewed and updated every ninety (90) days to determine the individual's continued need for services and progress achieved during the past ninety (90) days. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

(B) The plan shall be updated collaboratively with the individual and/or parent/guardian and reflect the individual's current strengths, needs, abilities, and preferences in the goals and objectives that have been established or continued based on the review. Updates must be documented in the individual record with one (1) of the following:

1. A progress note which specifies updates made to the treatment plan; or

2. A treatment plan review conducted quarterly; or

3. An updated functional assessment score with a brief narrative.

(C) The dated signature(s), title(s), and credential(s) of staff completing the review must be included on the treatment plan update. The individual served shall also sign the plan unless there is a current signed consent to treatment included in the individual record.

(7) Crisis Prevention Plan. If a potential risk for suicide, violence, risk of relapse, overdose, or other at-risk behavior is identified during the assessment process, or any time during the individual's engagement in services, a crisis prevention plan shall be developed as specified in 9 CSR 10-7.030(3).

(A) Documentation for completion of the crisis prevention plan shall include, at a minimum—

1. Factors that may precipitate a crisis;

2. A hierarchical list of skills/strengths identified by the individual to regain a sense of control to return to their level of functioning before the crisis or emergency; and

3. A hierarchical list of staff interventions that may be used when a critical situation occurs.

(8) Service Transition, Transfer, and Discharge Planning. Transfer, transition, and discharge planning begins at admission. Decisions concerning continued service, transfer, or discharge involve review of the treatment plan and assessment of the individual's progress, with clearly defined and agreed-upon goals and outcomes, rather than the result of a preset program structure.

(9) Data. The CSTAR program shall provide data to the department, upon request, regarding characteristics of individuals served, services, costs, or other information in a format specified by the department.

(10) Availability of Records. All documentation must be made available to department staff and other authorized representatives for review/audit purposes. Documentation must be legible and made contemporaneously with the delivery of the service (at the time the service was provided or within five (5) business days of the time it was provided), and address individual specifics including, at a minimum, individualized statements that support the assessment or treatment encounter.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Aug. 7, 2023, effective Feb. 29, 2024.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.152 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Utilizing the American Society of Addiction Medicine (ASAM) Criteria

PURPOSE: This rule specifies the requirements for Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs providing services in accordance with ***The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions****.*

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) This regulation applies to CSTAR programs that have not been granted a temporary waiver as specified in 9 CSR 30-3.150(4).

(2) Policies and Procedures. In addition to the policies and procedures specified in 9 CSR 10-7.090(4), the organization shall have policies and procedures addressing the following:

(A) Drug screenings in accordance with *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 2013, 3rd Edition, hereby incorporated by reference and made a part of this rule, developed by and available from the American Society of Addiction Medicine, Inc., 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication;

(B) Treatment of co-occurring disorders in accordance with *The ASAM Criteria* (abbreviated) as referenced above; and

(C) Staff training requirements in accordance with 9 CSR 30-3.155.

(3) Performance Improvement. In addition to the performance improvement requirements specified in 9 CSR 10-7.040, the organization shall have a performance improvement plan that addresses the clinical case review process via internal peer review in accordance with *The ASAM Criteria* as referenced in subsection (2)(A) of this rule.

(4) Levels of Care. Certification from the department is available for the following ASAM levels of care:

(A) Outpatient—

1. Level 0.5, early intervention;
2. Level 1, outpatient services; and
3. Level 1 OTP, opioid treatment services; and

(B) Intensive outpatient (team-based services)—

1. Level 1-WM, ambulatory withdrawal management without extended on-site monitoring;
2. Level 2-WM, ambulatory withdrawal management without extended on-site monitoring;
3. Level 2-WM-EM, ambulatory withdrawal management with extended on-site monitoring;
4. Level 2.1, intensive outpatient services; and
5. Level 2.5, partial hospitalization services; and

(C) Residential (team-based services)—

1. Level 3.1, clinically managed low intensity residential services;
2. Level 3.2-WM, clinically managed residential withdrawal management;
3. Level 3.3, clinically managed population-specific high-intensity residential services;
4. Level 3.5, clinically managed high-intensity residential services;
5. Level 3.5, clinically managed high-intensity residential services (women and children);
6. Level 3.5, clinically managed medium-intensity residential services (adolescents);
7. Level 3.7, medically monitored intensive inpatient services; and
8. Level 3.7-WM, medically monitored inpatient withdrawal management.

(5) Telemedicine. Telemedicine is considered a face-to-face service. Services in all levels of care may be provided via telemedicine, including individual services within residential levels of care such as medication services, individual counseling, and medication services support.

(6) Billing Requirements. No more than one (1) per diem treatment rate may be billed per day for team-based services (intensive outpatient and residential levels of care), with the exception of Level 1-WM and Level 2-WM.

(A) The minimum number of hours of services outlined in this rule for specific levels of care must be provided on a daily basis in order for the service provider to bill for a team-based service as supported by *The ASAM Criteria* and individual treatment plans. If a program does not provide the minimum number of hours specified, it is at risk of recoupment of funds by the department or other authorized representative(s).

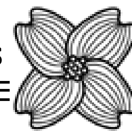
1. Level 1-WM and Level 2-WM may be offered in conjunction with other outpatient levels of care (ASAM Levels 1, 2.1, and 2.5) with the expectation that if additional services are needed, the individual receives them in the appropriate level of care. Providers shall comply with the *ASAM Billing Overlap Guidance,* 2022, hereby incorporated by reference and made a part of this rule, developed by and available from the Department of Mental Health, 1706 E. Elm St., PO Box 687, Jefferson City MO 65101, (573) 751-4942, https://dmh.mo.gov/media/file/asam-billing-overlap-guidance. This rule does not incorporate any subsequent amendments or additions to this publication.

(7) Minimum Staffing Requirements. Providers shall comply with the *The ASAM Minimum Staffing Standards for Department of Mental Health*, 2022, hereby incorporated by reference and made a part of this rule, developed by and available from the Department of Mental Health, 1706 E. Elm St., PO Box 687, Jefferson City MO 65101, (573) 751-4942, https://dmh.mo.gov/media/pdf/dbh-asam-minimum-staffing-requirements. This rule does not incorporate any subsequent amendments or additions to this publication.

(8) Multidimensional Assessment. The ASAM multidimensional assessment shall be utilized as specified in 9 CSR 30-3.151 to assist in determining each individual's placement in a level of care that meets individual service needs.

(A) The six (6) dimensions include—

1. Dimension 1, acute intoxication and/or withdrawal potential—exploring an individual's past and current experiences of substance use and withdrawal;



2. Dimension 2, biomedical conditions/complications—exploring an individual's health history and current physical condition;

3. Dimension 3, emotional, behavioral, or cognitive conditions and complications—exploring an individual's thoughts, emotions, and mental health issues;

4. Dimension 4, readiness to change—exploring an individual's readiness and interest in changing;

5. Dimension 5, relapse, continued use, or continued problem potential—exploring an individual's unique relationship with relapse or continued use or problems; and

6. Dimension 6, recovery/living environment—exploring an individual's recovery or living situation, and the surrounding people, places, and things.

(B) All components of *The ASAM Criteria,* as referenced in subsection (2)(A) of this rule, must be considered when determining level of care placement for individuals served. The levels of care available in the CSTAR program are defined in this rule.

(C) The admission guidelines included in this rule do not constitute a comprehensive list of placement criteria for the levels of care. All dimensional admission criteria specified in *The ASAM Criteria* must be considered when determining level of care placement for individuals served.

(9) Level 0.5 Early Intervention. Services shall be designed to address problems or risk factors related to substance use and to help individuals recognize the harmful consequences of high-risk substance use.

(A) Level 0.5 services include—

1. Individual counseling;
2. Group counseling;
3. Group rehabilitative support;
4. Family therapy;
5. Community support; and
6. Screening, brief intervention, and referral to treatment (SBIRT).

(B) Individuals meeting diagnostic criteria for a substance use disorder shall be referred to ongoing treatment, as appropriate. Referral may also include medical, psychological, or psychiatric services, including assessment and community social services.

(C) Length of service shall vary based on factors such as the individual's ability to comprehend the information provided and use that information to make behavior changes and avoid problems related to substance use, or the appearance of new problems that require treatment at another level of care.

(D) Admission guidelines for Level 0.5—

1. Acute intoxication and/or withdrawal potential—no signs or symptoms of withdrawal, or the individual's withdrawal can be safely managed in an outpatient setting;

2. Biomedical conditions and complications—none or very stable, any biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment;

3. Emotional, behavioral, or cognitive conditions and complications—none or very stable or receiving concurrent mental health monitoring. Adolescents are not at risk of harm and experiencing minimal current difficulties with activities of daily living, but there is significant risk of deterioration;

4. Readiness to change—the individual is open to recovery or willing to explore their substance use disorder and/or mental health condition and is at least contemplating change. The individual may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change;

5. Relapse, continued use, or continued problem potential—the individual is able to achieve or maintain non-use of alcohol and/or other drugs and pursue related recovery or motivational goals with minimal support; and

6. Recovery environment—family and environment can support recovery with limited assistance, or the individual has the skills to cope. Adolescents' risk of initiation of or progression in substance use and/or high-risk behaviors is increased by substance use or values about use. High-risk behaviors of family, peers, or others in the adolescent's social support system.

(10) Level 1 Outpatient Services. Level 1 outpatient services consist of professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized outpatient treatment setting.

(A) Services shall include, but are not limited to—

1. Individual counseling;
2. Group counseling;
3. Family therapy;
4. Peer and family support;
5. Group rehabilitative support;
6. Medication services;
7. Medication services support;
8. Crisis intervention; and
9. Community support.

(B) For individuals with mental health conditions, issues of psychotropic medications, mental health treatment, and their relationship to substance use shall be addressed, as needed.

(C) Services shall vary in level of intensity based on individual needs and shall be fewer than nine (9) contact hours per week for adults age eighteen (18) and older, and fewer than six (6) contact hours per week for adolescents age nine (9) through eighteen (18).

(D) The duration of treatment shall vary based on the severity of the individual's illness and their response to treatment.

(E) Admission guidelines for Level 1—

1. Acute intoxication and/or withdrawal potential—no signs or symptoms of withdrawal, or the individual's withdrawal can be safely managed in an outpatient setting;

2. Biomedical conditions and complications—any biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment;

3. Emotional, behavioral, or cognitive conditions and complications—none or very stable or receiving concurrent mental health monitoring. Adolescents are not at risk of harm and experiencing minimal current difficulties with activities of daily living, but there is significant risk of deterioration;

4. Readiness to change—the individual is open to recovery or willing to explore their substance use disorder and/or mental health condition and is at least contemplating change. The individual may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change;

5. Relapse, continued use, or continued problem potential—the individual is able to achieve or maintain non-use of alcohol and/or other drugs and pursue related recovery or motivational goals with minimal support; and

6. Recovery environment—family and environment can support recovery with limited assistance, or the individual has the skills to cope.

(11) Level 1 Opioid Treatment Program (OTP). Level 1 OTPs provide community-based outpatient treatment for individuals

with a diagnosed opioid use disorder. Medications shall be provided in conjunction with highly structured psychosocial programming that addresses major lifestyle, attitudinal, and behavioral issues that could undermine an individual's recovery-oriented goals.

(A) OTPs shall comply with the federal opioid treatment regulations set forth under 42 CFR 8.12 and 9 CSR 30-3.132.

(B) OTPs shall administer medications approved by the Food and Drug Administration (FDA) to treat opioid use disorder and alleviate the adverse medical, psychological, and physical side effects of opioid dependence.

(C) Interventions shall include, but are not limited to—

1. Nursing assessment at the time of admission which is reviewed by a physician to determine the need for opioid treatment services, eligibility, and appropriate level of care placement for admission and referral;

2. A fully documented physical examination by a program physician or an assistant physician (AP), physician assistant (PA), advanced practice registered nurse (APRN), or resident physician working under the supervision of the program physician. The full medical examination, including the results of serology and other tests, must be completed within fourteen (14) days following admission;

3. A pregnancy test for women, as deemed clinically appropriate; and

4. Referral and assistance, as needed, for the individual to gain access to other needed substance use disorder and/or mental health services.

(D) Admission guidelines for Level 1 OTP—

1. Acute intoxication and/or withdrawal potential—meets diagnostic criteria for an opioid use disorder;

2. Biomedical conditions and complications—meets biomedical criteria for opioid use disorder and may have a concurrent biomedical illness that can be treated on an outpatient basis;

3. Emotional, behavioral, or cognitive conditions and complications—none or stable or receiving concurrent mental health monitoring and/or treatment;

4. Readiness to change—requires a structured therapeutic and pharmacotherapy program to promote treatment progress and recovery;

5. Relapse, continued use, or continued problem potential—high risk of return to use of opioids or continued use without opioid pharmacotherapy, close outpatient monitoring, and structured support; and

6. Recovery environment—sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate primary or social support system, but has demonstrated motivation and willingness to obtain such a support system.

(12) Level 1-WM Ambulatory Withdrawal Management Without Extended On-Site Monitoring. Organized outpatient services shall be delivered by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Services shall be provided in regularly scheduled sessions under a defined set of policies and procedures or medical protocols.

(A) This level of care may be offered in conjunction with ASAM outpatient levels 1, 2.1, and 2.5 with the expectation that if additional services are needed, the individual receives them in the appropriate level of care.

(B) Services shall include, but are not limited to—

1. Assessment;

2. Medication or non-medication methods of withdrawal management;

3. Non-pharmacological clinical support;

4. Involvement of family members/natural supports in the withdrawal management process;

5. Physician and/or nurse monitoring, assessment, and management of signs and symptoms of intoxication and withdrawal; and

6. Referral for counseling and involvement in community recovery support groups and arrangements for counseling, medical, psychiatric, and continuing care.

(C) Individuals shall receive a minimum of thirty (30) minutes of services per day.

(D) Interventions shall include, but are not limited to—

1. A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within twenty-four (24) hours of admission, whichever occurs sooner.

A. A physical examination not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within seventy-two (72) hours, whichever occurs sooner, signifying their review of and concurrence with the findings;

2. Daily assessment of progress during withdrawal management and any treatment changes, or less frequent if the severity of withdrawal is sufficiently mild or stable;

3. Transfer, treatment, and discharge planning, beginning at the point of admission; and

4. Referral and assistance for the individual to gain access to other needed substance use disorder and/or mental health services.

(E) Individuals shall meet the diagnostic criteria for a substance withdrawal disorder and the ASAM dimensional criteria for admission to this level of care.

1. For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

(F) Individuals shall remain in this level of care until—

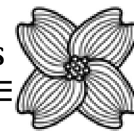
1. Their withdrawal signs and symptoms are sufficiently resolved such that they can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring; or

2. Their signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated; or

3. They are unable to complete withdrawal management at Level 1-WM despite an adequate trial; for example, they are experiencing intense craving and evidence insufficient coping skills to prevent continued use concurrent with the withdrawal management medication, indicating a need for more intensive services.

(13) Level 2-WM Ambulatory Withdrawal Management Without Extended On-Site Monitoring. Organized outpatient services shall be provided by trained clinicians to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate their entry into ongoing treatment and recovery.

(A) This level of care can be offered in conjunction with ASAM outpatient levels 1, 2.1, and 2.5 with the expectation that



if additional services are needed, the individual receives them in the appropriate level of care.

(B) Services shall include, but are not limited to—

1. Assessment;

2. Medication or non-medication methods of withdrawal management;

3. Non-pharmacological clinical support;

4. Involvement of family members/natural supports in the withdrawal management process;

5. Physician and/or nurse monitoring, assessment, and management of signs and symptoms of intoxication and withdrawal; and

6. Referral for counseling and involvement in community recovery support groups and arrangements for counseling, medical, psychiatric, and continuing care.

(C) Individuals shall receive a minimum of one hour and fifteen minutes (1.25 hours) of services per day.

(D) Interventions shall include, but are not limited to—

1. A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within twenty-four (24) hours of admission, whichever occurs sooner.

A. A physical examination not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within seventy-two (72) hours, whichever occurs sooner, signifying their review of and concurrence with the findings;

2. Daily assessment of progress during withdrawal management and any treatment changes;

3. Transfer, treatment, and discharge planning, beginning at the point of admission; and

4. Referral and assistance for the individual to gain access to other needed substance use disorder and/or mental health services.

(E) Individuals shall meet the diagnostic criteria for substance withdrawal disorder and the ASAM dimensional criteria for admission.

1. For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

(F) Individuals shall remain in this level of care until—

1. Their withdrawal signs and symptoms are sufficiently resolved such that they can be safely managed in a less intensive level of care; or

2. Their signs and symptoms of withdrawal have failed to respond to treatment and have intensified (based on a standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated; or

3. They are unable to complete withdrawal management at Level 2-WM despite an adequate trial; for example, they are experiencing intense craving and have insufficient coping skills to prevent continued alcohol or other drug use, indicating a need for more intensive services.

(14) Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring. Organized outpatient services shall be provided by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services. Services shall be designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery.

(A) This level of care can be offered in conjunction with ASAM outpatient levels 1, 2.1, and 2.5 with the expectation that if additional services are needed, the individual receives them in the appropriate level of care.

(B) Services shall include, but are not limited to—

1. Assessment;

2. Medication or non-medication methods of withdrawal management;

3. Non-pharmacological clinical support;

4. Involvement of family members/natural supports in the withdrawal management process; and

5. Physician and/or nurse monitoring, assessment, and management of signs and symptoms of intoxication and withdrawal.

(C) Individuals shall receive a minimum of two (2) hours of services per day.

(D) Services shall include up to twenty-three (23) hours of continuous observation, monitoring, and support in a supervised environment for the individual to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate level of care to continue the recovery process.

(E) Individuals must be discharged within twenty-three (23) hours of admission.

(F) Programs shall operate twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Twenty-four- (24-) hour access to emergency medical consultation services shall be available.

(G) Interventions shall include, but are not limited to—

1. A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within twenty-four (24) hours of admission, whichever occurs sooner.

A. A physical examination not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within seventy-two (72) hours, whichever occurs sooner, signifying their review of and concurrence with the findings;

2. Daily assessment of progress during withdrawal management and any treatment changes;

3. Transfer, continuing recovery, and discharge planning beginning at the point of admission;

4. Conduct or arrange for appropriate laboratory and toxicology tests which can be point-of-care testing, as medically necessary; and

5. Referral and assistance for the individual to gain access to other needed substance use disorder and/or mental health services.

(H) Individuals shall meet the diagnostic criteria for substance withdrawal disorder and the ASAM dimensional criteria for admission.

1. For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

(I) Individuals shall remain in this level of care until—

1. Their withdrawal signs and symptoms are sufficiently resolved such that the individual can be safely managed in a less intensive level of care; or

2. Their signs and symptoms of withdrawal have failed to respond to treatment and have intensified (based on a

standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated; or

3. They are unable to complete withdrawal management at Level 2-WM despite an adequate trial; for example, they are experiencing intense craving and have insufficient coping skills to prevent continued alcohol or other drug use, indicating a need for more intensive services.

(15) Level 2.1 Intensive Outpatient Treatment. This level of care shall include professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting.

(A) Services shall include, but are not limited to—

1. Psychiatric, medical, and laboratory services, as needed;

2. Comprehensive bio-psychosocial assessments and individualized treatment, allowing for a valid assessment of dependency;

3. Frequent monitoring/management of the individual's medical and emotional concerns in order to avoid hospitalization;

4. Individual counseling, group counseling, family therapy, peer and family support, crisis intervention, and community support; and

5. Monitoring of substance use, medication services, medication services support, medical and psychiatric examinations, crisis intervention, and orientation and referral to community-based support groups.

(B) Timely access to additional support systems and services including medical, psychological, and toxicology shall be available through consultation or referral.

(C) Services shall vary in level of intensity and shall include nine (9) or more contact hours per week for adults, age eighteen (18) years and older, not to exceed nineteen (19) hours per week. Services for adolescents age nine (9) through seventeen (17) shall include six (6) or more contact hours per week, not to exceed nineteen (19) hours per week. The week starts on the individual's date of admission.

1. The duration of treatment shall vary based on the severity of the individual's illness and their response to treatment.

2. Individuals shall receive a minimum of one hour and thirty minutes (1.5) hours of services per day.

(D) Interventions shall include, but are not limited to—

1. Monitoring, including biomarkers and/or toxicology testing, as medically necessary;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan; and

3. Documented referral to more or less intensive services.

(E) Individuals shall meet diagnostic criteria for a substance use disorder and the ASAM dimensional criteria for admission. If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian, or natural supports. Additional admission guidelines include—

1. Acute intoxication and/or withdrawal potential—no signs or symptoms of withdrawal, or the individual's withdrawal needs can be safely managed in an intensive outpatient setting. The adolescent who is appropriately placed in this level of care is likely to attend, engage, and participate in treatment as evidenced by being able to tolerate mild subacute withdrawal symptoms, has made a commitment to sustain treatment and follow treatment recommendations, and has external supports to promote engagement in treatment;

2. Biomedical conditions and complications—none or sufficiently stable to permit participation in outpatient treatment;

3. Emotional, behavioral, or cognitive conditions and complications—none to moderate. If present, the individual must receive appropriate co-occurring disorder services depending on their level of function, stability, and degree of impairment in this dimension;

4. Readiness to change—requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care were unsuccessful. Adolescents admitted to this level of care may be only passively involved in treatment or demonstrate variable adherence with attendance at outpatient treatment sessions or self-help groups;

5. Relapse, continued use, or continued problem potential—experiencing an intensification of symptoms of the substance-related disorder and level of functioning is deteriorating despite modification of the treatment plan. Alternatively, there is a high likelihood of relapse, continued use, or continued problems without close monitoring and support several times a week as indicated by the individual's lack of awareness of relapse triggers, difficulty in coping or in postponing immediate gratification, or ambivalence toward treatment; and

6. Recovery environment–insufficiently supportive environment and the individual lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment. Alternatively, the individual lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs.

(16) Level 2.5 Partial Hospitalization Services. A planned format of services shall be delivered on an individual and group basis to meet individual needs.

(A) Services shall include, but are not limited to—

1. Psychiatric, medical, and laboratory services, as needed;

2. Comprehensive bio-psychosocial assessments and individualized treatment, allowing for a valid assessment of dependency;

3. Frequent monitoring/management of the individual's medical and emotional concerns in order to avoid hospitalization;

4. Individual counseling, group counseling, family therapy, peer and family support, crisis intervention, and community support; and

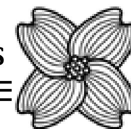
5. Monitoring of substance use, medication services, medication services support, medical and psychiatric examinations, crisis intervention, and orientation to community-based support groups.

(B) A minimum of twenty (20) hours of clinically intensive programming shall be provided per week, based on individual treatment plans. The week starts on the individual's date of admission.

1. Individuals shall receive a minimum of two hours and twenty-four minutes (2.4 hours) of services per day.

(C) Interventions shall include, but are not limited to—

1. A physical examination based on the individual's medical condition. Such determinations are made according to established program protocols which include reliance on the individual's personal healthcare provider, when possible. Examinations are based on the staff's capabilities and the



severity of the individual's symptoms, and are approved by a physician; and

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan.

(D) Individuals must meet diagnostic criteria for a substance use disorder as well as the ASAM dimensional criteria for admission. If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian, or natural supports. Additional admission guidelines include –

1. Acute intoxication and/or withdrawal potential – no signs or symptoms of withdrawal, or the individual's withdrawal needs can be safely managed in a partial hospital setting;

2. Biomedical conditions and complications – none or not sufficient to interfere with treatment but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management;

3. Emotional, behavioral, or cognitive conditions and complications – none to moderate. If present, the individual must receive appropriate co-occurring disorder services depending on the their level of function, stability, and degree of impairment in this dimension;

4. Readiness to change – the individual requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level were unsuccessful;

5. Relapse, continued use, or continued problem potential – the individual is experiencing an intensification of symptoms related to their substance use disorder and their level of functioning is deteriorating despite modification of the treatment plan and active participation in a Level 1 or Level 2.1 program; and

6. Recovery environment – insufficiently supportive environment and the individual lacks the resources or skills necessary to maintain an adequate level of functioning without services in a partial hospitalization program. Alternatively, family members and/or other natural supports who live with the individual are not supportive of their recovery goals or are passively opposed to their treatment.

(17) Level 3.1 Clinically Managed Low-Intensity Residential Services. Programs shall provide a structured recovery environment which allows sufficient stability to prevent or minimize relapse or continued use and continued problem potential for individuals served.

(A) Treatment services are focused on improving the individual's readiness to change and/or functioning and coping skills. Services shall include, but are not limited to –

1. Individual counseling;
2. Group counseling;
3. Group rehabilitative support;
4. Family therapy;
5. Medication services;
6. Medication services support; and
7. Community support.

(B) Individuals shall participate in at least five (5) hours of services per week. The week starts on the individual's date of admission. Mutual/self-help meetings shall not be included in the five (5) hours of treatment per week.

1. The target length of stay is one (1) to three (3) months, based on individual needs.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(D) Interventions shall include, but are not limited to –

1. Tuberculosis screening and testing, provided directly or by referral. Pre- and post-test counseling shall be provided, as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Documented physical examination one (1) month prior to admission or a physical examination completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination;

4. Referral and assistance, as needed, for the individual to gain access to other needed substance use disorder or mental health services;

5. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders, as appropriate and for the continuation of appropriate treatment; and

6. Specific and documented plans for community reintegration and transition to less intensive levels of residential and treatment support, including the aftercare to which the individual is being discharged.

(E) Individuals must meet diagnostic criteria for a substance use disorder as well as the ASAM dimensional criteria for admission. If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian, or natural supports. Additional admission guidelines include –

1. Acute intoxication and/or withdrawal potential – none, or minimal/stable withdrawal risk and can be safely managed in this level of care. The adolescent's status in this dimension is characterized by problems with intoxication or withdrawal (if any) that are being managed through concurrent placement at another level of care for withdrawal management (typically Level 1, 2.1, or 2.5);

2. Biomedical conditions and complications – biomedical problems, if any, are stable and do not require medical or nurse monitoring and the individual is capable of self-administering any prescribed medications. The adolescent's status in this dimension is characterized by a biomedical condition that distracts from recovery efforts and requires limited residential supervision to ensure adequate treatment and provide support to overcome the distraction, or continued substance use would place them at risk of serious damage to their physical health;

3. Emotional, behavioral, or cognitive conditions and complications – minimal problems in this area. The individual's mental status is assessed as sufficiently stable to allow them to participate in therapeutic interventions provided at this level of care and to benefit from treatment. The adolescent's status in this dimension is characterized by at least one (1) of the following:

A. Risk of dangerous consequences because of the lack of a stable environment;

B. Emotional, behavioral, or cognitive problems result in moderate impairment in social functioning;

C. Moderate impairment in their ability to manage the activities of daily living;

D. History and present situation suggests an emotional,

behavioral, or cognitive condition would become unstable without twenty-four (24) hours supervision; or

E. Emotional, behavioral, or cognitive condition suggests the need for low-intensity and/or longer term reinforcement and practice of recovery skills in a controlled environment;

4. Readiness to change — open to recovery, but in need of a structured, therapeutic environment to promote treatment progress and recovery due to impaired ability to make behavior changes without the support of a structured environment;

5. Relapse, continued use, or continued problem potential — understands the risk of relapse, but lacks relapse prevention skills or requires a structured environment to continue to apply recovery and coping skills. The adolescent is at high risk of substance use or deteriorated mental functioning with dangerous emotional, behavioral, or cognitive consequences in the absence of twenty-four- (24-) hour structured support; and

6. Recovery environment — able to cope for limited periods of time outside of the twenty-four- (24-) hour structure, but the environment jeopardizes recovery. The adolescent's home environment is too chaotic or ineffective to support or sustain treatment goals such that recovery is assessed as unachievable without residential support.

(18) Level 3.2 Clinically Managed Residential Withdrawal Management. Services shall be provided in an organized, residential, non-medical setting and be delivered by appropriately trained staff who provide safe, twenty-four- (24-) hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal.

(A) Programs may be staffed to supervise self-administered medications for management of withdrawal symptoms. All programs shall have established clinical protocols to identify individuals in need of medical services beyond the program's capacity and to arrange for transfer to an appropriate healthcare facility.

(B) Services shall include, but are not limited to —

1. Individual counseling;
2. Group counseling;
3. Group rehabilitation support;
4. Peer and family support;
5. Community support; and
6. Medical and medication services support.

(C) Target length of stay is one (1) to three (3) days.

(D) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(E) Interventions shall include, but are not limited to —

1. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual's treatment plan;

2. A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within twenty-four (24) hours of admission, whichever occurs sooner.

A. A physical examination that is not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within seventy-two (72) hours, whichever occurs sooner, signifying their review of and concurrence with the findings;

3. A comprehensive nursing assessment at admission which includes a substance use history and assessment recommendations that are reviewed with a physician; and

4. Documented referral and assistance for the individual to gain access to other needed substance use disorder and/or mental health services.

(F) Individuals admitted to this level of care are experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition and/or emotional, behavioral, or cognitive conditions) that withdrawal is imminent. The individual is assessed as not being at risk of severe withdrawal and moderate withdrawal is safely manageable at this level of service.

1. In addition, the individual may be assessed as not requiring medication to assist in managing withdrawal symptoms, but requires this level of service to complete withdrawal management and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting one (1) of the following criteria:

A. The individual's recovery environment is not supportive of withdrawal management and entry into treatment, and they do not have sufficient coping skills to safely manage issues in the recovery environment; or

B. The individual has a recent history of withdrawal management at less intensive levels of service that is marked by inability to complete withdrawal management or to enter into continuing substance use disorder treatment, and continues to have insufficient skills to complete withdrawal management; or

C. The individual recently demonstrated an inability to complete withdrawal management at a less intensive level of service, as evidenced by continued use of non-prescribed drugs or other substances.

(19) Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services (Adult Criteria). Programs shall provide a structured recovery environment in combination with high-intensity clinical services to meet the individual's functional limitations and to support recovery from substance-related disorders.

(A) Length of stay is based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive a minimum of twenty (20) hours of services per week. The week starts on the individual's date of admission.

1. At least ten (10) of the twenty (20) hours of services shall include a combination of individual counseling, group counseling, group rehabilitative support, family therapy, peer and family support, community support, medication services, and medication services support.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

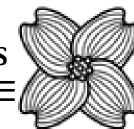
(D) Interventions shall include, but are not limited to —

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling shall be provided, as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual's treatment plan;

3. Comprehensive nursing assessment completed within seventy-two (72) hours of admission, with consultation with a physician when necessary;

4. A documented physical examination one (1) month prior to admission or a physical examination completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination;



5. Referral and assistance, as needed, for the individual to gain access to other needed substance use disorder and/or mental health services; and

6. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders as appropriate and for the continuation of appropriate treatment.

(E) Individuals admitted to this level of care must meet diagnostic criteria for a moderate or severe substance use disorder as well as the ASAM dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties such as family members/natural supports and legal guardians. Additional guidelines include—

1. Acute intoxication and/or withdrawal potential—none, or minimal risk of withdrawal, or withdrawal needs can be safely managed at this level;

2. Biomedical conditions and complications—none or stable. Any biomedical problems do not require medical or nurse monitoring and the individual is capable of self-administering any prescribed medications;

3. Emotional, behavioral, or cognitive conditions and complications—the individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment;

4. Readiness to change—because of the intensity and chronicity of the substance use disorder or the individual's cognitive limitations, they have little awareness of the need for continuing care or the existence of their substance use or mental health problem and need for treatment and, therefore, has limited readiness to change;

5. Relapse, continued use, or continued problem potential—the individual has limited awareness of relapse triggers and is in imminent danger of relapse or continued substance use. The individual requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively within a twenty-four (24) hour structured environment; and

6. Recovery environment—the environment interferes with recovery and is characterized by moderately high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance use is so prevalent the individual is unable to cope outside of a twenty-four- (24-) hour supervised setting.

(20) Level 3.5 Clinically Managed High-Intensity Residential Services (Adult Criteria). Programs shall be designed to serve individuals who, because of specific functional limitations, need a safe and stable environment in order to develop and/or demonstrate sufficient recovery skills so they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. Individual needs are of such severity that treatment cannot be safely provided in a less intensive level of care.

(A) Length of stay is based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive at least a twenty- (20-) hour combination of clinical and recovery services per week. The week starts on the individual's date of admission.

1. At least ten (10) of the twenty (20) hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services, and/or medication services support.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(D) Interventions shall include, but are not limited to—

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Comprehensive nursing assessment completed within seventy-two (72) hours of admission, with consultation with a physician when necessary;

4. A documented physical examination one (1) month prior to admission or a physical examination completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination;

5. Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable;

6. Referral and assistance as needed for the individual to gain access to other needed substance use disorder and/or mental health services;

7. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders as appropriate and for the continuation of appropriate treatment; and

8. Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged.

(E) Individuals admitted to this level of care must meet diagnostic criteria for a substance use disorder of moderate to high severity, as well as the ASAM dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties such as family members/natural supports, and legal guardians. Other admission guidelines include—

1. Acute intoxication and/or withdrawal potential—none, or withdrawal symptoms can be safely managed at this level;

2. Biomedical conditions and complications—none or stable and the individual can self-administer any prescribed medication or, if their condition is severe enough to distract from treatment and recovery, the individual can receive medical monitoring within the program or through another provider;

3. Emotional, behavioral, or cognitive conditions and complications—the individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment. Despite the individual's best efforts, they are unable to control their use of alcohol and/or other drugs, and their level of dysfunction is so severe they would not be successful in a less structured level of care;

4. Readiness to change—the individual has marked difficulty with or opposition to treatment, with dangerous consequences, and has limited insight and awareness of the need for continuing care or the existence of their substance use or mental health problem and need for treatment, thereby has

limited readiness to change;

5. Relapse, continued use, or continued problem potential — the individual is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued use, with limited ability to initiate or sustain ongoing recovery in a less structured environment; and

6. Recovery environment — the individual lives in an environment with moderately high risk of neglect, initiation, or repetition of physical, sexual, or emotional abuse, or is in a culture highly invested in substance use. The individual lacks skills to cope with challenges to recovery outside of a highly structured twenty-four- (24-) hour setting.

(21) Level 3.5, Clinically Managed Medium Intensity Residential Services (Adolescent Criteria). This is a residential program offering a twenty-four- (24-) hour supportive treatment environment. Adolescents placed in this level of care typically have impaired functioning across a broad range of psychosocial domains. These impairments may be expressed as disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situations, developmental immaturity, and psychological problems.

(A) Length of stay shall be based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive at least a twenty- (20-) hour combination of clinical and recovery services per week. The week starts on the individual's date of admission.

1. At least ten (10) of the twenty (20) hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, medication services, and/or medication services support.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(D) Interventions shall include, but are not limited to —

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Comprehensive nursing assessment completed within seventy-two (72) hours of admission, with consultation with a physician when necessary;

4. A documented physical examination one (1) month prior to admission or a physical examination completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination;

5. Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable;

6. Referral and assistance, as needed, for the individual to gain access to other needed medical, substance use disorder, and/or mental health services;

7. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders as appropriate and for the continuation of appropriate treatment;

8. Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged; and

9. Educational services provided in accordance with state regulations, including opportunities to address deficits in the education level of adolescents who have fallen behind because of their involvement with alcohol and/or other drugs.

(E) Adolescents admitted to this level of care must meet diagnostic criteria for a substance use disorder of moderate to high severity, as well as the ASAM dimensional criteria for admission. If the adolescent's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by family members/natural supports and legal guardians. Additional admission guidelines include —

1. Acute intoxication and/or withdrawal potential — at risk of or experiencing acute or subacute intoxication or withdrawal, with mild to moderate symptoms. Needs secure placement and increased treatment intensity to support engagement in treatment, ability to tolerate withdrawal, and prevention of immediate continued use. Alternatively, the adolescent has a history of unsuccessful treatment at the same or a less intensive level of care;

2. Biomedical conditions and complications — biomedical conditions distract from recovery efforts and require residential supervision (that is unavailable in a less intensive level of care) to ensure adequate treatment, or the adolescent requires medium-intensity residential treatment to provide support to overcome the distraction. Continued substance use would place the adolescent at risk of serious damage to their physical health because of a biomedical condition (such as pregnancy or HIV) or an imminently dangerous pattern of high-risk use;

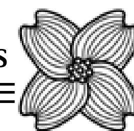
3. Emotional, behavioral, or cognitive conditions and complications — the adolescent is at moderate but stable risk of imminent harm to self or others and needs medium intensity, twenty-four- (24-) hour monitoring and/or treatment for protection and safety, however, does not require access to medical or nursing services. Their recovery efforts are negatively impacted by their emotional, behavioral, or cognitive problems in significant and distracting ways;

4. Readiness to change — because of the intensity and chronicity of their substance use disorder and/or mental health problems, the adolescent has limited insight into and little awareness of the need for continuing care or the existence of their substance use disorder or mental health issues and has limited readiness to change. The individual has marked difficulty in understanding the relationship between their substance use disorder, mental health, or life problems and their impaired coping skills and level of functioning, often blaming others for their problems;

5. Relapse, continued use, or continued problem potential — the adolescent does not recognize relapse triggers and lacks insight into the benefits of continuing care, and is therefore, not committed to treatment. Their continued use of substances poses an imminent danger of harm to self or others in the absence of twenty-four- (24-) hour monitoring and structured support; and

6. Recovery environment — living and social environments have a high risk of neglect or initiation or repetition of physical, sexual, or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential treatment.

(22) Level 3.5 Clinically Managed High-Intensity Residential Services (Women and Children). Programs shall provide a twenty-four- (24-) hour supportive treatment environment



specializing in services for women who are pregnant, postpartum, and/or have children. Programs shall arrange for gender-specific substance use disorder treatment and other therapeutic interventions for women and comply with child supervision and other requirements specified in 9 CSR 30-3.190.

(A) Length of stay shall be based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive at least a twenty- (20-) hour combination of clinical and recovery services per week. The week starts on the individual's date of admission.

1. At least ten (10) of the twenty (20) hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, crisis intervention, community support, medication services, and/or medication services support.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(D) Interventions shall include, but are not limited to—

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling shall be provided, as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Comprehensive nursing assessment completed within seventy-two (72) hours of admission, with consultation with a physician when necessary;

4. A documented physical examination one (1) month prior to admission or a physical examination completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination;

5. Children accompanying their mother to services shall receive a screening by a qualified mental health professional (QMHP) or qualified addiction professional (QAP) to determine the appropriateness and need for services.

A. If services are determined to be a need for the child(ren), a licensed diagnostician shall complete an assessment with diagnosis;

6. Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable;

7. Referral and assistance as needed for the individual to gain access to other needed substance use disorder and/or mental health services;

8. Orientation to and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders as appropriate and for the continuation of appropriate treatment;

9. Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged.

(E) Individuals who are admitted to this level of care must meet diagnostic criteria for a substance use disorder of moderate to high severity, as well as the ASAM dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties such as family members, legal guardians, and significant others.

(F) Priority shall be given to women who are pregnant, postpartum, or have children in their physical care and custody. Additional admission guidelines include—

1. Acute intoxication and/or withdrawal potential—none, or withdrawal symptoms can be safely managed at this level;

2. Biomedical conditions and complications—none or stable and the individual can self-administer any prescribed medication, or if the condition is severe enough to distract from treatment and recovery, the individual can receive medical monitoring within the program or through another provider;

3. Emotional, behavioral, or cognitive conditions and complications—mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment;

4. Readiness to change—significant difficulty with treatment, with negative consequences, and may have significant limitations in the areas of readiness to change. Recovery may be perceived as providing a lesser return for the effort;

5. Relapse, continued use, or continued problem potential—needs skills to prevent continued use and may have relapse, continued use, or continued problem potential; and

6. Recovery environment—the individual lives in an environment with moderately high risk of neglect, initiation or repetition of physical, sexual, or emotional abuse, or is in a culture highly invested in substance use. The individual lacks skills to cope with challenges to recovery outside of a highly structured twenty-four- (24-) hour setting. These social influences may represent a sense of hopelessness or an acceptance of deviance as normative.

(23) Level 3.7 Medically Monitored Intensive Inpatient Services (Adult Criteria). Programs shall provide a planned and structured regimen of twenty-four- (24-) hour professionally directed evaluation, observation, medical monitoring, and substance use disorder treatment in a residential setting. Individuals in this level of care may have co-occurring substance use and mental health disorders that need to be stabilized. The target population includes individuals with a high risk of withdrawal symptoms and moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require twenty-four- (24-) hour treatment.

(A) Length of stay shall be based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive thirty (30) hours of structured treatment per week. The week starts on the individual's date of admission.

1. At least ten (10) of the thirty (30) hours shall include a combination of individual counseling, group counseling, group rehabilitative support, family therapy, peer and family support, crisis intervention, community support, medication services, and/or medication services support.

(C) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(D) Interventions shall include, but are not limited to—

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Nursing assessment at time of admission by an RN (or APRN, physician, resident physician, assistant physician, physician assistant in the absence of an RN);

4. A physician or AP, PA, APRN, or resident physician assesses the individual within twenty-four (24) hours of admission or, within twenty-four (24) hours of admission, a physician reviews and updates the record of a physical examination that was conducted no more than seven (7) days prior to admission. A physician must be available to assess the individual thereafter, as medically necessary;

5. Additional medical specialty consultation, psychological, laboratory, and toxicology services are available onsite, through consultation, or referral;

6. Referral and assistance, as needed, for the individual to gain access to other needed substance use disorder and/or mental health services; and

7. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.

(E) Individuals admitted to this level of care must meet diagnostic criteria for a moderate or severe substance use disorder, as well as the ASAM dimensional criteria for admission. If the individual's presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by family members/natural supports and legal guardians. Additional admission criteria includes –

1. Acute intoxication and/or withdrawal potential – high risk of withdrawal symptoms that can be managed in a Level 3.7 program;

2. Biomedical conditions and complications – moderate to severe conditions which require twenty-four- (24-) hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital;

3. Emotional, behavioral, or cognitive conditions and complications – moderate to severe conditions and complications (such as diagnosable co-morbid mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others. Psychiatric symptoms are interfering with abstinence, recovery, and stability to such a degree that the individual needs a structured twenty-four- (24-) hour, medically monitored (but not medically managed) environment to address recovery efforts;

4. Readiness to change – the individual is unable to acknowledge the relationship between the substance use disorder and mental health and/or medical issues, or is in need of intensive motivating strategies, activities, and processes available only in a twenty-four- (24-) hour structured medically monitored setting (but not medically managed);

5. Relapse, continued use, or continued problem potential – the individual is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of twenty-four- (24-) hour monitoring and structured support; and

6. Recovery environment – the environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so prevalent that the individual is assessed as unable to achieve or maintain recovery at a less intensive level of care.

(24) Level 3.7 Medically Monitored Intensive Inpatient Services (Adolescent Criteria). Programs shall provide a planned and structured regimen of twenty-four- (24-) hour professionally directed evaluation, observation, medical monitoring, and substance use disorder treatment. For adolescents, this level of treatment is often necessary to orient the individual to the structure of daily life. Services must be provided in accordance with 9 CSR 30-3.192.

(A) Length of stay shall be based on the individual's severity of illness, level of function, and progress in treatment.

(B) Individuals shall receive at least thirty (30) hours of structured treatment per week. The week starts on the individual's date of admission.

1. At least ten (10) of the thirty (30) hours shall include a combination of individual counseling, group counseling, group rehabilitative support, family therapy, peer and family support, community support, medication services, and/or medication services support.

(C) Elements of the assessment and treatment plan review in this level of care for adolescents shall include –

1. An initial withdrawal assessment within twenty-four (24) hours of admission, or earlier if clinically warranted;

2. Daily nursing withdrawal monitoring assessments and continuous availability of nursing evaluation; and

3. Daily availability of medical evaluation, with continuous on-call coverage.

(D) Programs shall be staffed twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

(E) Interventions shall include, but are not limited to –

1. Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed;

2. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

3. Nursing assessment at the time of admission by an RN (or APRN, physician, resident physician, assistant physician, physician assistant in the absence of an RN);

4. A physician or AP, PA, APRN, or resident physician assesses the individual within twenty-four (24) hours of admission or, within twenty-four (24) hours of admission, a physician reviews and updates the record of a physical examination that was conducted no more than seven (7) days prior to admission. A physician must be available to assess the individual thereafter, as medically necessary;

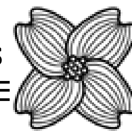
5. Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site, through consultation or referral;

6. Referral and assistance, as needed, for the individual to gain access to other needed substance use disorder and/or mental health services;

7. Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use, and co-occurring disorders, as appropriate, and for the continuation of appropriate treatment; and

8. Educational services provided in accordance with state regulations, including opportunities to address deficits in the educational level of adolescents who have fallen behind because of their involvement with alcohol and/or other drugs.

(F) Adolescents admitted to this level of care must meet diagnostic criteria for a moderate or severe substance use disorder, as well as ASAM dimensional criteria for admission. If the adolescent's presenting history is conflicting or inadequate



to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties such as parent/guardian, family members, or other natural supports. Additional admission guidelines include—

1. Acute intoxication and/or withdrawal potential—experiencing or at risk of acute or subacute intoxication or withdrawal with moderate to severe signs and symptoms. The individual needs twenty-four- (24-) hour treatment services including the availability of active medical and nurse monitoring to manage withdrawal, support engagement in treatment, and prevent immediate continued use;

2. Biomedical conditions and complications—significant risk of serious damage to physical health or concomitant biomedical conditions, or a biomedical condition requires twenty-four- (24-) hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital;

3. Emotional, behavioral, or cognitive conditions and complications—moderate and possibly unpredictable risk of imminent harm to self or others and needs twenty-four- (24-) hour monitoring and/or treatment in a high-intensity programmatic environment for safety;

4. Readiness to change—despite experiencing serious consequences or effects of the substance use disorder and/or behavioral health problem, does not accept or relate the disorder to the severity of the presenting problem. The individual is in need of intensive monitoring strategies, activities, and processes available in a twenty-four- (24-) hour setting;

5. Relapse, continued use, or continued problem potential—experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of the substance use or mental disorder such as poor impulse control or drug-seeking behavior; and

6. Recovery environment—has been living in an environment in which supports that might otherwise have enabled treatment at a less intensive level of care are unavailable, or the family is unable to sustain treatment attendance at a less intensive level of care.

(25) Level 3.7 Medically Monitored Inpatient Withdrawal Management (Adult Criteria). Services shall be provided by medical and nursing professionals who provide medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

(A) Twenty-four- (24-) hour observation, monitoring, and treatment shall be provided by an interdisciplinary team of trained staff.

(B) Individuals remain in this level of care until withdrawal signs and symptoms are sufficiently resolved such that they can be safely managed at a less intensive level of care, or their signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on a standardized scoring system).

(C) Services shall include assessment, individual and group counseling, group rehabilitative support, peer/family support, community support, medication services, crisis intervention, and medication services support.

(D) Admissions shall be accepted twenty-four (24) hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week. The week starts on the individual's date of admission.

(E) Interventions shall include, but are not limited to—

1. Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan;

2. A nursing assessment by an RN at admission (or APRN, resident physician, assistant physician, physician assistant in the absence of an RN) that is reviewed with a physician;

3. A physician or AP, PA, APRN, or resident physician assessment within twenty-four (24) hours of admission or, within twenty-four (24) hours of admission, a physician reviews and updates the record of a physical examination that was conducted no more than seven (7) days prior to admission. A physician must be available to assess the individual thereafter, as medically necessary;

4. Daily assessment of the individual's progress through withdrawal management and any treatment changes;

5. For individuals new to the program, it is recommended that an assessment be completed within twenty-four (24) hours of admission which substantiates appropriate level of care placement; and

6. Referral and assistance for the individual to gain access to other needed substance use disorder and/or mental health services.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Aug. 7, 2023, effective Feb. 29, 2024.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.155 Staff Requirements for Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs

PURPOSE: This rule describes requirements for caseload size, clinical privileging, training, and core competencies for staff working in CSTAR programs.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Other Regulations. Each organization that is certified/deemed certified by the department as a CSTAR program shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.110 Personnel.

(2) Qualified Staff. The program director shall ensure an adequate number of qualified professionals are available to provide CSTAR services.

(A) Caseload size may vary according to the acuity, symptom complexity, and needs of individuals served. An individual being served or his or her parent/guardian has the right to request an independent review by the CSTAR director if they believe individual needs are not being met. If the CSTAR director deems it necessary, caseload size or other changes may be implemented.

(B) The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by

persons served.

(C) The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

(3) Clinical Privileging. The program shall have and implement a process for granting clinical privileges to practitioners to deliver CSTAR services.

(A) Each treatment discipline shall define clinical privileges based upon identified and accepted criteria approved by the governing body.

(B) The process shall include periodic review of each practitioner's credentials, performance, education, and the like, and the renewal or revision of clinical privileges at least every two (2) years.

(C) Initial granting and renewal of clinical privileges shall be based on—

1. Well-defined written criteria for qualifications, clinical performance, and ethical practice related to the goals and objectives of the program;

2. Verified licensure, certification, or registration, if applicable;

3. Verified training and experience;

4. Recommendations from the agency's program, department service, or all of these, in which the practitioner will be or has been providing service;

5. Evidence of current competence;

6. Evidence of health status related to the practitioner's ability to discharge his/her responsibility, if indicated; and

7. A statement signed by the practitioner that he/she has read and agrees to be bound by the policies and procedures established by the provider and governing body.

(D) Renewal or revision of clinical privileges shall also be based on—

1. Relevant findings from the CSTAR program's quality assurance activities; and

2. The practitioner's adherence to the policies and procedures established by the CSTAR program and its governing body.

(E) As part of the privileging process, the CSTAR program shall establish procedures to—

1. Afford a practitioner an opportunity to be heard, upon request, when denial, curtailment, or revocation of clinical privileges is planned;

2. Grant temporary privileges on a time-limited basis; and

3. Ensure that non-privileged staff receive close and documented supervision from privileged practitioners until training and experience are adequate to meet privilege requirements.

(4) Training and Staff Competencies. Direct care staff and staff providing supervision to direct care staff shall complete training in the service competency areas listed below.

(A) Competent staff shall—

1. Operate from person-centered, person-driven, recovery-oriented, and stage-wise service delivery approaches that promote health and wellness;

2. Develop cultural competence that results in the ability to understand, communicate with, and effectively interact with people across cultures;

3. Deliver services according to key service functions that are evidence-based and best practices;

4. Practice in a manner that demonstrates respect and understanding of the unique needs of persons served;

5. Use effective strategies for engagement, re-engagement, relationship-building, and communication; and

6. Be knowledgeable of mandated reporting requirements for abuse and neglect of children and reporting requirements related to abuse, neglect, or financial exploitation of senior citizens and individuals who are disabled.

(B) Staff providing supervision to community support specialists must have additional training or experience in order to be knowledgeable in the supervision competency areas listed below. Competent supervisors—

1. Practice in a manner that demonstrates use of management strategies that focus on individual outcomes, care coordination, collaboration, and communication with other service providers both within and external to the organization;

2. Ensure new and existing staff are competent by providing training/supervision, guidance and feedback, field mentoring, and oversight of services to individuals served by the team;

3. Ensure processes exist for tracking and review of data such as missed appointments, hospitalization and follow-up care, crisis responsiveness and follow-up, timeliness and quality of documentation, and need for outreach and engagement; and

4. Monitor and review services, interventions, and contacts with individuals served to ensure services are implemented according to individualized treatment plans or crisis prevention plans, evaluate the effectiveness and appropriateness of services in achieving recovery/resiliency outcomes in areas such as housing, employment, education, leisure activities, and family, peer, and social relationships.

(C) New staff shall job shadow their supervisor and/or experienced staff in a position equivalent to their qualifications and skill level.

(D) Staff shall receive ongoing and regular clinical supervision.

(E) A written plan shall be developed indicating how competencies will be measured and ensured for all staff providing direct services and staff providing supervision including, but not limited to, some combination of the following:

1. Testing;

2. Observation/field supervision;

3. Clinical supervision/case discussion;

4. Quality review of case documentation;

5. Use of relevant findings from quality assurance activities;

6. Satisfaction with services as conveyed by individuals served and family members/natural supports;

7. Stakeholder/interagency satisfaction with services; and

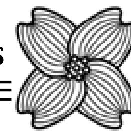
8. Treatment outcomes for individuals and family members/natural supports.

(F) Demonstrated competency must be documented within the first six (6) months of employment with the CSTAR program.

(G) Staff shall participate in at least thirty-six (36) clock hours of relevant training during any two (2) year period. A minimum of twelve (12) clock hours of training must be completed annually.

(H) CSTAR programs providing services in accordance with *The ASAM Criteria* shall ensure the following training requirements are met:

1. All direct care staff are trained on utilization of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 2013, 3rd edition, hereby incorporated by reference and made a part of this rule, developed by and available from the American Society of Addiction Medicine (ASAM), Inc., 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication.



Training must be provided by an entity with permission from ASAM to deliver the training;

2. All direct care staff participate in fifty (50) hours of annual training including, but not limited to—

A. Treatment of co-occurring disorders;

B. Suicide prevention (best-practice or evidence-based), as specified in the organization's Zero Suicide Plan;

C. Trauma-informed care, must align with the agency's trauma-informed assessment and implementation plan;

3. Annual training applies to the requirement specified in subsection (4)(G) of this rule; and

4. Ongoing training based on staff roles and responsibilities including, but not limited to—

A. Peer support, provided by the Missouri Credentialing Board;

B. Family support, provided by the Missouri Credentialing Board;

C. Smoking cessation, approved by the department; and

D. *The ASAM Criteria* advanced training (must be provided by an entity with permission from ASAM to deliver the training).

(I) Documentation of all orientation, training, job shadowing, and supervision activities must be maintained and available for review by department staff or other authorized representatives.

(J) Documentation of training must include the topic, date(s) and length, skills targeted/objective of skill, certification/continuing education units (as applicable), location, and name, title, and credentials of instructor(s).

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed May 28, 2021, effective Dec. 30, 2021. Amended: Filed Aug. 7, 2023, effective Feb. 29, 2024.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.157 Community Support in Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs

PURPOSE: This rule establishes the requirements for community support services provided in CSTAR programs.

(1) Service Delivery. The CSTAR program shall establish an identifiable unit which coordinates and provides community support services for children, youth, families, and/or adults. The unit shall be organized to perform functions within the scope of community support services, including critical interventions.

(2) Policies and Procedures. The CSTAR program shall implement policies and procedures to provide adequate, appropriate, and effective community support services to individuals. Policies and procedures shall include:

(A) A mechanism to assure the provision of all needed substance use disorder treatment services, as indicated in the individual's current treatment plan;

(B) A mechanism to assure the provision of all needed services in addition to those provided by the CSTAR program, as indicated in the individual's current treatment plan;

(C) A method for assigning individuals to a community support specialist or team, including:

1. Procedures to assure each individual is afforded an opportunity to express preferences in the selection of a community support specialist; and

2. A mechanism to assure all individuals admitted who need community support are assigned to an active caseload of a community support specialist;

(D) A process to assure an effective transfer and follow-up of an individual between or among community support specialists or community support teams. Staff shall document the rationale for the transfer, the individual's acceptance, and follow-up by the community support specialist in the clinical record;

(E) A process for determining overall increase or decrease in the level of functioning for individuals served through ongoing performance improvement activities;

(F) A method to assure staff providing community support services in the CSTAR program have the opportunity to participate and contribute to the agency's performance improvement process;

(G) Development of suitable revisions to treatment goal(s) as indicated by growth or deterioration of individual functioning and/or condition; and

(H) Program and aggregate evaluation activities to determine effectiveness of services delivered.

(3) Staff Requirements. The CSTAR program shall ensure an adequate number of appropriately qualified staff are available to provide community support services and functions.

(A) Qualified staff includes:

1. A qualified addiction professional (QAP) as defined in 9 CSR 10-7.140;

2. A qualified mental health professional (QMHP) as defined in 9 CSR 10-7.140;

3. An individual with a bachelor's degree in a human services field which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science, and rehabilitation counseling;

4. An individual with any four (4) year combination of higher education and qualifying experience;

5. An individual with any four (4) year degree and two (2) years of qualifying experience;

6. An individual with an Associate of Applied Science in Behavioral Health Support degree from an approved institution; or

7. An individual with four (4) years of qualifying experience.

(B) Qualifying experience must include delivery of services to individuals with mental illness, substance use disorders, or developmental disabilities. Experience must include some combination of the following:

1. Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;

2. Teaching and modeling for individuals how to cope and manage psychiatric, developmental, or substance use disorder issues while encouraging the use of natural resources;

3. Supporting individuals in their efforts to find and maintain employment and/or to function appropriately in family, school, and community settings; and

4. Assisting individuals to achieve the goals and objectives in their individual treatment plan.

(C) It is the responsibility of the CSTAR program to document how staff meet the qualifications based on the criteria in subsections (3)(A) and (3)(B) of this rule.

(D) Community support specialists must also complete orientation and training required by the department.

(E) Community support specialists must be supervised by—

1. A qualified addiction professional (QAP);
2. A qualified mental health professional (QMHP);
3. Staff possessing a Master's degree in a behavioral health or related field who has completed a practicum or has one (1) year of experience in a behavioral health field; or
4. Staff who meet the qualifications of a community support specialist with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions specified in paragraphs (5)(B)1. to 8. of this rule.

(F) Community support supervisors who are not a QAP or QMHP must be supervised by a QAP or QMHP.

(4) Monitoring. To the extent the individual is able to participate, periodic observation and monitoring shall take place in his/her home or other community location as stipulated in the individual treatment plan.

(A) Observation and monitoring shall be documented including, but not limited to:

1. Assessment of the individual's mental health status and/or substance use;
2. Safety and home care; and
3. Functional abilities and skill transference related to activities of daily living including educating, demonstrating, observing, and practicing skills in his/her environment.

(5) Service Delivery. Community support is a comprehensive service designed to reduce the individual's disability resulting from a mental illness, emotional disorder, and/or substance use disorder and restore functional skills of daily living, principally by developing natural supports and solution-oriented interventions intended to achieve recovery/resiliency as identified in the goals and/or objectives in the individual treatment plan.

(A) This service may be provided to the individual's family/natural supports when such services are for the direct benefit of the individual served, in accordance with the needs and goals identified in the treatment plan, to assist in the individual's recovery/resiliency. Most contact occurs in community locations where the individual lives, works, attends school, and/or socializes.

(B) Key service functions of community support shall include, but are not limited to:

1. Developing recovery goals and identifying needs, strengths, skills, resources, and supports and teaching individuals how to use them to support recovery, identifying barriers to recovery, and assisting individuals in the development and implementation of plans to overcome them;
2. Helping individuals restore skills and resources negatively impacted by their substance use disorder and/or co-occurring mental illness or emotional disorder including, but not limited to:
   A. Seeking or successfully maintaining employment or volunteering including, but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance;
   B. Maintaining success in school including, but not limited to, communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identifying and addressing behaviors that interfere with school performance; and
   C. Obtaining and maintaining housing in the least restrictive setting including, but not limited to, issues related to nutrition, meal preparation, and personal responsibility;
3. Supporting and assisting individuals in a crisis to access needed treatment services to resolve the crisis;
4. Continuing recovery planning and discharge planning with individuals who are hospitalized for a medical or behavioral health condition;
5. Assisting individuals, other natural supports, and referral sources in identifying risk factors related to relapse in mental illness and/or substance use disorders, developing strategies to prevent relapse, and advising and otherwise assisting individuals in implementing those strategies;
6. Promoting the development of positive support systems by providing information to family members/natural supports, as appropriate, regarding mental illness, emotional disorders, and/or substance use disorders and ways they can be of support to their family member's recovery. Such activities must be directed toward the primary well-being and benefit of the individual served;
7. Developing and advising individuals on implementing lifestyle changes needed to cope with the side effects of psychotropic medications and/or to promote recovery/resiliency from the disabilities, negative symptoms, and/or functional deficits associated with a mental illness, emotional disorder, and/or substance use disorder; and
8. Advising individuals on maintaining a healthy lifestyle including, but not limited to, recognizing the physical and psychological signs of stress, creating a self-defined daily routine that includes adequate sleep and rest, walking or exercise and appropriate levels of activity and productivity, involvement in creative or structured activities that counteract negative stress responses, learning to assume personal responsibility and care for minor illnesses, and knowing when professional medical attention is needed.

(6) Documentation. Documentation must be maintained in the individual record for each community support session, service, or activity in accordance with 9 CSR 10-7.030(13). The following must also be documented:

(A) Phone contacts; and/or

(B) Pertinent/significant information reported by family members/natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in his/her life.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed May 28, 2021, effective Dec. 30, 2021.*

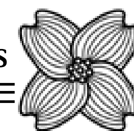
**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.160 Institutional Treatment Centers

PURPOSE: This rule describes the certification requirements, service delivery process, and staff qualifications for substance use disorder treatment programs within Department of Corrections' (DOC) institutions, referred to in this rule as Institutional Treatment Centers (ITCs).

(1) Definitions. The following definitions apply to terms used in this rule.

(A) Behavior contract—therapeutic intervention consisting of a written, time limited specific plan of behavior to be followed by the offender that is designed to assist him/her in modifying inappropriate behavior.



(B) Cardinal Rules—prohibitions that maintain the integrity of the treatment community or unit, protect against dangers to the community or unit, and ensure physical and psychological safety for all offenders and staff. Cardinal Rules include: all DOC major conduct rules 1-9 and minor assault; possession/use of an intoxicating substance; threats; sexual misconduct; theft; fighting; gambling; destroying property; and any written or verbal acts of discrimination to include race, creed, or gender.

(C) Clinical Director—staff member responsible for supervising the clinical services and/or programs of a DOC substance use disorders treatment center or ITC.

(D) Counseling services—address offender needs in an individual or group setting, provided by staff employed as treatment professionals who are supervised by experienced and/or credentialed supervisors. Counseling services involve processing of information in a collaborative fashion.

(E) Group counseling—face-to-face, goal-oriented therapeutic interaction between a treatment professional and no fewer than three (3), and no more than fifteen (15) offenders.

(F) Individual counseling—structured, goal-oriented therapeutic process in which the offender interacts on a face-to-face basis with a treatment professional to address problems identified on their individual treatment plan.

(G) Individual treatment plan—structured and individualized plan that directs an offender's treatment. The plan includes assessment information and the offender's needs, problem areas, and concerns to develop goals, objectives, and interventions to address the areas identified.

(H) Lack of therapeutic gain—an offender's consistent or serious failure to apply reasonable effort and attainment of therapeutic goals as documented by the substance use disorders treatment team. An offender must show a continued pattern of negative behavior in areas such as therapeutic programming engagement, program expectations, and/or institutional rule violations. All levels of therapeutic intervention are utilized prior to an unsuccessful exit for lack of therapeutic gain.

(I) Offender Management Team (OMT)—therapeutic in nature and utilized to address an offender's problematic actions in an attempt to re-direct the offender towards appropriate behavior so he/she can be successful in treatment. The team consists of at least two (2) staff members, one (1) of which is a treatment staff member, and one (1) from classification, probation and parole, or custody.

(J) Program Review Committee (PRC)—committee that evaluates an offender's progress in treatment and recommends continuation or exit from the program. The committee consists of at least three (3) staff members from the following areas: treatment, classification, custody, and/or probation and parole, as available. At least one (1) treatment staff member must be present. The chairperson is a substance use disorders unit supervisor, a functional unit manager, or a DOC (non-contracted) clinical director. A PRC is therapeutic in nature and addresses an offender's behavior and progress in the program. The PRC can be utilized to reengage an offender in the program, or to remove an offender via a no-fault or unsuccessful exit, if reengagement is determined not to be an option.

(K) Progress notes—entries by appropriate treatment staff documenting the offender's activities, progress toward achievement of the substance use disorders treatment plan goals, treatment contacts, significant events, services delivered, and future follow up.

(L) Recovery-oriented therapeutic class—didactic presentation of general information regarding substance use disorders, criminality and related topics, and the practical application of the information through group discussion, and as directed by the offender's treatment plan. The number of participants shall not exceed the comfort and safety level of the room utilized.

(M) Recovery support groups—voluntary associations of people who share a common desire to overcome a substance use disorder. Different groups use different methods, and the approaches range from completely secular to explicitly spiritual. In an ITC, abstinence from substance use is a requirement and expectation. Programs that provide spiritually-based groups such as Alcoholics Anonymous and Narcotics Anonymous must provide secular options as well.

(N) Structured recreational activity—scheduled and organized recreational activities that do not include a classroom/process component.

(O) Substance use disorders education—a therapeutic service designed to provide information on topics regarding substance use, addictions, and recovery. The information is provided to offenders through didactic and interactive educational methods and may be reinforced through homework assignments.

(P) Substance use disorders treatment file—the record of information established by assigned treatment staff pertaining to an offender's progress during participation in a substance use disorders treatment program.

(Q) Substance use disorders treatment plan—document recording each offender's individualized treatment goals and objectives, interventions to address the objectives, and his/her progress in the ITC.

(R) Substance use disorders treatment team—a group of professionals comprised of contracted treatment staff, DOC treatment staff, and other DOC staff who work collaboratively to guide the offender's progress on his/her substance use disorders treatment plan and within the ITC.

(S) Therapeutic community—residential substance use disorders treatment model in which participants are designated as families and/or communities. Staff members are considered rational authorities and the community itself is considered the primary agent of change.

(T) Therapeutic family—the institutional therapeutic community participants.

(U) Therapeutic gain—achievement of therapeutic goals and objectives established by the treatment plan, and growth toward responsible behavior as indicated by active participation, following rules, and personal application of ITC principles and concepts.

(V) Therapeutic interventions—tools for bringing negative or positive behaviors and attitudes to the awareness of an offender's therapeutic family to assist him/her in achieving and/or reinforcing therapeutic goals and growth toward responsible behaviors.

(W) Therapeutic services—have defined therapeutic benefit, are led or facilitated primarily by treatment staff, and may be provided in collaboration with other DOC or contracted staff.

(X) Treatment plan review—documented discussion between a treatment professional and the offender regarding specific treatment plan goals and objectives and progress made toward the goals and objectives. Written changes to the treatment plan are considered treatment plan updates. This is a component of each one-on-one (individual) counseling contact.

(Y) Treatment plan update—occurs in the course of a treatment plan review with the offender when a change to the plan is appropriate, such as the addition of new goals or objectives and closing of completed goals and objectives.

(2) Program Certification and Applicable Regulations. Institutional Treatment Centers (ITCs) applying for program

certification from the Department of Mental Health (department) shall comply with requirements set forth in 9 CSR 10-7.130. Other department regulations applicable to certified ITCs, in full or in part, are specified in this rule.

(A) ITCs shall comply with the following department regulations without modification:

1. 9 CSR 10-7.030; and
2. 9 CSR 10-7.140.

(B) ITCs shall comply with the following department regulations as specified:

1. 9 CSR 10-7.010, with the exception of subsection (6)(B);
2. 9 CSR 10-7.020, with the exception of paragraphs (3)(A)10., (3)(B)5., and (4)(C)1.;
3. 9 CSR 10-7.040, with the exception of subsection (2)(A);
4. 9 CSR 10-7.110, with the exception of subsection (2)(C), paragraph (2)(F)1., and section (4); and
5. 9 CSR 30-3.032, subject to the modifications specified in this rule.

(C) The following department regulations are waived for ITCs unless it is determined a specific requirement is applicable due to the unique circumstances and service delivery methods of a particular ITC:

1. 9 CSR 10-5.190;
2. 9 CSR 10-5.200;
3. 9 CSR 10-7.035;
4. 9 CSR 10-7.050;
5. 9 CSR 10-7.060;
6. 9 CSR 10-7.070;
7. 9 CSR 10-7.080, the application for program certification must include documentation verifying the ITC's dietary staff, services, and facility comply with applicable DOC dietary requirements;
8. 9 CSR 10-7.090;
9. 9 CSR 10-7.100;
10. 9 CSR 10-7.120, the application for program certification must include documentation verifying the ITC complies with DOC safety requirements including fire, emergency preparedness, security, cleanliness, and comfort; and
11. 9 CSR 30-3.100.

(3) ITC Services. Services delivered within an ITC shall provide a structured array of therapeutic processes and interventions to affect cognitive and behavioral changes for individuals who are incarcerated. Services shall address the individual's substance use disorder(s) and/or addiction and criminality.

(A) A treatment week for each individual in the program consists of a minimum of twenty-five (25) hours of treatment services, regardless of program length, and includes, at a minimum:

1. Two (2) hours of group counseling provided to groups of offenders, in addition to the individual counseling contact specified in paragraph (3)(B)5. of this rule;
2. Eighteen (18) hours of therapeutic services; and
3. Five (5) hours of adjunctive services.

(B) Counseling services identify individual needs and group needs of offenders. Services are provided by staff employed as treatment professionals who are supervised by experienced and/or credentialed supervisors as specified in section (8) of this rule. Regardless of program length, counseling services for each offender shall include:

1. An initial individual counseling contact within seven (7) calendar days of program admission;
2. An assessment and assessment interview within ten (10) calendar days of program admission;
3. Treatment planning and treatment planning follow-up sessions. The initial treatment plan must be completed within ten (10) calendar days of program admission, and treatment plan reviews shall occur at forty-five (45) day intervals at a minimum;
4. A minimum of two (2) hours of group counseling per week, and the maximum group size is fifteen (15) individuals;
5. A minimum of one (1) contact hour of individual counseling per month; and
6. Mental health counseling and group counseling, as applicable.

(4) Therapeutic Services. Therapeutic services have defined therapeutic benefit and are led or facilitated primarily by treatment professionals. Services may be provided in collaboration with other DOC staff or contracted staff.

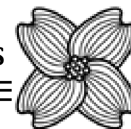
(A) Therapeutic services include—

1. Recovery-oriented therapeutic classes, a minimum of four (4) hours per week, to be counted toward the therapeutic activities allowance;
2. Education classes or classroom videos related to substance use disorders with clarifying discussions and/or assignments, with no more than eight (8) hours per week to be counted toward the therapeutic activities allowance;
3. Therapeutic community groups with treatment staff physically present;
4. Impact of Crime on Victims Classes (IC/VC) with interdisciplinary facilitation;
5. Anger management with interdisciplinary facilitation;
6. DOC-approved cognitive skills program with interdisciplinary facilitation;
7. Employment skills and/or life-skills classes;
8. Waysafe and/or other health-related HIV/hepatitis classes;
9. Recovery support groups facilitated by staff or an approved DOC volunteer;
10. Case management for release planning;
11. Reentry services and groups;
12. Work release hours, if accompanied by journaling and/or homework assignments;
13. Institutional jobs, if accompanied by journaling and/or homework assignments;
14. Therapeutic community job assignment at or above coordinator level;
15. High School Equivalency (HSE), Adult Education Literacy (AEL), and/or vocational classes, if accompanied by journaling and/or homework assignments;
16. Structured recreational activities with staff supervision; and
17. Graduation/program completion ceremony.

(5) Adjunctive Services. Adjunctive services provide potential benefit for the individual, but have no treatment or case management staff supervision or involvement.

(A) Adjunctive services shall include:

1. Mentoring (receiving or providing);
2. Tutoring (receiving or providing);
3. Films with therapeutic benefit without follow-up discussion or assignment;
4. Recovery support groups facilitated exclusively by offenders;
5. Restorative justice activities;
6. Temporary work assignments; and
7. Study hall, with no more than one (1) hour per week to be counted toward the adjunctive activities allowance.



(6) Admission and Exit Criteria. This section provides guidance related to admission and exit criteria for ITC programs. Placement, admission, and program exit for offenders is determined by policy and standard protocol for Missouri correctional facilities and substance use disorder services. The Assistant Division Director, Division of Offender Rehabilitative Services, Substance Use and Recovery Services, has final approval and authority on all matters related to program admission, placement, and exit.

(A) Admission to an ITC program is based on—

1. A court order for institutional substance use disorders treatment;

2. A probation and parole referral for institutional substance use disorders treatment; or

3. The results of a professional substance use disorders assessment and classification instrument indicating the need for treatment.

(B) Exit from an ITC program may occur based on the following:

1. Successful program exit—indicated when an offender has met program expectations by remaining in the treatment program for the duration of the assigned treatment episode as defined by governing laws and policies, and has successfully completed the objectives on their individualized treatment plan. The quality of the completion is to be described in the offender's exit/discharge summary and in any report initiated by the treatment provider to probation and parole and/or to the court;

2. No fault program exit/transfer—indicated when an offender's continued participation in the program is no longer feasible due to factors out of his/her control. Examples of no fault program exit/transfer include protective custody needs, increases in classification scores, or a need for federally-mandated services such as medical, mental health, and special education that exceed the capability of institutional staff to provide; and

3. Unsuccessful program exit—indicated when an offender poses a true threat to other offenders and/or staff, endangers the security of the treatment unit, causes significant and repeated disruptions, and/or endangers the program success of other offenders. Due to the important role of treatment in recovery from substance use disorders and criminal behavior, unsuccessful program exits should be held to a minimum.

A. Due to the significant consequences that may follow an offender's unsuccessful exit from an ITC, the minimal efforts, guidelines, and protocols explained in section (14) of this rule shall be followed and documented.

B. When determined necessary, offenders enrolled in an ITC may receive an unsuccessful program exit in accordance with DOC policies and procedures.

(7) Service Delivery and Documentation Requirements. All services provided for offenders shall be delivered and documented as specified in this rule.

(A) An assessment must be completed within ten (10) calendar days of the offender's admission to the ITC. If an assessment was completed within the twelve (12) months prior to the individual's admittance to the ITC and it is obtained for the treatment file, a new assessment may not be necessary. Documentation of the assessment must be included in the treatment and classification file (record) of each offender and include verification that the assessment report was reviewed with the individual. Documentation remains the same regardless of when the assessment was completed or obtained. The assessment shall include, but is not limited to:

1. Demographic and identifying information for the offender;

2. Statement of needs, goals, and treatment expectations from the offender;

3. Presenting situation/problem and referral source;

4. History of previous psychiatric and/or substance use disorders treatment, including number and type of admissions;

5. Alcohol and drug use for the thirty (30) days prior to current incarceration, during incarceration, and substance use history including duration, patterns, and consequences of use;

6. Current psychiatric symptoms;

7. Family, social, legal, vocational/educational status, and functioning, including history, if appropriate;

8. Personal and social resources and strengths, including the availability and use of family, social, peer, and other natural supports;

9. Stage of motivation; and

10. Screening using a DOC-approved instrument.

(B) An individualized treatment plan shall be developed based on the results of the offender's assessment. The plan is developed in collaboration with the offender within ten (10) working days of his/her admission to treatment. The treatment plan must reflect the offender's unique needs and goals. Documentation of the treatment plan interview shall be made in each offender's treatment record and include his/her involvement in the treatment planning process. The treatment plan shall be signed by the staff person and the offender and shall include, but is not limited to:

1. Goals and measurable objectives;

2. Interventions to accomplish each objective—documentation includes specific supports, actions, and services, and identifies the staff member responsible for providing the services/supports and action steps of the offender and members of his/her support system (such as family, social, peer, and other natural supports);

3. Involvement of family, when possible;

4. Service needs beyond the scope of ITC staff that are provided or assisted by other disciplines within the institution or through referral to other community resources and organizations, as applicable;

5. Projected time frame for the completion of each objective; and

6. Estimated program completion/exit date.

(C) Review of the treatment plan, objectives, and program progress shall be conducted and documented in the offender's treatment file a minimum of every forty-five (45) days. Each offender shall actively participate in the review of his/her treatment plan. The plan and objectives shall be updated, as appropriate, to reflect individual needs, accomplishments, and progress.

(D) A discharge summary shall be completed and entered in the treatment file within three (3) working days of an offender's transfer or exit from the ITC. The discharge summary shall include, but is not limited to:

1. ITC admission and exit dates;

2. Reason for admission and referral source;

3. Assessment summary;

4. Statement of the problem;

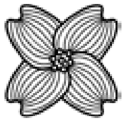
5. Description of treatment services provided and progress achieved;

6. Continuing care recommendations;

7. Reason and type of treatment program exit;

8. Known medical and/or mental health needs that may require ongoing support services, if available; and

9. Other service needs, if applicable.



(E) A relapse prevention/continuing care plan shall be completed with the offender and specific resources provided to him/her prior to exit from the ITC. The plan shall identify services, designated provider(s) of support services, and other planned activities designed to promote continuing recovery.

(F) Individual counseling contacts shall be documented in progress notes and include, at a minimum:

1. Description of the specific service provided;
2. The date and actual time (beginning and ending times) the contact was rendered;
3. Name and title of the treatment professional who rendered the service;
4. Reference to specific objectives addressed within the individualized treatment plan;
5. Description of the individual's response to services provided; and
6. Planned follow-up by the treatment professional and the offender.

(G) Individual treatment records shall be maintained by staff of the ITC and delivery of services must be recorded in a timely manner, as follows:

1. All entries are legible, clear, complete, and accurate;
2. All entries are dated and authenticated by the treatment professional providing the service, including name, title, and credential(s), as applicable;
3. Errors are indicated in the paper copy by the staff member marking through the error with a single line, initialing, and dating the correction;
4. Language is clear and concise, so it is readily understood by anyone reading the document, even if they are not familiar with the environment, profession, or discipline of substance use disorders or corrections; and
5. Acronyms, abbreviations, professional slang, or jargon is not used.

(H) All required documentation and forms shall be signed and dated by staff and the offender, as indicated. Documentation in the offender's record shall include, but is not limited to, the following:

1. Forms related to program orientation, with signed acknowledgement of receipt by the offender, including:
   A. Consent to treatment;
   B. Rights and responsibilities;
   C. Institutional treatment contract;
   D. Authorization for disclosure of medical/health information;
   E. Grievance process;
   F. Handbook;
   G. Receipt of orientation; and
   H. Verification of program options for self-help groups and information about the availability of self-help groups and related materials;
2. Assessment summary, with offender's signature;
3. Individualized treatment plan, with offender's signature;
4. Treatment plan reviews, with offender's signature;
5. Services delivered;
6. Treatment progress and any development, crisis, or significant incident occurring during the treatment episode;
7. Referrals, if made while the offender is in the ITC, including applicable release of information, as needed, and any known outcomes;
8. Missed appointments and efforts to reengage;
9. Behavior contract, effort, and outcomes;
10. Conduct violation reports and applied sanctions;
11. Offender Management Team (OMT), Program Review Committee (PRC), and all significant therapeutic staffing; and
12. Discharge summary, with plan for continuing recovery to address ongoing needs, as identified.

(I) A schedule of program services, groups, and other structured activities shall be maintained by the ITC and be readily available to offenders on site.

1. A program log shall be maintained to record any cancelled sessions, including the name, time, date, and reason for the cancellation.
2. A supervisor or program manager shall review the program log on a monthly basis, at a minimum.
3. A record of small process groups shall be maintained indicating beginning and ending times, individuals in attendance, and the name of the staff member providing the service. This record may be retained electronically.

(8) Staff Requirements. This section identifies the qualifications, ratios, and training requirements for staff employed as treatment professionals in an ITC.

(A) All staff who have direct contact with offenders must be at least eighteen (18) years of age and, at the time of their application for employment with DOC, verify and document they meet the qualifications of their respective profession and the specific requirements of DOC.

1. Interns and volunteers must be approved in accordance with DOC policies and procedures.

(B) At a minimum, staff must meet Missouri Office of Administration (OA) requirements for a position specified in subsection (C) of this section or as designated by contract. OA requirements are available online at: http://oa.mo.gov/personnel/classification-specifications.

(C) ITC staff positions are designated as follows:

1. Addiction Counselor I (AC I);
2. Addiction Counselor II (AC II);
3. Addiction Counselor III (AC III);
4. Treatment Unit Supervisor (TUS);
5. Corrections Manager Band I;
6. Corrections Manager Band II; and
7. Interns and volunteers, as defined in DOC policy.

(D) Organizations that are contracted by DOC to provide services in an ITC shall ensure staff are qualified in accordance with the positions identified in subsection (C) of this section.

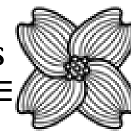
(E) Group counseling shall be provided by treatment professionals trained in substance use disorders treatment. Newly employed treatment staff shall be observed by and receive instructive feedback from an experienced facilitator for no less than eight (8) hours prior to facilitating group sessions.

(F) Substance use disorders education and recovery-oriented therapeutic classes shall be provided by staff who possess the education, background, or experience to deliver the information, demonstrate competency and skill in educational techniques, are knowledgeable about the topic being presented, and are present with offenders throughout the education process.

(G) Staff providing direct clinical services for offenders shall have a staff-to-offender ratio not to exceed one (1) staff person per twenty-five (25) offenders, or as specified by contract. Interns and volunteers may be used to provide rehabilitation services, but cannot be included in the required staff-to-offender ratio.

(H) All staff providing services in an ITC must receive training to ensure services are provided ethically and effectively in a competent, safe, and secure manner.

1. At a minimum, newly hired staff must receive a program orientation specific to the job function(s) for which he/she was hired. When possible, a staff mentor shall be provided to new



staff for guidance and to answer job-related questions.

2. A clinical training plan shall be developed for each ITC staff position. The plan shall be maintained in the staff person's training file and be updated yearly to reflect completion of the ITC training requirements.

3. All staff having direct contact with offenders shall complete a minimum of twenty (20) hours of in-service training per year. At least ten (10) of those hours must relate to substance use disorders treatment services and skills. Required annual training shall include:

A. Ethics and professional boundaries; and

B. Documentation.

4. Training related to substance use disorders treatment or job-related skills may include, but is not limited to:

A. Non-adversarial confrontation;

B. Group counseling;

C. Individual counseling;

D. Motivational interviewing;

E. Co-occurring substance use and mental health disorders;

F. Avoiding job burnout, re-energizing, and self-wellness;

G. The four (4) domains—screening, assessment, and engagement; treatment planning, collaboration, and referral; counseling; and professional and ethical responsibility;

H. Therapeutic continuum of intervention; and

I. Medication.

(I) All staff must attend Basic Training at the DOC Training Academy as required by DOC policy. Staff must also attend any required introductory level counseling skills training within the first six (6) months of employment, or otherwise specified in contract, or as directed by training plans recommended by the Assistant Division Director, Division of Offender Rehabilitation Services, Substance Use and Recovery Services or his/her designee.

(J) A training record that is separate from the personnel file must be maintained for all staff who deliver substance use disorders treatment services in an ITC. The training record must contain a complete record of all training completed and the employee's credentials. At a minimum, the record shall include documentation of the employee's—

1. Education, current and valid credentials/licensure, as applicable;

2. Completion of DOC Basic Training;

3. Completion of facility and program orientation;

4. Training and development plan (non-certified or non-licensed counselors);

5. In-service and outside training;

6. Completion of cognitive skills facilitation training, as required by DOC;

7. Completion of Prison Rape Elimination Act training;

8. Completion of cyber-security training;

9. Completion of annual discrimination, harassment, and retaliation training; and

10. Completion of any other training required by DOC.

(9) Staff Supervision Requirements. This section includes the staff supervision requirements for ITCs.

(A) Treatment professionals providing any ITC service must receive continuous supervision from a trained treatment professional supervisor(s), preferably an individual who is a credentialed or licensed professional.

(B) All treatment professional functions shall be performed with the knowledge, oversight, guidance, and full professional responsibility of the supervisor(s). The treatment supervisor shall maintain a record of their supervision activities. Supervisors, or a credentialed designee, must countersign specified documentation in the offender treatment file when it is entered by a non-credentialed addiction counselor, including, but not limited to:

1. Assessments;

2. Treatment plans and treatment plan updates;

3. Discharge summaries;

4. Behavioral contracts; and

5. Case evaluations/short-term treatment center reviews.

(C) Treatment supervisors shall maintain the appropriate credential(s) and/or license(s) for their respective position. Supervisors shall conduct and document regularly scheduled supervision sessions and ongoing direct observation of treatment professionals delivering services in the ITC.

(D) Supervision of staff who are seeking credentials must follow the supervision guidelines established by the specific credentialing body. Supervision must be tailored to the knowledge base, skills, and experience of each staff member in order to promote professional development and proficiency in substance use disorders counseling competencies.

(E) Non-credentialed and unlicensed staff of the ITC shall have access to their supervisor as frequently as possible to address immediate, brief questions. The supervisor shall meet with non-credentialed and unlicensed staff on a weekly basis and provide assistance with setting clear goals. All supervisory sessions with staff shall be recorded, including the date and time, personal goals, and notation of progress being made toward goals.

(10) Quality Assurance and Program Evaluation. This section includes the quality assurance and program evaluation requirements for ITCs.

(A) Each ITC must submit a quality assurance plan to the DOC Office of Substance Use and Recovery Services in accordance with established timelines. Plans must include the intended process by which internal measurement and/or program auditing will occur to ensure compliance with the quality assurance plan. Plans must be updated as specified by DOC.

(B) Plans will be returned to the ITC by the designated DOC staff person in accordance with established timelines indicating: approved as submitted; approved with modifications needed; or not approved. Plans needing revisions must be resubmitted by the ITC to designated DOC staff in accordance with established timelines.

(C) ITCs shall implement the quality assurance plan in accordance with timelines established by DOC.

(D) Quality assurance measures shall be reviewed and updated on a quarterly basis by staff of the ITC and submitted in the form of a written report to the DOC designee.

(E) Each ITC shall establish specific compliance indicators consisting of process quality assurance measures and outcome quality assurance measures.

(F) Process quality assurance measures must include, but are not limited to:

1. Review of clinical records of offenders in the ITC; and

2. A monthly, in-depth review of a random sample of one (1) clinical record maintained by each primary treatment professional of the ITC using a pre-defined criteria checklist. The review shall be conducted by a designated treatment professional supervisor(s), the clinical director, program manager, or other clinical administrative staff of the ITC. Results of the review determine whether the program is meeting ninety percent (90%) or more of the criteria pertaining to satisfactory quality in-chart documentation.

(G) Each non-licensed or non-credentialed treatment

professional's group performance shall be observed directly by a treatment professional supervisor at least one (1) time per month. Feedback shall be provided orally by the treatment professional supervisor to the non-licensed or non-credential treatment professional and documented in the performance log. If the ratio of direct treatment professional supervisors to treatment professionals does not allow monthly review by the direct treatment professional supervisor(s), another member of the clinical management team shall assist in this review. Credentialed and/or licensed treatment professionals shall be reviewed on a quarterly basis, at a minimum.

(H) Ongoing reviews of fidelity to the practices and curricula being utilized in the ITC shall be conducted and documented by ITC staff.

(I) Each ITC shall establish and monitor multidisciplinary indicators to measure maintenance of a therapeutic environment. The indicators will be reviewed quarterly by DOC custody, classification, and treatment supervisors. Reviews shall include, but are not limited to:

1. OMTs and PRCs;
2. Conduct violations;
3. Informal resolution requests;
4. Grievances;
5. Unsuccessful program exits;
6. Offender satisfaction surveys;
7. Number of in-service trainings;
8. Sentinel events;
9. Temporary administrative segregation confinement or disciplinary segregation;
10. Staff turnover;
11. Other program exits; and
12. ITC Exit Evaluations.

(11) Maintenance of Records. Each ITC shall maintain an organized record system as specified in this rule.

(A) All records shall be maintained in accordance with all state and federal laws and regulations related to the confidentiality of records and release of information.

(B) Electronic records must conform to federal and state regulations, and there must be a backup system to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.

(C) Individual records shall be retained for at least six (6) years, or until all litigation, adverse audit findings, or both, are resolved.

(D) The ITC shall assure timely access to records by authorized staff and other authorized parties, including DOC staff.

(12) Interdisciplinary Services and Referrals. ITCs shall advocate for and pursue interdisciplinary collaboration and provide adequate services and/or make referrals to meet the diverse treatment needs of individuals served.

(A) ITCs shall actively seek to promote interdisciplinary involvement in assessment, treatment planning, service delivery, and evaluation of progress with all agencies represented at the program site, as appropriate, based on individual needs.

(B) ITCs shall refer or provide needed services for offenders, as appropriate under the scope of practice by contract or DOC guidelines, related to:

1. Psychological, mental health, or emotional needs, in cooperation with the designated mental health service provider of the institution;
2. Physical well-being or medical needs, in cooperation with the designated medical services provider of the institution;
3. Educational needs, in cooperation with the designated educational services provider of the institution;
4. Spiritual needs, in cooperation with the on-site chaplain;
5. Institutional adjustment and functioning, in cooperation with the designated DOC classification staff at each location;
6. Behaviors, safety, and security of offenders, in cooperation with the appropriate DOC custody staff; and
7. Criminal cases, sentencing, and release, in cooperation with the designated institutional probation and parole staff.

(C) Documentation of referrals related to the needs of offenders and/or collaboration with other agencies shall be maintained in the individual's treatment record.

(D) ITCs shall hold regularly scheduled quality assurance meetings with collaborative service providers. Documentation of quality assurance meetings must be maintained in the form of minutes, identifying all individuals in attendance. Representation at these meetings shall include, but is not limited to, the following agencies and/or disciplines:

1. DOC custody;
2. DOC classification;
3. DOC administration;
4. Mental health;
5. Medical;
6. Education;
7. Probation and parole;
8. Chaplain;
9. Recreation officers; and
10. ITC staff.

(13) Exceptions Process. The primary treatment supervisor of the ITC may request the department to waive any of the requirements in these rules by submitting a request in accordance with 9 CSR 10-5.210, Exceptions Committee Procedures.

(14) Disciplinary Guidance. This section provides guidance to staff of the ITC for taking disciplinary or corrective action with offenders who fail to comply with program expectations or rules and directives.

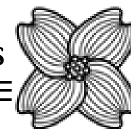
(A) Offenders admitted to an ITC are referred as the result of self-defeating thinking patterns and problematic, anti-social behaviors that lead to commission of crimes. Program staff must focus on facilitating necessary changes in thinking and behavior over the course of treatment. Every offender is expected to diligently strive for change in their thinking and behavior, and be receptive to the guidance and redirection provided by ITC staff.

(B) Behaviors that represent a certain and severe threat to offenders, staff, or the good order of the correctional institution shall not be tolerated.

1. Such behaviors are identified under Cardinal Rules in DOC Policies. Violation of Cardinal Rules must result in referral for review by the PRC. The PRC determines the appropriate action to be taken.
2. Action may include unsuccessful exit from the ITC, if such action is deemed appropriate by the PRC.

A. Unsuccessful exit for a Cardinal Rule violation should never be the only option for consideration. Many program rules do not meet the criteria of Cardinal Rules, but may create a security risk.

(C) Offenders adapt over time to increasingly higher levels of behavioral compliance. It is reasonable to expect such adaptation to take longer for some offenders than for others. It is part of the mission of ITCs to continue to work with the offenders as they navigate the stages of change in relation



to their self-defeating thinking patterns and non-compliant behaviors.

(D) Compliance with program rules and directives are important, but it is vital that offenders be allowed time to learn the skills required to move forward in their recovery, and for staff to resist the temptation to prematurely execute the unsuccessful program exit of an offender.

(E) DOC classification and DOC administrative staff are primarily responsible for responding to an offender's behavior that results in writing a conduct violation report. ITC treatment staff may write conduct violation reports, but they shall not interfere with the due process involved in the hearing of such reports and in the adjudication of those reports.

(F) An offender's behavior that results in a conduct violation report, or otherwise has been documented as negative behavior or behavior that is inconsistent with the rules and regulations of the ITC, shall be addressed through the therapeutic intervention continuum.

1. Depending on the seriousness or consistency of the offender's non-compliant behavior, stages of the continuum may be superseded. Every effort shall be made to intervene at the least intensive level of intervention possible, and to proceed forward over time in intensified interventions. The continuum of therapeutic intervention shall include, but is not limited to:

A. Non-adversarial confrontation;

B. Non-adversarial confrontation with therapeutic assignments;

C. Treatment plan modifications;

D. Behavioral contracts;

E. Referral to the OMT; and

F. Referral to the PRC.

2. Depending on the offender's receptiveness to a given intervention, some interventions may be repeated. Interventions repeated for different types of behavior shall be considered distinct and separate.

3. Successful interventions shall be acknowledged as such, with documentation in the offender's record. A successful intervention is an indication of progress, even if the intervention may need to be repeated later in the offender's treatment.

(G) Consistent non-compliance with program rules by an offender, despite documented and intensified interventions, may result in referral to the PRC due to lack of therapeutic gain.

1. Such referral must indicate documented attempts to assist the offender in understanding the need to change their behavior and challenging thinking patterns that have resulted in the non-compliance. The integrity of the therapeutic process shall be emphasized. Substantial documentation of all interventions is required to substantiate a termination based on lack of therapeutic gain.

AUTHORITY: sections 313.842, 630.050, and 630.655, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 20, 2019, effective Oct. 30, 2019.*

**Original authority: 313.842, RSMo 1991, amended 1996, 2000; 630.050, RSMo 1980, amended 1993, 1995, 2008; and 630.655, RSMo 1980.*

9 CSR 30-3.190 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for Women and Children

PURPOSE: This rule establishes requirements for CSTAR programs serving women and children.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Treatment Philosophy and Guiding Principles. Women and children's CSTAR programs shall demonstrate through policy and practice that women's substance use disorders differ from men's, both in their etiology and the services and supports needed for recovery.

(A) Women and children's CSTAR programs shall ensure—

1. Emotional and physical safety of the women and children served takes precedence over other considerations in the delivery of services;

2. Women-only therapeutic environments are available;

3. Trauma-sensitive services and supports to increase women's access to care, engagement, and retention in treatment are provided or arranged, such as community support, transportation, and child care;

4. Women-specific service needs and topic areas are addressed in treatment and through support services; and

5. Multiple modalities are offered to meet the needs of women such as group and individual counseling, community support, peer support, and opportunities for women to be in treatment with their children.

(B) Staff shall possess the knowledge and expertise to engage women with histories of trauma, recognize the presence of trauma symptoms, understand the role of trauma in the lives of women seeking services, and conduct themselves in ways that are not retraumatizing to those being served. The following trauma-informed principles shall be integrated into the program's service delivery practices:

1. Safety—ensuring physical and emotional safety for individuals and staff;

2. Trustworthiness—maximizing trustworthiness through task clarity, consistency, and maintaining appropriate interpersonal boundaries;

3. Choice—maximizing the experience of developmentally appropriate choice and control;

4. Collaboration—maximizing collaboration and sharing of power between individuals and staff; and

5. Empowerment—building on individuals' capacities, encouraging them to have a voice and mastery of life, and prioritizing power and growth.

(C) All women shall receive or have trauma-informed, evidence-based services available and shall not be required to disclose their trauma history in order to receive those services. Women's treatment shall incorporate universal, trauma-informed principles into every service, regardless of whether trauma is disclosed.

(D) The Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment Improvement Protocol 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women*, 2015, hereby incorporated by reference and made a part of this rule, shall serve as a guide for the program's service delivery practices. This document is published by and available from SAMHSA, 1 Choke Cherry Road, Rockville, Maryland 20857, (877) 726-4727, www.samhsa.gov. This rule does not incorporate any subsequent amendments or additions to this publication.

(2) Eligibility Criteria and Program Structure. The program shall provide treatment services and other supports solely to women and their children. Services shall be based on individual and family needs, in accordance with admission and eligibility criteria for CSTAR.

(A) Priority admission shall be for women who are—

1. Pregnant and inject drugs;

2. Pregnant;

3. Postpartum (up to one (1) year after delivery);

4. Have children in their care and custody, including those at risk of losing custody or attempting to regain custody of their children;

5. Applicants or recipients of Temporary Assistance for Needy Families referred by the Department of Social Services, Family Support Division; and

6. Other populations specified by the department.

(B) Women who meet priority criteria shall be immediately admitted to the CSTAR program and receive appropriate services.

1. If the program is unable to provide immediate admission, staff shall facilitate referral to another women and children's CSTAR program that can provide immediate admission.

2. If immediate admission with an alternative women and children's CSTAR program is not available for a woman who is pregnant, program staff shall contact designated department staff to obtain assistance in facilitating arrangements for immediate admission with another program.

3. Women shall not be denied admission based solely on medication prescribed and monitored by a licensed physician, physician assistant, assistant physician, or advanced practice registered nurse (APRN) for an opioid disorder or other physical or behavioral health disorder.

(C) Adolescents who meet priority criteria shall be admitted if, in the staff's clinical judgment, the adolescent can appropriately participate in and benefit from the services and milieu offered. Programs shall have policies and procedures for serving adults and adolescents in the same environment.

(D) Culturally competent services shall be provided in the context of a family-centered and family-focused treatment model. Members of the treatment team shall be responsible for adapting to the needs of the mother and her family. An array of services shall be available to—

1. Assist families in functioning as a unit by establishing and maintaining a schedule, structure, regular habits, and healthy routines;

2. Allow for an integrated family plan that builds coherence and prioritizes the needs of individual family members;

3. Accommodate children who accompany their mother, in accordance with the mother's wishes;

4. Address substance use, mental, physical and emotional health, developmental, social, economic, and environmental needs of women and their families;

5. Allow women to define their families and focus on healthy relationships between parents, children, and others identified by the mother;

6. Address evolving and changing family engagement, recognizing everyone may not participate at the same time, stay the same length of time, or have the same motivations; and

7. Assist women and their families in accessing other services and supports in the community.

(E) Family oriented living arrangements, indoor recreational space for children and families, and safe, protected outdoor recreational and leisure space shall be available.

(F) Women and their children shall have access to age-appropriate physical healthcare, including obstetric and pediatric care.

(3) Gender-Responsive Services. The program shall address therapeutic issues relevant to women and their specific needs, as identified in individual treatment plans.

(A) Staff shall understand and recognize the distinctive characteristics and biopsychosocial issues associated with women in general, and specifically women who have substance use disorders, to provide effective treatment.

(B) Services shall be culturally sensitive and recognize the unique characteristics of women's initiation of substance use, effects of use, histories of trauma, co-occurring mental, developmental, and physical health disorders, and other treatment issues specific to women.

(C) Services shall be designed to assist women in maintaining their recovery and resiliency, such as—

1. Parenting and child development;

2. Life skills;

3. Family programs;

4. Facilitation of supervised parent-child bonding;

5. Educational remediation and support;

6. Employment readiness services;

7. Linkages with legal and child welfare systems, including reunification with children if applicable;

8. Housing support efforts and referrals;

9. Co-occurring disorder services, including access to psychological and pharmacological treatments for mental health disorders;

10. Education and linkage to eating disorder and nutrition services;

11. Medication services, including access to approved medication to treat substance use disorders for women who are pregnant; and

12. Recovery support and community support services that address long-term recovery needs such as domestic violence services, career counseling, legal services, and transportation services.

(4) Child Care. The program shall ensure child care is not a barrier to engagement in services or retention in treatment by ensuring coordination or facilitation of child care when the mother is participating in services.

(A) Programs offering on-site child care shall obtain licensure as a child care center as specified in 5 CSR 25-500.

(B) On-site child care shall—

1. Be designed to meet the developmental needs of the various age groups served and address cultural and other identified needs;

2. Provide each child with a variety of easily accessible, developmentally appropriate learning and play materials;

3. Provide for a balance between free play and organized activities, between individual play and sharing experiences among children, and promote individual contact between staff and each child;

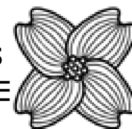
4. Provide reasonable regularity of age-appropriate activities with allowance for a variety of special events and time for children to be outdoors daily, weather permitting;

5. Be culturally responsive, nonjudgmental, trauma sensitive, and respectful;

6. Take responsible precautions to ensure a safe, welcoming, and sanitary environment appropriate for children;

7. Ensure no weapons are brought on to the premises;

8. Provide privacy (such as use of bathroom, sleeping arrangements) for opposite sex children transitioning into



school and for any children demonstrating a need for privacy; and

9. Accommodate the needs of children with disabilities in accordance with the Americans with Disabilities Act as amended (ADAAA) or refer to another provider if the child's needs are identified to be beyond the scope of the program. The ADAAA, effective January 1, 2009, is hereby incorporated by reference and made a part of this rule and is available from the U.S. Department of Justice, 950 Pennsylvania Avenue NW, Civil Rights Division, Disability Rights Section-NYA, Washington, DC 20530, (800) 514-0301 voice, (800) 514-0383 TTY. This rule does not incorporate any subsequent amendments or additions to this publication.

(C) Child care may be arranged through a contractual agreement with a local, licensed child care center. Contracts shall comply with 9 CSR 10-7.090(6).

(D) Child care will not be funded by the department for children who are over fourteen (14) years of age, unless specific authorization has been granted by department staff.

(5) Supervision of Children. The program shall ensure children in child care are supervised in accordance with Department of Elementary and Secondary Education staff/child ratios as specified in 5 CSR 25-500.

(A) The parent/guardian shall be responsible for providing supervision when the child is not attending child care or participating in other scheduled program activities.

(B) Program staff shall assist the parent in providing age-appropriate activities, training, and guidance.

(6) Education for Children. The program shall assist the parent/guardian as necessary to ensure educational opportunities for school-age children in accordance with the requirements of the Department of Elementary and Secondary Education.

(7) Assessing Children's Needs and Documenting Services. Program staff shall inform women of the services available for children and educate them about involving their children in treatment while respecting the mother's wishes.

(A) When the mother chooses to involve her children in treatment, a trained staff member shall complete an initial screening utilizing an age-appropriate, validated instrument to determine specific service needs beyond child care and community support. The screening shall include an interview with at least one (1) parent and the child, whenever appropriate.

(B) If the need for a clinical assessment is indicated by the screening, a qualified staff member shall complete an assessment utilizing an age-appropriate, validated instrument. The assessment must be completed prior to delivery of services beyond child care and community support.

(C) An individual plan shall be developed based on the needs of the mother and child, with the results of the assessment serving as a guide. The child's consent for treatment must be signed by the legal guardian.

(D) Services provided for children, including child care and community support, shall be documented in a separate clinical record for the child. The record shall include the child's developmental, physical, emotional, social, educational, and family background and current status.

(8) Services for Children. The program shall ensure trauma-informed services are available to address therapeutic issues relevant to children, based on the needs of individuals being served at those locations.

(A) Developmentally appropriate activities and services shall be offered to meet the social, emotional, and behavioral needs of children to—

1. Build self-esteem and self-awareness;

2. Learn to identify and express feelings;

3. Build positive family relationships;

4. Learn healthy social engagement, peer relationships, social pressure skills, and teamwork;

5. Develop decision-making skills;

6. Learn self-management (impulse control, stress management, and goal-setting);

7. Understand substance use disorders and its effects on the family;

8. Learn and practice nonviolent ways to resolve conflict;

9. Learn safety practices such as personal space, boundaries, and personal safety;

10. Address developmental needs; and

11. Provide education on preventing alcohol, tobacco, and other drug use.

(B) Services for children shall address the issues and needs identified by the mother and her children, as documented in the individual plan, utilizing structured and unstructured therapeutic activity.

(C) Specialized services shall be provided including, but not limited to, children with high risk of sexual abuse, sexual acting-out behaviors, suicide risk, and the service needs of infants, toddlers, and preschoolers.

(D) Services for children from birth to three (3) years of age shall include, at a minimum, developmentally appropriate parent-child interactive bonding activities and developmentally appropriate structured activities that promote and nurture the growth and well-being of the infant.

(9) Qualified and Competent Staff. The program shall maintain a core workforce (employed or contracted) that is appropriately qualified and determined to be competent to adequately address the needs of women and children and deliver the behavioral health services the program is certified to provide.

(A) The program shall document that staff providing services for women and/or children have training in the following areas:

1. Trauma knowledge, trauma-informed treatment, identification of signs and symptoms of domestic violence, spousal or partner abuse, and child abuse and neglect, with special emphasis on failure to thrive and sexual abuse of children;

2. Child development and age-appropriate behaviors;

3. Parenting attachment styles and skills appropriate to infants, toddlers, preschool, and school-age children; and

4. The impact of substance use and substance use disorders on parenting and family units.

(B) The program shall document that staff working with children have ongoing training and demonstrate job-appropriate functional comprehension in the following areas:

1. The impact of prenatal drug and alcohol exposure on child development;

2. The effect of substance use disorders on parenting children and families;

3. Trauma knowledge, trauma's impact on child brain development, and long-term impact of adverse childhood experiences;

4. Parenting attachment styles and skills appropriate to infants, toddlers, preschool, and school-age children;

5. Appropriate play activities according to developmental stage;

6. Common children's behavioral and developmental

problems;

7. Recognition of sexual acting-out behavior; and

8. The substance use disorder recovery process, especially as it relates to family units.

(10) Health Promotion. The program shall maintain a safe, healthy environment that is responsive to the physical, behavioral, and emotional health needs of women and children.

(A) A full-time licensed nurse shall be accessible to women and children to provide trauma-informed medical and other consultative services necessary to monitor and manage health issues.

1. Services performed by a licensed practical nurse (LPN) must fall within their scope of practice and shall be supervised by a licensed physician (including psychiatrist), licensed physician assistant, licensed assistant physician, APRN, or registered nurse (RN).

(B) Key service functions of the nurse(s) shall include, but are not limited to—

1. Obtaining initial medical histories and vital signs of individuals admitted to the program;

2. Monitoring general health needs and meeting with individuals about medical concerns;

3. Providing disease prevention, risk reduction, and reproductive health education;

4. Reviewing medication requirements and educating individuals about the benefits of taking medications as prescribed and monitoring medication compliance; and

5. Monitoring lab levels, including consultation with the individual served, her physician, and the treatment team.

(C) The program shall employ staff in sufficient numbers and with appropriate training to respond to emergency situations and provide cardiopulmonary resuscitation (CPR) when necessary.

1. At least one (1) staff member who has current training in First Aid and CPR for infants, children, and adults shall be on duty seven (7) days per week, twenty-four (24) hours per day.

2. Staff must maintain current First Aid and CPR certification for healthcare providers through training that includes hands-on practice and in-person skills assessment. Online-only training is not acceptable.

(D) The program shall demonstrate effective working relationship(s) with a licensed physician, hospital, and/or clinic to provide access to emergency services and/or ongoing medical care for women, including pregnant and postpartum women, and their children.

(E) The program shall ensure an evaluation of medical need for each woman and child and shall ensure that each woman and child is medically stable to safely and adequately participate in services. For women, the evaluation of medical need shall include:

1. Current physical status, including vital signs; and

2. Symptoms of intoxication, impairment, or withdrawal.

(F) The program shall ensure that recommendations related to an individual's behavioral or physical health from a licensed physician (including psychiatrist), licensed physician assistant, licensed assistant physician, or APRN are encouraged and coordinated regularly by their primary health care provider.

(G) Health-related services may include but are not limited to—

1. Nutritional counseling;

2. Education about reproductive health;

3. Wellness programs;

4. Education on sleep and dental hygiene;

5. Education about trauma and long-term physical health risks and conditions;

6. Education about sexually transmitted infections and infectious diseases, such as viral hepatitis and HIV/AIDS; and

7. Preventive healthcare education.

(H) If a specialized program for women and children provides withdrawal management/detoxification services, the program shall comply with applicable standards under 9 CSR 30-3.120. A specialized program for women and children shall not be required to accept applications for ninety-six- (96-) hour civil detention of intoxicated persons due to the presence of children within the program.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded and readopted: Filed Aug. 17, 2022, effective March 30, 2023.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.192 Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program for Adolescents

PURPOSE: This rule establishes requirements for certified/deemed certified CSTAR programs for adolescents.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Other Regulations. Adolescent CSTAR programs shall comply with 9 CSR 10-7 Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-5 General Program Procedures, and 9 CSR 30-3 Substance Use Disorder Prevention and Treatment Programs, as applicable.

(2) Age Criteria. The program shall provide treatment, rehabilitation, and other services solely to individuals age nine through seventeen (9-17) and their family members/natural supports, as appropriate. Services in a residential setting shall be available for individuals age twelve through seventeen (12-17).

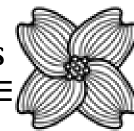
(A) Exceptions to the age requirements may be authorized through the department's clinical review process.

(3) Registered Sex Offenders and Youth Identified on the Juvenile County Registry. Prior to admission, program staff shall verify whether the individual is registered as a juvenile sex offender in the county in which they reside pursuant to section 211.425, RSMo, or is identified as an offender on the Missouri State Highway Patrol (MSHP) sex offender registry pursuant to sections 589.400-589.425, RSMo.

(A) If the individual is an identified juvenile sex offender on the juvenile county sex offender registry, admission to the CSTAR program can be considered.

(B) If the individual is an identified offender on the MSHP sex offender registry, admission to the CSTAR program shall not be made.

(C) All results of verification with the county juvenile sex



offender registry or MSHP sex offender registry, as well as decisions related to program admission, shall be documented and a record of communication to the individual's parent/guardian and referral source(s), as applicable, shall be maintained by the program.

1. If the parent/guardian disagrees with a decision of ineligibility for admission, they shall be informed of the grievance process of the CSTAR program.

(D) If the individual is not admitted to the program within sixty (60) days after program staff have conducted verification of the county juvenile sex offender registry, staff are responsible for rechecking the registry prior to admission. Rechecking the registry is always an option and should be completed any time there is a concern, even when the sixty (60) days have not yet passed.

(E) The MSHP registry is updated in real time and should be checked any time the sixty (60) days has passed.

(4) Eligibility Criteria and Level of Care. The program shall comply with 9 CSR 30-3.151 Eligibility Determination, Assessment, and Treatment Planning in CSTAR Programs, to ensure individuals are placed in the appropriate level of care and receive individualized services.

(5) Treatment Principles and Therapeutic Issues Relevant to Adolescents. The program shall address therapeutic issues relevant to adolescents and shall address their specific needs. The following principles and methods shall be reflected in services delivered to adolescents:

(A) Adolescents are effectively treated in therapeutic environments that are programmatically and physically separate from treatment services for adults;

(B) Services shall maintain individuals in the family and community setting, as clinically appropriate;

(C) Services shall involve parents/guardian and other family members/natural supports in the treatment and recovery process, when clinically appropriate. If the caregivers are not available, program staff shall assist in developing alternate social and family/natural support systems for the adolescent;

(D) Services to family members/natural supports shall be directed to understanding and supporting the adolescent's recovery and resiliency, identifying and intervening with any behavioral health needs of their caregiver(s), improving parenting skills and communication skills within the family or with other caregivers/natural supports, and facilitating improved family function;

(E) A cooperative team approach shall be utilized in order to provide a consistent therapeutic environment;

(F) Effectively treating substance use disorders in adolescents requires identifying and treating other co-occurring conditions they may have;

(G) Services shall be coordinated with the juvenile justice system, children's services, and other community agencies to ensure the needs of individuals are met;

(H) Staff shall possess the knowledge and expertise to engage adolescents with histories of trauma, recognize the presence of trauma symptoms, understand the role of trauma in the lives of adolescents, and conduct themselves in ways that are not retraumatizing to those being served;

(I) Issues such as violence, child abuse, and risk of suicide shall be identified and addressed;

(J) Communicable disease counseling and testing for sexually transmitted infections, such as HIV and hepatitis B and C, are important aspects of adolescent treatment (refer to 9 CSR 30-3.110(C) for service delivery requirements). Testing may be waived if parent/guardian consent is not obtained and is documented, as applicable to the individual served; and

(K) Service delivery shall address recovery/resiliency skill development including, but not limited to—

1. Substance use prevention and education;
2. Assertiveness training;
3. Conflict resolution skills;
4. Emotional regulation;
5. Social network development;
6. Leisure time management;
7. Problem-solving skills;
8. Adolescent development;
9. Sexual health; and
10. Trauma.

(6) Treatment Setting. Adolescents may receive substance use disorder treatment services in a variety of settings including but not limited to the following:

(A) Home of the parent/guardian;

(B) Foster home;

(C) Residential settings operated by the CSTAR program;

(D) Juvenile detention (services are not reimbursable by Medicaid);

(E) Other supervised living arrangements;

(F) Independent living; and

(G) School.

(7) Family Involvement. Each adolescent's living arrangement and family situation shall be reviewed by program staff in order to identify needs and to develop treatment goals and recovery supports for the adolescent and their family members and/or other natural supports.

(A) This review shall be conducted by a licensed mental health professional (LMHP) or a qualified addiction professional (QAP) or qualified mental health professional (QMHP) who is under the supervision of an LMHP.

(B) Refusal by the caregiver for an in-home visit shall not constitute automatic denial of treatment services for the individual.

(C) The program shall actively involve family members/natural supports in the treatment process including educational and counseling sessions and transfer and discharge planning, unless contraindicated for legal or clinical reasons which are documented in the individual record. Efforts to involve family members/natural supports, and any reasons for lack of participation, shall be included in documentation.

(D) Staff shall orient the parent or legal guardian regarding—

1. Treatment philosophy and design;
2. Discipline and any emergency safety interventions used by the program;
3. Availability of staff to conduct home-based treatment and community support services;
4. Emergency medical procedures; and
5. Expectations about ongoing participation by family members/natural supports.

(8) Educational and Vocational Opportunities. The program shall have established partnerships with local school district(s) to ensure individuals' academic and vocational needs are met in accordance with their Individual Education Program (IEP) and/or 504 Plan.

(A) For youth enrolled in American Society of Addiction Medicine (ASAM) Level 1, Level 2.1, or Level 2.5, certain CSTAR services may be provided within the school setting. An agreement for the provision of such services must be arranged

by the CSTAR provider and their local school district(s). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd Edition, 2013, is hereby incorporated by reference and made a part of this rule as published by and available from The American Society of Addiction Medicine, 11400 Rockville Pike, Suite 200, Rockville, MD 20852, (301) 656-3920. This rule does not incorporate any subsequent amendments or additions to this publication.

(B) CSTAR services delivered in the school setting are limited to three (3) hours, twelve (12) units per week total.

(C) CSTAR services that may be delivered in school settings are limited to the following:

1. Comprehensive assessment;
2. Community support;
3. Individual counseling;
4. Group counseling;
5. Group rehabilitative support;
6. HIV pre-testing and post-testing counseling;
7. Medication services support;
8. Family therapy/conference; and
9. Peer support.

(9) Privilege System. Any system used by the program that encourages/rewards appropriate behaviors or restricts privileges in response to an individual exhibiting impermissible behaviors must be trauma sensitive, defined in writing, stated in behavioral terms to the extent possible, and applied consistently to all individuals.

(10) Safety and Health. The program shall maintain a safe, healthy environment which is responsive to the behavioral and physical health needs of adolescents.

(A) Adolescents shall be prohibited from using tobacco or products containing nicotine on the premises, grounds, and any off-site program functions with the exception of prescribed nicotine replacement therapies with parent/guardian consent.

(B) Physical examinations shall be completed as specified in 9 CSR 30-3.152.

(C) The program shall demonstrate effective collaborative working relationship(s) with local healthcare providers, hospital(s), urgent care clinic(s), and other community resources to provide physical health care for adolescents, as needed.

(11) Staff Training and Supervision. The program shall comply with *The ASAM Minimum Staffing Standards for Department of Mental Health*, September 2022, hereby incorporated by reference and made a part of this rule, developed by and available from the Department of Mental Health, 1706 E. Elm St., PO Box 687, Jefferson City MO 65101, (573) 751-4942, https://dmh.mo.gov/media/pdf/dbh-asam-minimum-staffing-requirements. This rule does not incorporate any subsequent amendments or additions to this publication.

(12) Structured Activities. In addition to treatment services, individuals receiving services in a residential level of care shall participate in structured activities during daytime and evening hours such as academic education, completing assignments, self-help groups, family visits, and positive leisure activities.

(13) Staffing Patterns in Residential Levels of Care. Programs shall comply with *The ASAM Minimum Staffing Standards for Department of Mental Health*, September 2022, hereby incorporated by reference and made a part of this rule, developed by and available from the Department of Mental Health, 1706 E. Elm St., PO Box 687, Jefferson City MO 65101, (573) 751-4942, https://dmh.mo.gov/media/pdf/dbh-asam-minimum-staffing-requirements. This rule does not incorporate any subsequent amendments or additions to this publication.

(A) If the program serves a mixed-gender population in residential levels of care, the staffing pattern shall include at least one (1) female and at least one (1) male staff member any time individuals are present.

(B) If a residential level of care is provided only for individuals of the female gender, a female staff member must be present twenty-four (24) hours per day, seven (7) days per week.

(C) If a residential level of care is provided only for individuals of the male gender, a male staff member must be present twenty-four (24) hours per day, seven (7) days per week.

1. Refer to 9 CSR 10-7.010(4)(A)7. and 9 CSR 10-7.020(3)(A)4., related to service delivery practices that are responsive to individual needs.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 15, 2002, effective Nov. 30, 2002. Amended: Filed July 29, 2002, effective March 30, 2003. Amended: Filed Sept. 14, 2023, effective March 30, 2024.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.195 Outpatient Substance Use Disorder Treatment Programs

PURPOSE: This rule specifies service delivery requirements for certified/deemed certified outpatient substance use disorder treatment programs that do not have a contractual relationship with the department for the provision of services.

(1) General Requirements. Each agency that is certified/deemed certified by the department as an outpatient substance use disorder treatment program shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.010 through 9 CSR 10-7.140, as applicable.

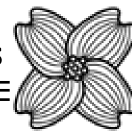
(A) The agency shall have written policies and procedures defining eligibility for services, screening, admission, and clinical assessment to assist in the support of each individual.

(B) The program shall maintain reasonable hours to assure accessibility.

(2) Services. An intake screening and admission assessment shall be conducted in accordance with 9 CSR 10-7.030 (1) and (2).

(A) At a minimum, the following services as defined in 9 CSR 30-3.110, or in other regulations as indicated, shall be provided on an outpatient basis in accordance with individual needs:

1. Case management;
2. Continuing recovery planning, as defined in 9 CSR 10-7.030(8);
3. Crisis prevention and intervention;
4. Family conference;
5. Family therapy;
6. Group rehabilitative support;
7. Individual and group counseling, including trauma and co-occurring disorders;
8. Medication services;
9. Treatment planning as defined in 9 CSR 10-7.030(4) and (5); and
10. Information and education, such as community



resources available, substance use disorders, and behavioral health disorders.

(B) If the program does not directly provide all of the services specified in paragraphs (2)(A)1. to 10. of this rule, the services must be available to all individuals through coordinated and documented service delivery practices with other qualified providers within the same geographic area.

(3) Treatment Planning. Services shall be provided under the direction of an individual treatment plan as specified in 9 CSR 10-7.030(4). Each individual served or parent/guardian must provide informed, written consent to treatment prior to delivery of services, and a copy of the consent form must be retained in the individual's record. Consent to treat documentation shall be updated annually, as applicable.

(A) An initial treatment plan goal shall be developed at intake to address immediate needs during the admission process to the outpatient treatment program.

(B) The treatment plan shall be completed within the first three (3) outpatient visits.

1. Each individual shall participate in the development of his/her treatment plan.

(C) Treatment plans shall be reviewed and updated every ninety (90) days to reflect the individual's progress and changes in treatment goals and services.

(D) Treatment plans must be revised and rewritten at least annually.

(E) Treatment plans shall be developed and approved by a licensed mental health professional or qualified addiction professional (QAP).

(4) Staff Requirements. Individual and group counseling must be delivered by a licensed mental health professional, QAP, or associate counselor.

(5) Records. Each agency shall maintain an organized clinical record system (electronic or paper) in accordance with 9 CSR 10-7.030(13) which ensures easily retrievable, complete, and usable records stored in a secure and confidential manner.

(A) Each agency shall implement written procedures to assure quality of individual records, including a routine review to ensure documentation requirements are being met.

AUTHORITY: sections 630.050, 630.655, and 631.010, RSMo 2016. Original rule filed May 28, 2021, effective Dec. 30, 2021.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.200 Research
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.192–630.198 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.201 Substance Awareness Traffic Offender Programs

PURPOSE: This rule identifies the Department of Mental Health as being responsible for the certification of Substance Awareness Traffic Offender Programs (SATOP) as mandated by state statute. The rule includes program purpose and mission, functions, certification requirements, and types of SATOPs certified by the department.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Purpose and Mission. The Substance Awareness Traffic Offender Programs (SATOP) is a statewide system of comprehensive, accessible, community-based education and treatment programs for individuals referred as the result of an alcohol- or drug-related traffic offense. The department develops the standards by which SATOPs operate in Missouri and certifies programs to provide services in accordance with those standards.

(A) The mission of SATOP is to—

1. Inform and educate individuals about the dangers and consequences of alcohol- and drug-impaired driving;

2. Educate youth about the risks and consequences of alcohol and drug use and help them develop skills to make healthy choices;

3. Motivate individuals for personal change and growth; and

4. Contribute to the public health and safety of Missouri by preventing and reducing the prevalence of alcohol- and drug-impaired driving.

(B) Completion of a SATOP is a prerequisite for driver's license reinstatement for individuals who—

1. Have pleaded guilty or have been found guilty of an alcohol- or drug-impaired driving offense;

2. Have been referred as a result of an administrative suspension or revocation of their driver's license, court order, condition of probation, or plea bargain; or

3. Have been charged with minor in possession and zero tolerance offenses.

(2) Program Functions. SATOPs shall provide or arrange for screening, clinical assessment when indicated, education, and treatment services for individuals referred to the program.

(A) All SATOPs shall comply with the 2023 edition of the *SATOP Provider Manual*, hereby incorporated by reference and made a part of this rule as published by and available from the Department of Mental Health, 1706 E. Elm Street, PO Box 687, Jefferson City, MO 65102. This rule does not incorporate any subsequent amendments or additions to this publication.

(3) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the SATOP to demonstrate achievement of the program's purpose, mission, and functions. Indicators can include, but are not limited to—

(A) Characteristics of persons participating in SATOP such as demographics, blood alcohol content (BAC) at the time of arrest, prior drinking and driving arrests, prior participation in a SATOP, and prior treatment for a substance use disorder;

(B) Consistent use of screening criteria including the rate at which persons are assigned to the various types of education and treatment programs;

(C) Rate at which persons successfully complete a SATOP and

the various types of programs available;

(D) Reductions in alcohol- and drug-impaired driving among those who complete a SATOP; and

(E) Program satisfaction and feedback from individuals served.

(4) Types of Programs. The department certifies the following types of SATOPs:

(A) Offender Management Unit (OMU) – entry point for individuals referred to a SATOP where they are screened by a SATOP Qualified Professional (SQP) and referred to the appropriate education or treatment program;

(B) Adolescent Diversion Education Program (ADEP) – basic education for individuals under the age of twenty one (21) who have been charged with or convicted of alcohol- and drug-related driving offenses under Missouri's Abuse and Lose, Minor in Possession, or Zero Tolerance laws;

(C) Offender Education Program (OEP) – basic education for first-time adult offenders to assist them in understanding the consequences of alcohol- and drug-impaired driving and identifying strategies to assist in changing their behavior;

(D) Weekend Intervention Program (WIP) – specialized intervention services and education for high-risk, first-time offenders and individuals with multiple driving while intoxicated or driving under the influence (DWI/DUI) offenses who are showing signs and symptoms of a substance use disorder with mild to moderate severity;

(E) Clinical Intervention Program (CIP) – intensive outpatient treatment for individuals who have multiple DWI/DUI offenses or high-risk, first-time offenders who are showing signs and symptoms of a substance use disorder with moderate severity; and

(F) Serious and Repeat Offender Program (SROP) – intensive treatment for individuals who have multiple DWI/DUI offenses and are identified through the screening process as having high-risk, high-need risk factors, and a diagnosed substance use disorder.

(5) Requirements for Program Certification. SATOPs must be located in an office, clinic, or other professional setting that allows for private, one-on-one interviews and ensures confidentiality for individuals served. The department must approve program location(s) prior to the delivery of services.

(A) All SATOPs shall comply with 9 CSR 30-3.032.

(B) CIPs and SROPs shall comply with 9 CSR 30-3.130 and fulfill department contract requirements.

(C) The following rules are waived for OMUs, OEPs, ADEPs, and WIPs unless the department determines a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.030;
2. 9 CSR 10-7.060;
3. 9 CSR 10-7.080;
4. 9 CSR 30-3.100; and
5. 9 CSR 30-3.110.

(6) Other Requirements. In addition to the requirements listed under 9 CSR 30-3.032, the department uses the following criteria in certifying Substance Awareness Traffic Offender Programs:

(A) The department reserves the right to limit the issuance of SATOP certification in areas of the state where it cannot be determined a need exists for the service and/or it cannot be determined the proposed service will serve the best interest of individuals in that area.

1. Determination of need is at the department's sole discretion as the designated state authority responsible for SATOP certification.
2. The determination of need is based on applicable data, such as the number of DWI/DUI arrests and the number of currently certified SATOPs within the proposed service area;

(B) The department must approve any new program site prior to the delivery of SATOP services at the site; and

(C) The department reserves the right to deny certification to any SATOP that does not provide a minimum of services for at least fifty (50) persons per year.

(7) Treatment Programs Recognized for SATOP. When the screening results indicate the need for treatment for a substance use disorder, arrangements shall be made for the person to participate in treatment services.

(A) The department recognizes the following types of treatment programs for individuals with an alcohol- and/or drug-related traffic offense whose SATOP screening indicates the need for treatment:

1. Substance use disorder treatment programs certified by the department;
2. CIPS; and
3. SROPs.

(8) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

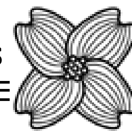
AUTHORITY: sections 302.420, 302.425, 302.540, 302.580, 630.050, 630.053, 630.655, and 631.010, RSMo 2016, and section 577.001, RSMo Supp. 2023. This rule was originally filed as 9 CSR 30-3.700. Emergency rule filed April 22, 1983, effective May 2, 1983, expired Aug. 11, 1983. Original rule filed May 13, 1983, effective Sept. 11, 1983. Amended: Filed May 6, 1985, effective Sept. 1, 1985. Rescinded and readopted: Filed Nov. 2, 1987, effective May 15, 1988. Amended: Filed Sept. 5, 1990, effective Feb. 14, 1991. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.201 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed June 15, 2004, effective Jan. 30, 2005. Amended: Filed Feb. 16, 2018, effective Aug. 30, 2018. Amended: Filed Nov. 4, 2020, effective May 30, 2021. Amended: Filed June 29, 2023, effective Jan. 30, 2024.*

**Original authority: 302.420, RSMo 1987, amended 1991, 1993, 1996, 2003, 2014; 302.425, RSMo 1987, amended 1991, 1996, 2014; 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 302.580, RSMo 1982, amended 1993, 1996, 2003, 2014; 577.001, RSMo 1982, amended 1986, 1996, 2005, 2014, 2015, 2016, 2017, 2018, 2020; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2011; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.202 SATOP Administration and Service Documentation

PURPOSE: This rule establishes administrative procedures and practices in the operation of Substance Awareness Traffic Offender Programs.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this



rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Access. The program shall be accessible to the public by maintaining reasonable business hours and ready telephone access.

(2) Admission. Substance Awareness Traffic Offender Programs (SATOPs) shall accept individuals referred by a court order, condition of probation or parole, or plea bargain who have had their driver's license administratively revoked or suspended for reasons of an alcohol- or drug-related traffic offense. Individuals will be screened by a qualified staff person to determine program placement. Women who are pregnant must be referred to a department-certified women's treatment program for a clinical assessment to determine service needs.

(3) Conflict of Interest. An agency which operates probation services, court supervision programs, or counseling programs not certified by the department must keep these functions separate and distinct from SATOP.

(A) The agency must clearly communicate to individuals that completion or the failure to complete these programs will not affect the outcome of their participation in SATOP.

(4) Notice to Individuals Served. Written notice shall be provided to individuals regarding the cost of the program, dates, times, location, and requirements for successful program completion.

(5) Attendance Records. Attendance records shall be maintained for each session.

(6) Receipts. Receipts shall be issued for all fees collected from individuals enrolled in a SATOP.

(7) Program Participation. All SATOPs shall have written policies and procedures which are followed by staff to manage situations in which an individual arrives at a program under the influence of alcohol and/or illegal drugs, is not taking prescription medication(s) as directed, or is detracting from a program due to uncooperative behavior.

(A) A written report of the situation shall be prepared by the staff person(s) involved. The report shall be reviewed by the program administrator who is responsible for determining the individual's continued participation in the program.

(B) A person who has justifiably been denied access or is removed from a program is not considered to have satisfactorily completed the program.

(C) Readmission to a program for an individual who has justifiably been denied access or removed shall be in accordance with the program's policies and procedures. Proactive measures should be taken to assist individuals in reengaging in services and successfully completing a program.

(D) Individuals who continue to actively use alcohol and/or illegal drugs, or do not take prescribed medication as directed while enrolled in a program, may be referred to more intensive services such as withdrawal management and substance use disorder treatment with residential support. In these instances, the individual may fulfill SATOP requirements by completing a comparable program.

(8) Screening and Referral Process. Offender Management Unit (OMUs) must have written policies and procedures for conducting individualized screenings and issuing program recommendations based on screening results.

(A) The screening recommendation is provided in writing to each individual at the completion of the screening.

(B) Each individual is informed of their right to a second opinion from an alternative OMU and right to judicial review if he/she objects to the recommendation of the originating OMU. The notice must be in written format and signed by the individual.

1. The following criteria applies to second opinions:

A. The right to a second opinion is forfeited if the individual has enrolled in the originating OMU's recommended program;

B. The alternative OMU must conduct a thorough review of the individual's original screening recommendation and obtain a copy of the SATOP Offender Assignment form from the originating OMU (release of information is not required);

C. The alternative OMU must obtain a current driving record from the Department of Revenue or other reliable source;

D. The individual must pay the screening fee for the second opinion but is not required to pay the supplemental fee; and

E. The OMU issuing the second opinion is the official OMU of record. The OMU is responsible for issuing the screening recommendation to the individual, monitoring the individual's compliance with the recommendation, and notifying the originating OMU to close the individual's record in their program.

(C) An individual who objects to an OMU's screening recommendation may file a petition for review and determination in the circuit court of the county in which the recommendation was made pursuant to sections 302.304 and 302.540, RSMo. The motion must be filed using the printed form provided by the Office of State Courts Administrator, 2112 Industrial Drive, PO Box 104480, Jefferson City, MO 65110.

(9) Resources and Referrals. All SATOPs shall maintain a resource directory of area self-help groups and substance use disorder treatment programs that is readily accessible to individuals being served.

(A) Each individual who receives a recommendation for substance use disorder treatment shall be given a directory of certified treatment programs for the area in which he/she chooses to obtain services. A statement shall be signed by the individual acknowledging receipt of the directory as well as notice that he/she is not required to obtain recommended services from the same agency that conducted the screening.

(10) Program Evaluation. All persons participating in a SATOP shall be asked to complete a course evaluation. The evaluation process must assure anonymity.

(A) Participants may be encouraged, but not required, to sign the evaluation form.

(B) Evaluations shall be retained by the program for one (1) calendar year.

(11) Data Collection. The program shall cooperate with all SATOP quality assurance and data collection requirements regarding the program operation, individual demographics, or other data collection that may be required by the department.

(12) Organized Record System and Individual Records. All

SATOPs must maintain an organized record system which ensures easily retrievable, complete, and usable records. Records must be stored in a secure and confidential manner in accordance with state and federal requirements.

(A) Records required by the department shall be maintained in paper form or electronic medium at the location services are provided or at the provider's address of record with the department.

(B) Copies of records must be provided upon request by the department or its authorized representative(s), regardless of the medium in which they are maintained.

(C) Individual records must be retained for at least six (6) years or until all litigation, adverse audit findings, or both, are resolved regardless of the medium in which they are maintained.

(D) Individual records for OMUs shall include, but are not limited to:

1. Demographic information;
2. Proper signed release of information forms, as applicable;
3. Signed acknowledgement by the individual indicating receipt of—
   A. Individual rights, responsibilities, and grievance procedures;
   B. Screening recommendation;
   C. Notice of option for a second opinion and judicial review;
   D. List of referral sources; and
   E. Notice that services may be obtained from another provider;
4. Driving record check by the Department of Revenue (if another source is used, provider is responsible for ensuring its reliability);
5. Documentation of an individualized screening including date administered, name and signature of the SATOP Qualified Professional, summary of results including substance use history, and education or treatment recommendation;
6. SATOP Offender Assignment form; and
7. SATOP Completion Certificate (if program was completed).

(E) Individual records for persons enrolled in an education program shall include, but are not limited to:

1. Dates of attendance;
2. Demographic information;
3. Scored pretest(s) and posttest(s) measuring knowledge gain and attitude change;
4. Proper signed release of information forms, as applicable;
5. Signed acknowledgement by the individual indicating receipt of individual rights, responsibilities, and grievance procedures, list of referral sources, and notice that services may be obtained from another provider;
6. Results of blood alcohol content (BAC) tests, as applicable;
7. SATOP Offender Assignment form; and
8. SATOP Completion Certificate (if program was completed).

(F) Individual records for persons enrolled in the Clinical Intervention Program and Serious and Repeat Offender Program shall include, but are not limited to:

1. Consent to treatment;
2. Proper signed release of information forms, as applicable;
3. Individual treatment plan;
4. Treatment plan reviews and updates;
5. Continuing recovery plan based upon the principles of recovery and resilience as identified in 9 CSR 10-7.010(7) including at a minimum:
   A. Date of next appointment for follow-up services or other supports;
   B. Action steps to access personal support system(s) or other resources to assist in continuing his/her recovery, well-being, and community integration or if symptoms recur and additional services/supports are needed;
   C. Instructions for safe use of medication(s) as prescribed; and
   D. Referral information such as contact name, telephone number, locations, hours, and days of services, when applicable;
6. Discharge plan that includes, but is not limited to:
   A. Admission date;
   B. Reason for admission;
   C. Referral source;
   D. Reason for or type of discharge;
   E. Date of discharge;
   F. Description of services provided and the extent to which established goals and objectives were achieved;
   G. Recommendations for continued services and supports;
   H. Medical status and information on medication(s) prescribed or administered, when applicable; and
   I. Signature of staff completing the plan.

(13) Additional Record Requirements for the Adolescent Diversion Education Program (ADEP). For individuals participating in the ADEP who are under the age of eighteen (18) and are not emancipated, there shall be documentation showing—

(A) Efforts to involve the parent or guardian in the program;

(B) Results of the efforts, that is, whether the parent or guardian participated and the extent of participation; and

(C) Where applicable, the parent or guardian's view of substance use patterns and possible effects on family, social, legal, emotional, physical, financial, educational, and vocational functioning.

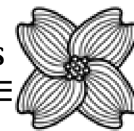
(14) Compliance. Failure to adhere to the stipulations, conditions, and the requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

AUTHORITY: sections 302.304, 302.420, 302.425, 302.540, 302.580, 630.050, 630.053, 630.655, and 631.010, RSMo 2016, and section 577.001, RSMo Supp. 2020. This rule was originally filed as 9 CSR 30-3.730. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-2.202 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed June 15, 2004, effective Jan. 30, 2005. Amended: Filed Feb. 16, 2018, effective Aug. 30, 2018. Amended: Filed Nov. 4, 2020, effective May 30, 2021.*

**Original authority: 302.304, RSMo 1961, amended 1972, 1973, 1979, 1983, 1984, 1989, 1991, 1996, 1999, 2001, 2002, 2003, 2008, 2012, 2013, 2014, 2015; 302.420, RSMo 1987, amended 1991, 1993, 1996, 2003, 2014; 302.425, RSMo 1987, amended 1991, 1996, 2014; 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 302.580, RSMo 1982, amended 1993, 1996, 2003, 2014; 577.001, RSMo 1982, amended 1986, 1996, 2005, 2014, 2015, 2016, 2017, 2018, 2020; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2011; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.204 SATOP Personnel

PURPOSE: This rule describes the personnel policies and staff qualifications for Substance Awareness Traffic Offender Programs



and establishes specific policies and procedures for the revocation or suspension of credentialed personnel.

(1) Qualifications of Staff. Staff must have specialized training in providing services for individuals who have been arrested for an alcohol- and/or drug-related traffic offense.

(A) Staff must be credentialed by the Missouri Credentialing Board, 428 E. Capitol Avenue, 2nd Floor, Jefferson City, MO 65101, and must meet the designated requirements prior to the delivery of services. Substance Awareness Traffic Offender Programs (SATOP) credentials include:

1. SATOP Qualified Professional (SQP); and
2. SATOP Qualified Instructor (SQI).

(B) SATOP screenings shall be conducted by a SQP.

(C) Treatment services shall be provided by a SQP or Qualified Addiction Professional.

(D) Education services shall be provided by a SQP or SQI.

(E) Staff who administer screenings and provide education and treatment services shall—

1. Not have a suspension or revocation of their driver's license within the preceding two (2) years of administering screenings or providing education and treatment services. Verification of staff driving records shall be completed annually and maintained in personnel records;
2. Not have received a citation or been charged with any state or municipal alcohol- or drug-related offense within the preceding two (2) years of administering screenings and providing education and treatment services, except when found not guilty in a court of competent jurisdiction;
3. Not have allowed the use of alcohol, illegal drugs, or misuse of prescription medications to interfere with the conduct of their SATOP job duties;
4. Successfully complete SATOP training offered or approved by the department; and
5. Meet background screening requirements specified in 9 CSR 10-5.190.

(2) Reporting Requirements. Administrators and staff of a certified SATOP have the duty to report to the department the suspected failure of any individual to meet applicable program standards and requirements.

(A) Complaints or allegations which must be reported to the department include:

1. Failure of a SATOP to meet personnel requirements under this rule;
2. Violations of individual rights under 9 CSR 10-7.020;
3. Fraudulent or false reporting to the department, Department of Revenue, courts, or other entity;
4. Performance of duties for which an individual is not appropriately credentialed;
5. Conviction, plea of guilty, or suspended imposition of sentence for any felony or alcohol- or drug-related offense;
6. Failure to cooperate in any investigation by the department or authorized by the department;
7. Abuse, neglect, or misuse of funds/property in accordance with 9 CSR 10-5.200; and
8. Offenses considered disqualifying crimes under section 630.170, RSMo.

(3) Guest Speakers. A program which utilizes guest speakers shall have written policies and procedures for their recruitment, selection, training, supervision, dismissal, and compensation.

(A) The program shall maintain a roster of all approved guest speakers and a description of the duties or tasks of each.

(B) Guest speakers are not considered instructors for the purpose of these rules.

(C) At no time shall a guest speaker assume sole responsibility for a class.

(4) Compliance. Failure to adhere to stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

AUTHORITY: sections 302.420, 302.425, 302.540, 302.580, 630.050, 630.053, 630.655, and 631.010, RSMo 2016, and section 577.001, RSMo Supp. 2020. This rule was originally filed as 9 CSR 30-3.750. Original rule filed Nov. 2, 1987, effective May 15, 1988. Amended: Filed Oct. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed Oct. 17, 1994, effective April 30, 1995. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.204 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed June 15, 2004, effective Jan. 30, 2005. Amended: Filed Feb. 16, 2018, effective Aug. 30, 2018. Amended: Filed Nov. 4, 2020, effective May 30, 2021.*

**Original authority: 302.420, RSMo 1987, amended 1991, 1993, 1996, 2003, 2014; 302.425, RSMo 1987, amended 1991, 1996, 2014; 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 302.580, RSMo 1982, amended 1993, 1996, 2003, 2014; 577.001, RSMo 1982, amended 1986, 1996, 2005, 2014, 2015, 2016, 2017, 2018, 2020; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2011; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.206 SATOP Structure

PURPOSE: This rule establishes basic requirements and structure for Substance Awareness Traffic Offender Programs, including the screening and referral process and fee structure.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Assessment Process and Program Assignment. Offender Management Units (OMU) are the designated entry point for individuals referred to a Substance Awareness Traffic Offender Programs (SATOP).

(A) All OMUs must be certified by the department to provide the Offender Education Program. Substance use disorder treatment programs that are contracted by a DWI court to serve serious and repeat offenders are excluded from this requirement.

(B) All individuals are screened at the OMU by a SATOP Qualified Professional (SQP). The SQP assigns the individual to an education or treatment program based on screening results, department referral criteria, and his/her professional judgment.

(C) The OMU issues a SATOP Offender Assignment form to each individual at the completion of the screening.

(D) Individuals are not required to fulfill their SATOP requirement with the OMU that conducted his/her screening. Individuals may request to attend a program based on

circumstances such as distance, work schedule, or other factors. The originating OMU shall provide each individual with the contact information for certified SATOPs in his/her chosen location in order to select a service provider.

(E) The OMU provides a referring court or probation and parole office with a copy of the SATOP Offender Assignment form, upon request, and with proper release of information from the individual.

(2) Assessment Process. A SQP shall conduct a screening for each individual who presents to the OMU to determine his/her service needs. Screening recommendations are impartial and based solely on the needs of the individual and the welfare of society.

(A) The screening process includes, but is not limited to:

1. Collection of basic demographic information;

2. Completion of the 2013 edition of the *Driver Risk Inventory-2* (DRI-2) published by and available from Behavior Data Systems, PO Box 44256, Phoenix, AZ 85064-4256. The document incorporated by reference does not include any later amendments or additions;

3. A face-to-face interview with the SQP, including information related to any previous substance use treatment;

4. A written summary of findings and program assignment;

5. Driving record report from the Department of Revenue or other reliable source;

6. Blood alcohol content (BAC) at time of arrest and/or toxicology results, if available; and

7. Completion of the SATOP Assignment Form and, when required, a narrative report to the court with release of information from the individual.

(B) Coordination with the courts, probation and parole, Department of Revenue, or other entities shall be provided, as necessary, to verify service recommendations are understood by all parties.

(C) Individuals who have a serious emotional disorder or serious mental illness which may interfere with his/her participation in SATOP shall be referred to a qualified mental health professional for an evaluation. Participation in SATOP may be delayed until the individual's mental health needs are evaluated and necessary services are obtained.

1. The OMU shall maintain an affiliation agreement or memorandum of understanding with a certified community mental health center or a licensed mental health professional in order to promptly coordinate mental health services.

(D) Individuals shall receive written notification from the OMU that the screening is valid for six (6) months from the date of completion and payment for a second screening will be required if the six- (6-) month time period lapses prior to engagement in the assigned level of service, unless—

1. A motion for judicial review has been filed, or;

2. A second opinion from an alternate OMU is obtained prior to the end of the six- (6-) month period.

(E) Individual records may be closed after the six- (6-) month period expires unless a motion for judicial review or second opinion applies.

(3) Program Referral Guidelines. The SQP shall base program assignment on his/her professional judgment, screening results, and referral guidelines established by the department, as follows:

(A) 1st Offense—Offender Education Program (OEP) or Adolescent Diversion Education Program (ADEP) unless a more intense program is indicated by factors such as blood alcohol content at time of arrest, other alcohol- or drug-related arrests, results of the DRI-2, prior treatment for a substance use disorder, or occupational, relationship, medical, or other issues;

(B) 2nd offense—Weekend Intervention Program (WIP) unless a more intense program is indicated by factors such as blood alcohol content at the time of arrest, other alcohol- or drug-related arrests, results of the DRI-2, prior treatment for a substance use disorder, or occupational, relationship, medical, or other issues;

(C) 3rd offense—Clinical Intervention Program (CIP) unless a more intense program is indicated by factors such as blood alcohol content at the time of arrest, other alcohol- or drug-related arrests, results of the DRI-2, prior treatment for a substance use disorder, or occupational, relationship, medical, or other issues;

(D) Prior and Persistent Offender—Serious and Repeat Offender Program (SROP). Individuals who have a BAC of 0.15 or greater at time of arrest, two (2) or more arrests for driving under the influence of alcohol or drugs with administrative action by the Department of Revenue, and meet diagnostic criteria for a substance use disorder, thereby meeting the statutory definition as a prior or persistent offender, shall be referred to intensive treatment.

1. As used in these SATOP rules, the terms prior and persistent offender mean—

A. Prior offender, a person who has pleaded guilty to or has been found guilty of one (1) intoxication-related traffic offense, where such prior offense occurred within five (5) years of the occurrence of the intoxication-related traffic offense for which the person is charged;

B. Persistent offender, a person who has pleaded guilty to or has been found guilty of two (2) or more intoxication-related traffic offenses; a person who has pleaded guilty to or has been found guilty of involuntary manslaughter pursuant to section 565.024.1(2) or (3), RSMo; assault in the second degree pursuant to section 565.060.1(4), RSMo; assault of a law enforcement officer in the second degree pursuant to section 565.082.1(4), RSMo;

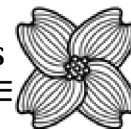
(E) Exceptions to these referral guidelines require prior approval from the department.

(4) OEP and ADEP Requirements. The OEP and ADEP are designated for individuals with a first-time alcohol- or drug-impaired driving offense. Educational sessions and discussions focus on helping individuals assess his/her personal responsibility related to alcohol- and drug-impaired driving.

(A) OEPs and ADEPs must maintain a contract with the department and conduct the respective program in accordance with the 2017 edition of the *OEP Missouri Curriculum Guide* or the 2014 edition of the *ADEP Missouri Curriculum Guide* produced by The Change Companies, 5221 Sigstrom Dr., Carson City, NV 89706. Prior approval from the department is required to alter the content and methods in the curriculum guides incorporated herein by reference. The referenced guides do not include any later amendments or additions.

(B) At least ten (10) hours of education and discussion must be provided to individuals over a period of at least two (2) calendar days. Sessions shall not exceed six (6) hours per day (excluding breaks) and should begin and end at times that are accessible for participants. No more than twenty percent (20%) of the educational component may consist of electronic media/audiovisual aids.

(C) Program size must ensure the opportunity for participation from individuals in attendance. Group sessions are limited to thirty (30) individuals. Parents, guardians, or other natural



supports who attend a session or part of a session are not included in the limit of thirty (30) individuals.

(D) Prior to successful program completion, each individual must develop a personal plan of action to assist them in preventing alcohol- and drug-impaired driving behavior in the future.

(5) WIP Requirements. The WIP is designated for individuals with a second alcohol- or drug-impaired driving offense and those identified through the SATOP screening as being a high risk, first-time driving while intoxicated or driving under the influence (DWI/DUI) offender.

(A) WIPs must maintain a contract with the department and conduct the program in accordance with the 2017 edition of the *WIP Missouri Curriculum Guide* produced by The Change Companies, 5221 Sigstrom Dr., Carson City, NV 89706. Prior approval from the department is required to alter the content and methods in the curriculum guide incorporated herein by reference. The referenced guide does not include any later amendments or additions.

(B) The WIP is an intensive education program conducted during a forty-eight (48) hour weekend in a supervised and structured location approved by the department. Sessions shall begin and end at times that are accessible for participants.

(C) The program requires a minimum of twenty (20) hours of combined individual counseling and group education and discussion that assists individuals in assessing their personal responsibility related to alcohol- and drug-impaired driving and taking proactive steps to prevent future occurrences of impaired driving.

1. Individual counseling shall be provided by a SQP.

2. Small group discussions shall be facilitated by at least one (1) SQP or Qualified Addiction Professional (QAP) per twelve (12) participants. In the event two (2) staff co-facilitate a small group, one (1) of the staff may be a SATOP Qualified Instructor or an Associate Alcohol Drug Counselor if the group size does not exceed twenty-four (24) individuals.

3. Group education sessions shall not exceed thirty (30) individuals per staff member, including lectures and audiovisual presentations. Group education shall be conducted by a SQP or SQI.

(D) Meals and snacks shall be provided for individuals participating in the WIP at times comparable to normal meal times in the community. Preparation and management of meals and snacks must meet applicable state, county, and/or city health regulations.

(E) Instructional aids shall be incorporated into education sessions to enhance understanding and promote discussion and interaction among participants. Aids may include but are not limited to DVD's or other electronic media, worksheets, and informational handouts and shall not comprise more than twenty percent (20%) of group education sessions.

(F) Guest speakers may be utilized in education sessions but shall not comprise more than twenty percent (20%) of the educational component of the program.

(6) CIP Requirements. The CIP addresses the needs of high-risk first and second-time DWI/DUI offenders, third-time offenders, and individuals identified during the SATOP screening process as meeting diagnostic criteria for a substance use disorder or being at risk for a substance use disorder. Services focus on substance use disorders and the resolution of problems related to substance use and the individual's drinking and driving behavior.

(A) CIPs must maintain a contract with the department and comply with 9 CSR 30-3.130.

(B) A SQP or QAP shall utilize a department-approved instrument to administer a comprehensive assessment for each individual admitted to the program.

1. Assessment results shall be utilized to develop an individual treatment plan. Treatment plan reviews and updates shall be conducted as specified in 9 CSR 10-7.030.

2. Family members and/or other natural supports shall be involved in the development of the individual treatment plan, as appropriate and allowable. The reason(s) for non-participation of family members/natural supports shall be documented in the individual record.

(C) Each individual admitted to a CIP must complete fifty (50) hours of therapeutic, structured activities through a combination of individual and group counseling and group rehabilitative support in accordance with contract requirements. Services and activities must be accessible to individuals who are employed, in school, have family/childcare responsibilities, or other obligations.

(D) The CIP is intended to be completed over a six (6) to eight (8) week time period and should not be completed in less than (3) weeks nor extend beyond six (6) months. The actual time period for completion of the program is based on individual needs.

(E) Individual and group counseling sessions must be facilitated by a Qualified Addiction Professional or SQP. Group counseling sessions are limited to twelve (12) individuals per staff member. In order to accommodate individuals in accessing services, group size may be greater than twelve (12) individuals with approval from the department.

(F) Group rehabilitative support sessions shall be facilitated by a SQP or SQI. Group rehabilitative support sessions are limited to thirty (30) individuals per staff member.

(G) A blood alcohol content (BAC) or urine test shall be conducted for each individual a minimum of one (1) time per week. Random BAC tests and/or urine tests may also be conducted. All test results shall be documented in the individual record.

(7) SROP Requirements. The SROP addresses the needs of high-risk, high-need adults who have a DWI/DUI offense and meet criteria for a moderate to severe substance use disorder with the potential for recidivism. Services focus on substance use disorders and the resolution of problems related to substance use and the individual's drinking and driving behavior.

(A) SROPs must maintain a contract with the department and comply with 9 CSR 30-3.130.

(B) A SQP or Qualified Addiction Professional shall utilize a department-approved instrument to administer a comprehensive clinical assessment for each individual admitted to the program.

1. Assessment results shall be utilized to develop an individual treatment plan. Treatment plan reviews and updates shall be conducted as specified in 9 CSR 10-7.030.

2. Family members and/or other natural supports shall be involved in the development of the individual treatment plan, as appropriate and allowable. The reason(s) for non-participation of family members/natural supports shall be documented in the individual record.

(C) Each individual admitted to a SROP must complete a minimum of seventy-five (75) hours of therapeutic, structured activities through a combination of individual and group counseling and group rehabilitative support in accordance with contract requirements. Services shall be structured to address the specific and unique needs of serious and repeat

DWI/DUI offenders.

(D) Services shall include at least thirty-five (35) hours of individual and group counseling provided by a Qualified Addiction Professional or SQP. Group counseling sessions are limited to twelve (12) individuals per staff member. In order to accommodate individuals in accessing services, group size may be greater than twelve (12) individuals with approval from the department.

(E) Services shall be based on individual needs and should be completed in no less than ninety (90) days.

(8) Treatment Services for Youth. Individuals under the age of eighteen (18) whose screening results indicate the need for intensive treatment shall be referred to and successfully complete a substance use disorder treatment program for adolescents. The program must be certified by the department or nationally accredited to provide services for adolescents.

(9) Comparable Program for Missouri Residents. Missouri residents who have pled guilty or have been found guilty of an alcohol- or drug-related traffic offense may complete a comparable program in lieu of a SATOP to be eligible for license reinstatement.

(A) A comparable program is one that is state-certified and/or nationally accredited as a substance use disorder treatment program by The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, or other accrediting body recognized by the department.

(B) Individuals must receive a drug and alcohol screening, comprehensive assessment, and successfully complete the recommended treatment services from the comparable program.

1. Missouri residents must complete a minimum of one hundred twenty (120) hours of treatment in no less than twenty-one (21) days. Treatment hours must include a minimum of forty (40) hours of individual and group counseling. The remaining hours must include a combination of driver-related education, individual counseling, group counseling, group rehabilitative support, and family therapy.

(C) The provider of services shall verify the individual's successful program completion on the SATOP Comparable Program Completion form.

1. The individual shall present the SATOP Comparable Program Completion form to an OMU where a SATOP Completion Certificate will be issued to him/her. A SATOP screening is not required; however, the supplemental fee shall be collected from the individual. The OMU may charge an additional processing fee.

2. The OMU shall conduct a review of the individual's current driving record to ensure there are no alcohol- or drug-related traffic offenses during or after the treatment episode.

(10) Comparable Program for Out-of-State Residents. Individuals who have had an alcohol- or drug-related traffic offense in Missouri but live in or have moved to another state must complete a SATOP or a comparable program to be eligible for license reinstatement.

(A) To complete a comparable program, the individual must have a drug and alcohol screening and complete the recommendation of the screening. The provider of the screening and provider of services must be certified/licensed by the state of residence and/or be accredited by The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, or other accrediting body recognized by the department.

1. A minimum of ten (10) hours of drug and alcohol education is required unless the screening results indicate the need for more intensive services.

2. The department shall make the final determination regarding the acceptability of the out-of-state program.

(B) A completed SATOP Comparable Program Completion form must be submitted to the department by one (1) of the following methods:

1. Email to satop@dmh.mo.gov;

2. Mail to Department of Mental Health, Controller's Office, SATOP, PO Box 596, Jefferson City, MO 65102-0596; or

3. Submit electronically to the department by accessing the form at https://dmh.mo.gov/media/pdf/satop-comparable-program-completion-form.

(C) Payment of the SATOP supplemental fee for a SATOP comparable program must be submitted to the department by one (1) of the following methods:

1. Electronic payment following the instructions at https://magic.collectorsolutions.com/magic-ui/en-US/Login/mo-mental-health; or

2. Mail the supplemental fee of two hundred forty-nine dollars ($249) in the form of a signed money order made payable to the Mental Health Earnings Fund, Department of Mental Health, Controller's Office, SATOP, PO Box 596, Jefferson City, MO 65102-0596.

A. The supplement fee should not be paid until after the SATOP Comparable Program Completion form has been submitted in accordance with the instructions in subsection (10)(B) of this rule.

B. Payment must include the individual's name, date of birth, last four (4) digits of their Social Security number, and driver's license number, if known.

(D) Questions regarding the SATOP Comparable Program Completion form or payment of the supplemental fee should be directed to the SATOP help desk at (573) 522-4020. Information is also available on the SATOP website at https://dmh.mo.gov/behavioral-health/satop.

(E) Following review of the comparable program, department staff will provide notification of the individual's program completion to the Missouri Department of Revenue.

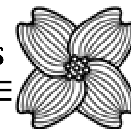
(11) Department of Corrections Treatment Programs. Substance use disorder treatment programs completed by individuals who are incarcerated in a Missouri Department of Corrections facility may be recognized as a SATOP comparable program. Individuals must contact the Department of Corrections to obtain information on approved programs.

(12) SATOP Costs and Fees. The costs for the screening, education, and treatment programs are established by the department and reviewed periodically. Costs shall not be greater than relative costs indicate. Programs shall not establish costs or fees that are not specified in this rule unless prior authorization from the department is granted. All fees are to be paid by the individual being served.

(A) The screening fee includes monitoring the individual's progress in the assigned education or treatment program and case coordination with the department, courts, probation and parole, Department of Revenue, and other entities as necessary.

(B) The cost for treatment in a department-certified and contracted substance use disorder treatment program is based on actual services provided.

(C) All individuals referred to a SATOP, including those participating in a comparable program as outlined in this rule,



are required to pay a supplemental fee as specified in 9 CSR 30-3.208. The supplemental fee is in addition to the cost of the screening, education, and treatment services.

(D) Costs for individuals participating in a WIP, CIP, SROP, or a department-certified and contracted substance use disorder treatment program may be partially offset in accordance with 9 CSR 10-31.011.

(13) Successful Program Completion. Successful completion of a SATOP requires that the individual—

(A) Is free from alcohol or illegal drug use when participating in services and, as applicable, uses prescription medication as prescribed during program participation;

(B) Attends all sessions on time;

(C) Attends sessions in their proper sequence unless the instructor approves an alternate sequence;

(D) Completes all assignments and cooperatively participates in all class activities;

(E) Pays all fees prior to program completion; and

(F) Completes and signs all required forms.

(14) Completion Certificate. A SATOP Completion Certificate is issued to each individual within seven (7) calendar days of his/her successful completion of an education or treatment program.

(A) The OMU that completed the screening and issued the program recommendation is responsible for issuing the SATOP Completion Certificate to the individual. The Department of Revenue receives automatic notification of each individual's successful program completion via the department's automated processing system.

(B) If an individual fulfills their SATOP requirement with a provider other than the OMU that completed the screening and issued the program recommendation, the provider of services notifies the originating OMU of the individual's successful program completion. Notification must be provided to the originating OMU in a timely manner to ensure the SATOP Completion Certificate is issued to the individual within seven (7) calendar days of successful program completion.

(C) If an individual completes a comparable program, an OMU must create the SATOP Completion Certificate and indicate that a comparable program was completed. Automated notification of the individual's successful program completion is provided to the department through the department's automated processing system.

(15) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation or denial of program certification.

AUTHORITY: sections 302.420, 302.425, 302.540, 302.580, 630.050, 630.053, 630.655, and 631.010, RSMo 2016, and section 577.001, RSMo Supp. 2023. This rule was originally filed as 9 CSR 30-3.760. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed April 20, 1988, effective May 15, 1988, expired Aug. 31, 1988. Amended: Filed April 20, 1988, effective Aug. 31, 1988. Amended: Filed July 6, 1992, effective Feb. 26, 1993. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.206 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed March 8, 2002, effective Sept. 30, 2002. Amended: Filed July 29, 2003, effective March 30, 2004. Amended: Filed June 15, 2004, effective Jan. 30, 2005. Amended: Filed Feb. 16, 2018, effective Aug. 30, 2018. Amended: Filed Nov. 4, 2020, effective May 30, 2021. Amended: Filed June 29, 2023, effective Jan. 30, 2024.*

**Original authority: 302.420, RSMo 1987, amended 1991, 1993, 1996, 2003, 2014; 302.425, RSMo 1987, amended 1991, 1996, 2014; 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 302.580, RSMo 1982, amended 1993, 1996, 2008, 2014; 577.001, RSMo 1982, amended 1986, 1996, 2005, 2014, 2015, 2016, 2017, 2018, 2020; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2011; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.208 SATOP Supplemental Fee

PURPOSE: This rule establishes a supplemental fee which shall be collected by all certified Substance Awareness Traffic Offender Programs as required by state statute and outlines the procedures for submitting supplemental fees to the department.

(1) Supplemental Fee. All Substance Awareness Traffic Offender Programs shall collect a supplemental fee from each individual admitted to the program in accordance with section 302.540, RSMo.

(A) The supplemental fee is determined by the department and is in addition to any other costs associated with the program.

(B) The supplement fee is collected one (1) time per offense, regardless of the level of service the individual receives.

(2) Remittance of Supplemental Fees. On or before the fifteenth day of each month, program administrators shall remit the total of all supplemental fees collected during the prior calendar month, less two percent (2%) which, by law, may be retained by the program to offset collection and remittance costs.

(A) Remittance shall be mailed to: Mental Health Earnings Fund, Controller's Office, Department of Mental Health, 1706 East Elm Street, PO Box 596, Jefferson City, MO 65102.

(B) Transfer of supplemental fees from the program to the Mental Health Earnings Fund shall be in the form of a single check made payable to the Mental Health Earnings Fund. The payment shall include the SATOP Supplemental Fee Remittance Summary and Agency Tally Sheet.

(C) Failure to remit supplemental fees to the department on a timely basis will be considered cause for revocation of program certification.

1. If supplemental fees, including interest and penalties, are not remitted to the department within six (6) months of the due date, the Attorney General of the state of Missouri shall initiate appropriate action for collection of the fees.

(3) Documentation of Supplemental Fee Transactions. Each program shall maintain, at its principal administrative center, a single record of all supplemental fee transactions which is separate from all other program records. This separate record will facilitate audits conducted by the department or the State Auditor's Office. A separate program record of supplemental fee transactions shall include copies of monthly remittance forms, copies of checks forwarded to the Mental Health Earnings Fund, and receipts issued by the department.

(4) Acceptance of Supplemental Fees. The department will only accept supplemental fee remittances from certified SATOPs. If an agency's certification is revoked, the department will accept the supplemental fees owed prior to the date of revocation. The agency shall issue a refund to any individuals from whom a

supplemental fee was collected after the date of revocation.

(5) Notice of Supplemental Fee. Programs shall post, in places readily accessible to persons served, one (1) or more copies of a Student Notice Poster which shall be provided by the department at no cost to the program. Posters shall explain the statutory requirement for the supplemental fees, disposition of supplemental fees, and the means by which programs collect and remit supplemental fees.

(6) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation of program certification.

AUTHORITY: sections 302.420, 302.425, 302.540, 302.580, 630.050, 630.053, 630.655, and 631.010, RSMo 2016, and section 577.001, RSMo Supp. 2020. This rule was originally filed as 9 CSR 30-3.790. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Moved to 9 CSR 30-3.208 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed July 29, 2003, effective March 30, 2004. Amended: Filed June 15, 2004, effective Jan. 30, 2005. Amended: Filed Feb. 16, 2018, effective Aug. 30, 2018. Amended: Filed Nov. 4, 2020, effective May 30, 2021.*

**Original authority: 302.420, RSMo 1987, amended 1991, 1993, 1996, 2003, 2014; 302.425, RSMo 1987, amended 1991, 1996, 2014; 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002, 2003, 2014; 302.580, RSMo 1982, amended 1993, 1996, 2003, 2014; 577.001, RSMo 1982, amended 1986, 1996, 2005, 2014, 2015, 2016, 2017, 2018, 2020; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2011; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.210 Clients' Records
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, 630.140 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed Jan. 19, 1988, effective July 1, 1988. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.220 Referral Procedures
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.230 Required Educational Assessment and Community Treatment Program (REACT)

PURPOSE: This rule identifies the Department of Mental Health (department) as being responsible for the certification of REACT programs as mandated by state statute.

(1) Mission. As specified in section 559.633, RSMo, REACT is a statewide system of comprehensive, accessible, community-based education and treatment programs designed for individuals who have been found guilty of, or pled guilty to a Chapter 195 felony drug offense. The mission of REACT is—

(A) To promote a drug- and crime-free lifestyle for individuals served;

(B) To provide education and/or treatment on the multi-faceted consequences of substance use for individuals served;

(C) To engage individuals appropriate for treatment towards personal change and recovery; and

(D) To contribute to public health and safety in Missouri.

(2) Program Functions. REACT programs shall provide or arrange for screening, education, and treatment services for individuals referred to the program.

(3) Performance Indicators. The following are intended as examples of indicators that can be used by the department and the organization providing REACT to demonstrate achievement of the program's mission and functions. Indicators can include, but are not limited to the following:

(A) Characteristics of persons participating in REACT such as type of offense, prior alcohol and drug offenses, and prior treatment history;

(B) Consistent use of screening criteria including the rate at which persons are assigned to education and treatment programs;

(C) Rate at which persons successfully complete REACT;

(D) Reductions in alcohol and drug offenses among those who complete REACT; and

(E) Satisfaction with services and feedback as reported by individuals served.

(4) Types of Programs. The department recognizes and certifies the following types of REACT programs:

(A) REACT Screening Unit (RSU)—provide substance use screenings as part of the assessment process, including an individualized interview and recommendation and referral for further services for individuals under the purview of section 559.630, RSMo; and

(B) REACT Education Program (REP)—provide basic education over the course of ten (10) hours to assist individuals in understanding the choices they made that led to their arrest and the resulting consequences. All persons completing this course shall develop a personal change plan to assist them in preventing future offenses.

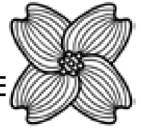
(5) Requirements for Program Certification. REACT programs shall comply with 9 CSR 30-3.032.

(A) Requirements under 9 CSR 10-7.120 shall be applicable based on the type of services provided by the program and whether services are offered to individuals and groups at the program site. In addition—

1. The program must be located in an office, clinic, or other professional setting.
2. Screenings must be located in a setting which provides space for private, one-on-one interviews and ensures confidentiality. With the department's written approval, screenings may be conducted at other locations on a limited basis, if confidentiality is assured and the individual agrees to a screening at the alternate site.

(B) The following regulations shall be waived for REACT programs unless the department determines a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.010;
2. 9 CSR 10-7.030;
3. 9 CSR 10-7.060;
4. 9 CSR 10-7.070;
5. 9 CSR 10-7.080;
6. 9 CSR 30-3.100; and
7. 9 CSR 30-3.110.



(6) Other Requirements. Agencies certified as a REACT program shall follow the regulations in 9 CSR 30-3.201 through 9 CSR 30-3.208, unless otherwise specified in this rule.

(7) Staff Requirements. REACT programs shall not utilize any person under the supervision of any federal, state, county, and/or city correctional department to provide services to offenders.

(8) Screening Requirements. All persons referred to REACT shall receive an individualized screening prior to participating in services to determine the severity of his or her substance use disorder and the type of education and/or treatment needed. The program shall utilize a screening instrument approved by the Department of Corrections (DOC).

(A) Policies and procedures shall define the program's screening process, including referral criteria when the screening determines additional services are needed. The screening process shall include, but is not limited to:

1. Collection of demographic information;
2. Use of the standardized screening instrument as required by DOC;
3. A face-to-face interview with a qualified addiction professional (QAP);
4. A summary report of screening results;
5. Completion of the REACT Offender Assignment form and a narrative report provided to the individual's probation/parole officer; and
6. Case coordination as needed with the courts, probation and parole, and/or DOC to verify education and treatment recommendations have been completed.

(B) A written screening recommendation shall be provided to the person served.

(C) With proper authorization from the individual served, collaborative data may be obtained such as treatment history and relevant information from family members and other natural supports.

(D) Individuals may participate in a REP with an agency that did not conduct his/her screening due to reasonable circumstances such as distance, work schedule, or other time-related factors.

(9) Quality Recommendations. The program must develop screening recommendations that are—

(A) Impartial and solely based on the needs of the offender and the welfare of society; and

(B) Never used as a means of case finding for any particular treatment program or as a marketing tool for any REACT program.

(10) Referral Guidelines. The program must base its recommendation and referral plan for each person on the following guidelines:

(A) REP unless treatment for a substance use disorder is indicated by factors such as other alcohol/drug-related arrests, screening instrument recommendations, prior alcohol/drug treatment, or other occupational, relationship, or medical problems; and

(B) Individuals who have a serious emotional disorder or serious mental illness which may interfere with his/her participation in REACT shall be referred to a qualified mental health professional for an evaluation. Participation in REACT may be delayed until the individual's mental health needs are evaluated and necessary services are obtained.

1. RSUs shall maintain an affiliation agreement or memorandum of understanding with a certified community mental health center or a licensed mental health professional in order to promptly coordinate mental health services.

(11) Screening Cost. The cost of the screening is determined by DOC and shall be paid by the individual served. The screening fee shall not be excessively greater than relative costs indicate and include the costs for any case coordination functions necessary to—

(A) Monitor the individual's progress in the education or treatment program(s); and/or

(B) Coordinate with the courts or probation and parole.

(12) Notice of Program Assignment and Completion. The RSU that conducts the screening shall provide each individual with a REACT Offender Assignment form after completion of the screening and a REACT Report of Offender Compliance form indicating successful completion or unsuccessful completion of the education portion of the program.

(A) The RSU shall provide a copy of the REACT Offender Assignment form to the referring probation and parole office within one (1) week of completion of the screening. The RSU shall provide a copy of the REACT Report of Offender Compliance form to the referring probation and parole office within one (1) week of each individual's successful program completion.

(B) The RSU shall send a copy of the REACT Offender Assignment form and the REACT Report of Offender Compliance form to DOC, Division of Offender Rehabilitation Services, 2715 Plaza Drive, Jefferson City, MO 65109.

(C) The RSU shall provide a REACT Completion Certificate to each individual served who successfully completes the program.

(13) Cost of the REP. The individual served shall pay for the cost of the REP. The cost is determined and approved by DOC and shall cover the operating expenses of the REP.

(14) Curriculum Guide. The REP shall be conducted in accordance with the curriculum established by DOC. A program must specifically request and obtain approval from DOC before deviating in any manner from the established curriculum.

(15) Treatment Programs Recognized for REACT. When the screening indicates the individual's need for substance use disorder treatment, arrangements shall be made for the person to participate in such services.

(A) The recognized providers of treatment services for individuals in the REACT program include department-certified, deemed certified, and nationally accredited substance use disorder treatment programs.

(16) Criteria for Successful Completion of Treatment. In order to be recognized by REACT as successfully completing treatment, the individual must have written verification from a department-certified, deemed certified, or nationally accredited substance use disorder treatment program that he or she has—

(A) Participated as scheduled in treatment services for a period of at least ninety (90) days;

(B) Successfully achieved his/her personal recovery goals; and

(C) Met any other program requirements for successful completion of treatment. Individuals with a moderate to severe substance use disorder who have a history of multiple offenses

must participate in a minimum of seventy-five (75) hours of treatment services during the treatment episode.

(D) Individuals who complete a department-certified, deemed certified, or nationally accredited substance use disorder treatment program after being charged or adjudicated for their offense, but prior to screening with a RSU, must receive approval from DOC to waive the REACT requirements as a result of his/her participation in such treatment.

(17) Cost of Treatment. The individual served is responsible for all costs related to completion of substance use disorder treatment referenced in or required by this rule.

(A) Costs related to treatment shall be based on the department's Standard Means Test sliding fee scale.

(B) Programs may develop long-term payment plans to reasonably assist individuals in paying any outstanding balances.

(18) Review and Approval of Costs. All REACT screening and education fees approved by DOC shall be periodically reviewed and adjusted, if necessary, based on the best interests of individuals served, society, and the programs.

(19) Supplemental Fee. All REACT programs shall collect a sixty dollar ($60) supplemental fee from all individuals entering the program in addition to any other costs that may be charged by the program. The supplemental fee shall be collected no more than one (1) time from any individual who has entered REACT, whether for screening or for an educational program.

(20) Remittance of Supplemental Fees. On or before the fifteenth (15th) day of each month, REACT program directors shall remit the total of all supplemental fees collected during the prior calendar month, less two percent (2%) which, by law, may be retained by the program to offset collection and remittance costs.

(A) Remittance shall be mailed to: Correctional Substance Abuse Earnings Fund, Department of Corrections, 2729 Plaza Drive, Jefferson City, MO 65102.

(B) Transfer of supplemental fees from the program to the Correctional Substance Abuse Earnings Fund shall be in the form of a single check made payable to the Correctional Substance Abuse Earnings Fund.

(C) Program remittance checks shall be accompanied by a Supplemental Fee Remittance Form (to be provided by DOC at no cost to the program), which shall list name and Social Security Number of persons paying each supplemental fee being remitted.

(21) Documentation of Supplemental Fee Transactions. Each REACT program shall maintain, at its principal administrative center, a single record of all supplemental fee transactions which is separate from all other program records. This separate record will facilitate audits that may be conducted periodically by the department, DOC, or the state auditor's office. A separate program record of supplemental fee transactions shall include copies of monthly remittance forms and copies of checks forwarded to the Correctional Substance Abuse Earnings Fund.

(22) Acceptance of Supplemental Fees. DOC shall accept supplemental fee remittances only from certified REACT programs. Supplemental fee remittances, if received by DOC from any agency not certified, will be returned to that agency. If an agency's certification has been revoked, DOC will only accept supplemental fee remittances that were collected prior to the date the agency's certification was revoked. Remittances collected by the agency from individuals after the date of the revocation shall not be accepted by DOC. In such case, the supplemental fee must be returned to the individual by the agency.

(23) Compliance. Failure to adhere to the stipulations, conditions, and requirements set forth in this rule shall be considered cause for revocation of program certification.

AUTHORITY: sections 559.630, 559.633, 559.635, 630.050, 630.655, and 631.010, RSMo 2016. This rule originally filed as 9 CSR 30-3.800. Original rule filed Oct. 16, 1998, effective March 30, 1999. Moved to 9 CSR 30-3.230 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Jan. 22, 2019, effective Aug. 30, 2019.*

**Original authority: 559.630, RSMo 1998; 559.633, RSMo, 1998, amended 2014; 559.635, RSMo 1998; 630.050, 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 631.010, RSMo 1980.*

9 CSR 30-3.240 Medication
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.250 Dietary Services
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Amended: Filed June 2, 1988, effective Nov. 1, 1988. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.300 Prevention Programs

PURPOSE: This rule identifies the expected outcomes, strategies, and operational requirements for prevention programs.

(1) Program Description. A prevention program offers a planned, organized set of activities designed to reduce the risk of and incidence of illegal or age-inappropriate use of alcohol, tobacco, and other drugs.

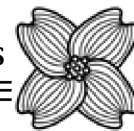
(A) Prevention activities and services are provided to an identified target population within a designated geographic area.

(B) The target population may include individuals, groups, organizations, communities, and the general public. The target population may include individuals or groups considered to be at-risk or high-risk in their potential for substance use; however, prevention activities are not specifically or primarily directed to persons who need treatment for a substance use disorder.

(C) A prevention program provides services that are comprehensive, research based, and culturally sensitive and relevant.

(D) A prevention program serves all age groups and populations where the need is evident, including special populations.

(2) Use of Risk Reduction Strategies. A prevention program



implements strategies which reduce the risk of and the incidence of illegal or age-inappropriate use of alcohol, tobacco, and other drugs. The program shall implement the following risk reduction strategies in accordance with the type of prevention services and programming it offers:

(A) Increase awareness of the nature and extent of such substance use and their effects on individuals, families, and communities;

(B) Inform others about available prevention and treatment services;

(C) Develop social and life skills which reduce the potential for such substance use;

(D) Identify and address risk and protective factors associated with substance use;

(E) Provide and assist with constructive and healthy activities to offset the attraction of such substance use or to meet needs which otherwise may be fulfilled by these substances;

(F) Identify persons who may have become involved in the initial, inappropriate, or illegal use of alcohol, tobacco, and/or other drugs and then arrange support and other referrals, as needed;

(G) Assess community needs and assist in the development of community planning and action;

(H) Establish or change community attitudes, norms, and policies known to influence the incidence of such substance use;

(I) Actively intervene with individuals and populations who have multiple risk factors for such substance use; and

(J) Organize, coordinate, train, and assist other community groups and organizations in their efforts to reduce such substance use.

(3) Types of Certified Programs. An agency may be certified to provide one (1) or more of the following types of prevention programs:

(A) Primary Prevention Program;

(B) Targeted Prevention Program; or

(C) Statewide Prevention Resource Center.

(4) Requirements for Certification. A prevention program shall comply with rules and standards listed under 9 CSR 30-3.032.

(A) Requirements under 9 CSR 10-7.120 are applicable based on the type of services provided by the prevention program and whether services are offered to individuals and groups at the program site.

(B) The following rules and standards are waived for prevention programs, unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a program:

1. 9 CSR 10-7.010;
2. 9 CSR 10-7.020;
3. 9 CSR 10-7.030;
4. 9 CSR 10-7.060;
5. 9 CSR 10-7.070;
6. 9 CSR 10-7.080;
7. 9 CSR 30-3.100; and
8. 9 CSR 30-3.110.

(5) Qualifications of Staff. Services shall be provided by a qualified prevention specialist who demonstrates substantial skill by being—

(A) A graduate of an accredited college or university with a bachelor's degree in community development, education, public administration, public health, psychology, sociology, social work, or closely related field and have one (1) year or more of full-time equivalent professional experience in education, public health, mental health, human services, or a closely related area. Additional years of experience may be substituted on a year-for-year basis for the education requirement; or

(B) A prevention professional that is credentialed by the Missouri Credentialing Board to provide prevention services.

(6) Documentation of Resources and Services. All prevention programs shall maintain—

(A) A current listing of resources within the geographic area in order to readily identify available substance use disorder treatment and prevention resources, as well as other resources applicable to the target population;

(B) Informational and technical materials that are current, relevant, and appropriate to the program's goals, content, and target population.

1. Materials and their use shall accommodate persons with special needs, or the materials can be readily adapted to meet those needs.

2. Materials shall be periodically reviewed by staff and advisory board to ensure relevance to the target population and consistency with current prevention research. The advisory board shall include members of the target population and a broad range of representatives from other community groups and organizations; and

(C) A record of all service activities. The record shall—

1. Identify the presenter and participants;
2. Describe the service activity;
3. State how the activity meets the specific needs of the individual, group, or community organization served;
4. Include consents for participation or releases of information, as applicable; and
5. Include or summarize participant evaluations, as applicable.

(7) Primary Prevention Program. A Primary Prevention Program shall offer comprehensive services and activities to a specified target population(s) in its effort to reduce the risk of and incidence of illegal or age-inappropriate use or misuse of alcohol, tobacco, and other drugs.

(A) A primary prevention program shall offer all of the following types of prevention services: information, education, alternatives, problem identification and referral, community-based process, and environmental services.

1. Unless otherwise indicated, the target population for information, education, alternatives, and problem identification and referral services shall include, but is not limited to, one (1) or more of the following: persons who are at risk for a substance use disorder; families or friends, or both, of persons at risk for a substance use disorder; school officials or employers of persons at risk for a substance use disorder; caretakers and families of elderly or populations with other special needs.

2. Unless otherwise indicated, the target population for community-based process and environmental services shall include, but is not limited to, persons at risk for a substance use disorder; community groups mobilizing to combat inappropriate substance use including civic and volunteer organizations; church; schools; business; healthcare facilities and retirement communities; state and municipal governments; and other related community organizations.

(B) Information services shall increase awareness of the nature, extent, and effects of such substance use.

1. Information services are characterized by one- (1-) way

communication from the presenter to the target population.

2. In addition to the target populations listed in subsection (7)(A), the target population information services may include the general public.

3. Examples of information service activities include: distributing written materials such as brochures, pamphlets, newsletters, resources directories, and other relevant materials; distributing audiovisual materials such as films, tapes, public service announcements, and other relevant materials; functioning as information resource center or clearinghouse; arranging speakers and presentations; and operating as a designated access point for computerized information networks.

(C) Education services shall develop social and life skills, such as conflict resolution, decision-making, leadership, peer resistance, and refusal skills.

1. Education services are characterized by interaction between the facilitator and the participants to promote certain skills and behaviors.

2. Examples of education service activities include classroom or small group sessions for person of any age, peer leader and helper programs, and parenting and family management classes.

(D) Alternatives shall provide healthy and constructive activities to offset the attraction of such substance use or to meet needs which otherwise may be fulfilled by these substances.

1. Alternative services engage the target population in recreational and other activities that exclude such substance use.

2. Examples of alternative service activities include developing and supporting community service activities, teen institutes and other leadership training and activities for youth, adults, parents, school faculty, or others.

(E) Problem identification and referral services shall assist in arranging support, education, and other referrals, as needed, for persons who have become involved in the initial, inappropriate, or illegal use of alcohol, tobacco, and drugs.

1. This service does not include a professional or comprehensive assessment and determination of the need for substance use disorder treatment.

2. Examples of specific problem identification and referral activities include training and consultation to student assistance programs, employee assistance programs, medication support programs for the elderly, and other programs and organizations that may intervene with persons in the target population.

(F) Community-based process shall involve the assessment of community needs and the promotion of community planning and action in order to enhance other prevention and treatment services and to reduce the incidence of such substance use.

1. The target population shall include community coalitions. A community coalition must have broad-based community representation and participation, such as civic organizations, neighborhood groups, churches, schools, law enforcement, healthcare and substance treatment facilities, businesses, and governmental organizations.

2. Examples of community-based process activities include assessing community needs and risk factors and recruiting, training, and consulting with community coalitions.

(G) Environmental services shall positively effect community policies, attitudes, and norms known to influence the incidence of such substance use.

1. Environmental services may address legal/regulatory initiatives, service/action initiatives, or both.

2. Examples of environmental services include maintaining current information regarding environmental strategies; training and consulting with community coalitions in the development and implementation of such strategies; serving as a resource to school, businesses, and other community organizations in the development of policies; and providing information regarding alcohol and tobacco availability, advertising and pricing strategies.

(8) Targeted Prevention Program. A Targeted Prevention Program shall actively intervene with individuals and populations that have multiple risk factors for the illegal or age-inappropriate use or misuse of alcohol, tobacco, and other drugs. The program shall reduce risk factors and reduce the likelihood of such substance use and include effective prevention strategies that are based on research findings.

(A) The target population shall include:

1. Persons at risk of developing a substance use disorder, such as out-of-school youth, youth dropouts, or persons prone to violence; and

2. Individuals and groups that influence those persons at risk for a substance use disorder, such as parents; teachers, families and caretakers of elderly, or populations with other special needs; and school based and community groups, including civic and volunteer organizations, churches, and other related community organizations.

(B) The program may be located in school or other community settings.

(C) The program shall provide and promote social and emotional support, skill development, counseling, and other preventive services for persons and populations with multiple risk factors.

(D) Examples of specific services and activities include early identification and intervention; efforts to prevent dropping out of school; after-school recreational and educational activities; development of social and life skills such as conflict resolution, decision making, leadership, peer resistance, and refusal skills; group counseling or individual counseling, or both; parent training and consultation with school staff or other community organizations.

(9) Statewide Prevention Resource Center. A statewide prevention resource center shall organize, coordinate, train, assist, and recognize community, regional, and state resources in their efforts to reduce the illegal or age-inappropriate use or misuse of alcohol, tobacco, and other drugs.

(A) The target population shall include community coalitions and other community organizations including primary prevention programs; and other community and state resources.

(B) Examples of specific activities include:

1. Conducting statewide and regional workshops and conferences;

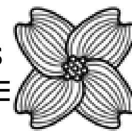
2. Where applicable, distributing a state-wide newsletter that contains current information about prevention activities and issues;

3. Providing information and technical assistance regarding effective prevention strategies that are based on research findings;

4. Recognizing accomplishments by community coalitions and sponsoring recognition events;

5. Coordinating prevention activities and resources development with other state level organizations and state agencies; and

6. Expanding and strengthening the network of community and state organizations involved in prevention activities.



(10) All prevention programs shall participate in program evaluation activities as required by the department.

AUTHORITY: section 630.655, RSMo 2016. This rule was originally filed as 9 CSR 30-3.630. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded and readopted: Filed June 27, 1995, effective Dec. 30, 1995. Moved to 9 CSR 30-3.300 and amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Oct. 15, 2001, effective April 30, 2002. Amended: Filed March 9, 2018, effective Oct. 30, 2018.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-3.310 Recovery Support Programs

PURPOSE: This rule describes the certification and service delivery requirements for recovery support programs.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Program Description. Recovery support programs offer individuals recovery support services such as care coordination, spiritual and group counseling, life skills training, recovery housing, and transportation assistance, before, during, after, or independent of substance use disorder treatment provided by an organization certified by the department. These services are offered in a multitude of settings including, but not limited to, community support groups, faith-based organizations, and self-help and peer recovery groups. Recovery support programs are person-centered, allowing individuals the opportunity to direct his/her recovery process.

(2) Types of Programs. Certification is available for the following types of recovery support programs and services:

(A) Care coordination. Care coordination consists of assisting individuals with accessing the network of services and other community resources available to facilitate retention in substance use disorder treatment and/or sustained recovery. This may include, but is not limited to, consultation with the individual's treatment provider, procurement of medication for a mental and/or substance use disorder through charitable programs, assistance in finding and securing permanent housing, development of a social support system, and when funded by the department, bus passes to eligible individuals. A care coordination service provider shall meet the following requirements:

1. Services shall be provided by recovery support program staff;
2. Services shall include, but are not limited to:
   A. Arranging, referring, and when necessary, advocating for quality services to which the individual is entitled;
   B. Monitoring provider service delivery and ensuring communication among service providers;
   C. Locating and coordinating services specific to crisis resolution; and
   D. Training in resource acquisition;

(B) Peer recovery drop-in center. Peer recovery drop-in center service emphasizes building peer relationships to help support personal choice(s), respect, and recovery. A peer recovery drop-in center shall meet the following requirements:

1. Each center shall be managed by a Missouri Recovery Support Specialist or Missouri Recovery Specialist – Peer as designated by the Missouri Credentialing Board;
2. Each center shall be staffed with a minimum of eighty percent (80%) staff and volunteers who are in recovery from a substance use disorder or co-occurring mental and substance use disorder;
3. The drop-in center shall create a home-like environment, including a living room type space with chairs, couches, and lighting for informal conversation, and a separate space for group meetings;
4. The drop-in center shall provide coffee, tea, or other free or low-cost beverages and may offer free or low-cost healthy food items;
5. The drop-in center shall offer recreational activities that induce social interaction, such as playing cards and other games, as well as the opportunity to participate in formal peer counseling and structured life-skill building groups;
6. The drop-in center shall provide a physically and emotionally safe environment that is accessible on foot or through public transportation; otherwise, the program shall provide or arrange for alternative transportation;
7. The drop-in center hours of operation shall be geared to the needs of individuals and include evening and weekend hours, at a minimum five (5) days per week for four (4) hours per day;
8. Drop-in center services shall be voluntary, free of charge, and free of expectations of length of participation;
9. A calendar of groups meetings, educational opportunities, and recreational activities shall be posted and updated at least monthly; and
10. Drop-in center services shall provide information on and coordination with social service support agencies in the community, as well as traditional behavioral health and physical health care service providers;

(C) Recovery coaching. Recovery coaching offers the individual support to develop proactive recovery-oriented problem solving skills for the future. A recovery coaching program shall meet the following requirements:

1. Recovery coaching shall be offered before, after, or concurrently with any department-funded certified substance use disorder treatment program;
2. Recovery coaching shall be a one-to-one service delivered face-to-face or, with department approval, through telehealth;
3. Recovery coaching shall not be considered a substitute for services delivered by a certified substance use disorder treatment program;
4. Recovery coaching shall be provided by a Missouri Recovery Support Specialist or a Missouri Recovery Support Specialist - Peer as designated by the Missouri Credentialing Board; and
5. Recovery coaching services and activities shall include, but are not limited to:
   A. Helping individuals connect with peers and their communities to develop a network for information and support;
   B. Sharing experiences of recovery, including the use of recovery tools, and modeling successful recovery behaviors;
   C. Helping individuals make independent choices and taking a proactive role in their recovery;

D. Assisting individuals with identifying strengths and personal resources to aid in setting and achieving recovery goals; and

E. Conducting periodic recovery management check-ups and assessing victories, strengths, challenges, and setbacks;

6. Wellness coaching is recovery coaching that focuses on the relevant physical health factors previously identified by the individual as problematic, including:

A. Low levels of physical activity/sedentary lifestyle;

B. Use of tobacco and other addictive substances;

C. Lack of nutrition and dietary education;

D. Diet and glucose monitoring for diabetes prevention and management;

E. Oral hygiene/dental health practices; and/or

F. Use of medications which contribute to metabolic syndrome, obesity, and other health conditions;

7. Employment coaching is recovery coaching that assists individuals in finding and maintaining competitive and gainful employment and may include, but is not limited to:

A. Assisting in identifying tasks and activities geared toward career exploration and planning;

B. Assisting with job searching and preparation; and/or

C. Assisting in the development of self-management skills, interpersonal skills for the workplace, social and communication skills, and job maintenance;

(D) Spiritual counseling. Spiritual counseling helps individuals explore problems and conflicts from a spiritual perspective. Spiritual counseling shall meet the following requirements:

1. Services shall be provided by qualified clergy. A qualified clergy is defined as an ordained clergy by a recognized religious organization with at least one (1) of the following credentials:

A. Missouri Recovery Support Specialist (MRSS);

B. Missouri Recovery Support Specialist-Peer (MRSS-P);

C. Certified Alcohol Drug Counselor (CADC);

D. Certified Reciprocal Alcohol Drug Counselor (CRADC);

E. Certified Reciprocal Advanced Alcohol Drug Counselor (CRAADC);

F. Recognized Substance Abuse Professional (RSAP);

G. Certified Criminal Justice Professional (CCJP);

H. Physician;

I. Licensed Professional Counselor (LPC);

J. Licensed Marriage and Family Therapist (LMFT);

K. Licensed Clinical Social Worker (LCSW); or

L. Licensed Psychologist;

2. Religious organization shall mean that defined in 352.400.1(5), RSMo.

3. The individual's spiritual beliefs, morals, ideas, values, and conflicts shall be explored in a safe and non-judgmental manner; and

4. Spiritual counseling services shall include one (1) or more of the following:

A. Establishing or re-establishing a relationship with a higher power;

B. Developing personal connectedness with a spiritual, religious, or faith-based entity;

C. Acquiring skills needed to cope with life-changing incidents;

D. Adopting positive values or principles;

E. Identifying a sense of purpose and mission for one's life;

F. Achieving serenity and peace of mind;

G. Finding life purpose;

H. Overcoming emotional, social, mental, or physical obstacles; and/or

I. Putting pain and grief into perspective;

(E) Support, educational, or life-skills groups. Support, educational, or life-skills groups provide support for individuals in recovery by offering encouragement and connections with others who share similar experiences. Support, educational, or life-skills groups shall meet the following requirements:

1. Group services shall address recovery, employment, spiritual, and/or wellness issues relevant to the needs of the individuals served;

2. Groups may be formed around shared identity such as common cultural or religious affiliation, shared experiences, and/or goals such as community re-entry following incarceration, HIV status, or challenges in parenting;

3. Group sessions may consist of the presentation of general information and application of the information to participants through group discussion designed to promote recovery and enhance social functioning;

4. Support group services shall include, but are not limited to:

A. Classroom-style didactic lecture to present information about a topic and its relationship to substance use disorders and recovery;

B. Presentation of educational audiovisual materials with required follow-up discussion;

C. Promotion of discussion and questions about the topic presented to the individuals in attendance;

D. Generalization of the information and demonstration of its relevance to recovery and enhanced functioning;

E. Facilitating disclosure of issues that permits generalization of the issue to the larger group;

F. Promoting positive help-seeking and supportive behaviors; and

G. Encouraging and modeling productive and positive interpersonal communication;

5. A support, educational, or life-skills group session shall include a qualified facilitator and at least two (2) but no more than thirty (30) individuals per group in order to promote participation;

(F) Transportation. Transportation services assist individuals enrolled in a certified recovery support program or substance use disorder treatment program in achieving and sustaining recovery goals when they do not have the means to provide personal transportation. Transportation services shall meet the following requirements:

1. Transportation shall be limited to specific destinations and/or appointments as defined by the department. Allowable transportation services shall include:

A. To and from a certified substance use disorder treatment program;

B. To and from a certified recovery support program;

C. To and from a doctor's appointment, dental appointment, or appointment with other healthcare providers;

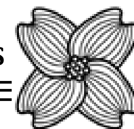
D. To and from probation and parole, court, or other criminal justice agencies; and

E. To and from employment-seeking activities and/or active employment;

2. Staff or volunteers who provide transportation services shall meet the background screening requirements in 9 CSR 10-5.190 and hold a class E chauffeur's license, or if transporting more than fifteen (15) passengers, a CDL license;

3. The vehicle used for transportation shall be currently licensed, properly insured, and provide safe and reliable transportation for individuals served;

4. Staff or volunteers who provide transportation shall have access to a communication device in the vehicle at all



times;

(G) Recovery housing. Recovery housing is a direct service that provides supervised, short-term housing to individuals with substance use disorders or co-occurring mental and substance use disorders. Recovery housing services shall meet the following requirements:

1. To be eligible for recovery housing, the individual shall be participating in a department certified and funded substance use disorder treatment program or recovery support program;

2. Recovery housing levels of support and supervision shall include one (1) of the following:

A. Peer-run: At least weekly house meetings facilitated by staff; or

B. Monitored: At least a daily monitoring visit by staff; or

C. Supervised: twenty-four- (24-) hour supervision of individuals by staff, with a minimum of three (3) different staff members providing supervision per twenty-four- (24-) hour period;

3. Each recovery housing provider that offers the self-pay option to individuals served shall have written rental agreement policies and procedures that include, but are not limited to:

A. An explanation of the housing arrangements shall be posted in all housing units;

B. The grounds for termination of the rental agreement;

C. The terms of the agreement shall be established and explained to each individual at admission to housing services; and

D. If an individual enters into a rental agreement for housing with the recovery support organization, a signed copy of that rental agreement shall be kept in the individual record;

4. Recovery housing properties shall—

A. Provide proof of an initial successful Housing Quality Standards (HQS) inspection conducted by an HQS inspector;

B. Provide proof of a successful annual fire inspection; and

C. Provide proof of meeting all local government occupancy/safety requirements such as an occupancy permit, zoning approval, and/or other correspondence showing approval from the local municipal or county governing body;

5. Recovery housing properties inspected and approved as meeting standards of a state/local/regional/national provider organization such as the National Association of Recovery Residences shall be exempt from requirements in paragraph (2)(G)4. of this rule.

(3) Specialized Services. Recovery support programs that specialize in serving minority or other populations with unique recovery needs may tailor individual and group services to address specific needs. These specialized populations, services, and philosophies may be combined in multiple ways to include, but not be limited to:

(A) Employment;

(B) Faith and spiritual beliefs;

(C) Housing;

(D) Offender re-entry;

(E) Peer supports; and

(F) Wellness.

(4) Program Certification. Certification is required for a recovery support organization to obtain and maintain a contract with the department, to participate in department programs eligible for Medicaid reimbursement, and to serve individuals whose referral sources require the provider to be certified by the department. Organizations accredited under standards of care for recovery support services by the National Association of Recovery Residences (NARR), the Council on Accreditation of Peer Recovery Support Services (CAPRSS), the local affiliates of NARR or CAPRSS, or other entity recognized by the department may be eligible for certification through deeming. Certification or deemed status does not constitute an assurance or guarantee that the department or other entity will fund or utilize designated services or programs.

(A) An organization seeking certification or deemed status as a recovery support program shall comply with certification requirements set forth in 9 CSR 10-7.130, as well as all department rules and standards contained herein.

(B) The following core rules for psychiatric and substance use disorder treatment programs shall be met by recovery support programs:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;
2. 9 CSR 10-7.020 Rights, Responsibilities, and Grievances;
3. 9 CSR 10-7.040 Quality Improvement;
4. 9 CSR 10-7.050 Research;
5. 9 CSR 10-7.060 Behavior Management;
6. 9 CSR 10-7.070 Medications;
7. 9 CSR 10-7.080 Dietary Service;
8. 9 CSR 10-7.090 Governing Authority and Program Administration;
9. 9 CSR 10-7.100 Fiscal Management;
10. 9 CSR 10-7.110 Personnel;
11. 9 CSR 10-7.120 Physical Plant and Safety;
12. 9 CSR 10-7.130 Procedures to Obtain Certification;
13. 9 CSR 10-7.140 Definitions.

(C) The following general program procedures shall be met by recovery support programs:

1. 9 CSR 10-5.190 Background Screening for Employees and Volunteers;
2. 9 CSR 10-5.200 Report of Complaints of Abuse, Neglect, and Misuse of Funds/Property;
3. 9 CSR 10-5.206 Report of Events;
4. 9 CSR 10-5.210 Exceptions Committee Procedures;
5. 9 CSR 10-5.220 Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA); and
6. 9 CSR 10-5.230 Hearings Procedures.

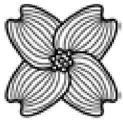
(D) The following department rules and standards shall be waived for recovery support programs unless the department determines that a specific requirement is applicable due to the unique circumstances and service delivery methods of a particular recovery support program:

1. 9 CSR 10-7.030 Service Delivery Process and Documentation;
2. 9 CSR 30-3.100 Service Delivery Process and Documentation; and
3. 9 CSR 30-3.110 Service Definitions and Staff Qualifications.

(5) Staff. Qualified staff shall be available in sufficient numbers to ensure effective service delivery.

(A) All staff and volunteers of recovery support programs shall meet background screening requirements in 9 CSR 10-5.190. The Missouri Department of Health and Senior Services Family Care Registry or other department-approved background screening service shall be used.

(B) All staff and volunteers who have contact with individuals receiving services shall, at a minimum, meet department-approved qualifications and complete six (6) hours of annual training on ethics and professional boundaries. The six (6) hours of annual ethics and boundaries training shall apply to the required thirty-six (36) hours of training, every two (2)



years, for personnel as referenced in 9 CSR 10-7.110(2)(E)1.

(C) Training activities shall be documented in each employee's personnel file and shall include the training topic, name of instructor, date(s) of training, certification/continuing education units, and location.

(D) Former recipients of services who transition to staff and volunteer roles shall have been in continuous personal recovery from a substance use disorder or co-occurring mental and substance use disorder for a period equal to or greater than twelve (12) months. Continuous personal recovery shall mean the individual—

1. Has not used any illegal drugs;

2. Has not used any physician-prescribed medication in a non-prescribed way;

3. Has not used any over-the-counter medication except for its intended use;

4. Has abstained from all use of alcohol; and

5. Is successfully managing their mental illness.

(E) All staff and volunteers of a certified recovery support program shall adhere to the Missouri Recovery Support Specialist (MRSS) *Code of Ethics*, or if functioning in a peer role, Missouri Recovery Support Specialist - Peer (MRSS-P) *Code of Ethics*, January, 2016, incorporated by reference, without any later amendments or additions, as published by the Missouri Credentialing Board, 428 E. Capitol Avenue, Jefferson City, MO 65101.

(F) The recovery support program shall establish and consistently implement policies and procedures to guide the roles and activities of volunteers and staff in an organized and productive manner.

(G) Minimum qualifications for supervision of staff and volunteers include holding any of the following credentials: qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR); Licensed Professional Counselor (LPC); Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); Licensed Psychologist; qualified clergy as defined in paragraph (2)(D)1. of this rule; or a director of a certified recovery support program. Acceptable supervision shall include a minimum of one (1) hour every month of face-to-face individual or group supervision.

(6) Admission Criteria. The criteria for admission to a recovery support program shall include at least one (1) of the following:

(A) The individual has a current substance use disorder or co-occurring mental and substance use disorder as identified in the screening and assessment process outlined in section (8) of this rule;

(B) The individual is in recovery from a substance use disorder or co-occurring mental and substance use disorder and in need of services as identified in the screening and assessment process outlined in section (8) of this rule; or

(C) The individual is re-entering the community from a correctional facility and has a prior history of a substance use disorder or co-occurring mental and substance use disorder.

(7) Treatment Goals. Successful outcomes for individuals participating in recovery support services include, but are not limited to:

(A) Obtaining and maintaining sobriety;

(B) Minimizing the risk of relapse;

(C) Improving family, natural support, and social relationships;

(D) Improving employment/educational functioning;

(E) Promoting productive use of time;

(F) Developing social support;

(G) Developing spiritual support;

(H) Developing safe and stable housing;

(I) Complying with all legal, court, probation, or parole requirements;

(J) Minimizing harmful social or behavioral risk; and/or

(K) Improving physical health and wellness.

(8) Screening, Assessment, and Recovery Plan. Each individual participating in recovery support services, as defined in this rule, shall be subject to a screening, an assessment, and the development of an individualized recovery plan.

(A) Screening. Each individual requesting a recovery support service(s) shall have prompt access to a screening to determine eligibility, substance use and/or co-occurring mental and substance use disorder history, and recovery needs. The screening shall—

1. Be conducted by a recovery support program and/or substance use disorder treatment program certified by the department;

2. Be conducted by trained staff;

3. Be responsive to the individual's requests and needs; and

4. Include written notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community. Referrals to other community resources shall include active care coordination to ensure the individual accesses appropriate supports.

(B) Assessment. Each individual requesting a recovery support service(s) shall participate in a recovery-oriented assessment that identifies his/her needs and goals, guides the development of an individualized recovery plan, and ensures engagement in appropriate recovery services. The participation of family and other natural supports and collateral parties (e.g., referral source, employer, other community agencies) in the assessment and development of the recovery plan shall be encouraged, as appropriate, and based upon the wishes of the individual.

1. The assessment shall be conducted by an organization certified by the department as a substance use disorder treatment program or a recovery support program.

2. The assessment shall be completed by a person who meets established criteria for a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR).

3. The assessment shall be completed within thirty (30) days of initial contact with the recovery support program. This time period does not include weekends and holidays observed by the state of Missouri.

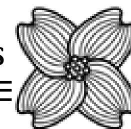
A. If an individual is determined to have active or a severe substance use disorder, mental illness, or co-occurring mental and substance use disorder, presents symptoms of intoxication, impairment or withdrawal, cannot achieve abstinence without close monitoring, or requires structured support and daily supervision, he or she shall be referred to a certified substance use disorder treatment program or certified community mental health center for services.

B. The recovery support program may provide interim services for individuals with severe substance use, mental illness, or a co-occurring mental and substance use disorder while he/she is waiting for higher intensity services.

4. Documentation of the screening and assessment shall include, but is not limited to, the following:

A. Demographic and identifying information;

B. Needs, goals, and expectations from the person requesting services;



C. Presenting situation/problem and referral source;
D. History of previous and current psychiatric and/or substance use disorder treatment;
E. Wellness screening;
F. Current medications and medication allergies;
G. Alcohol and drug use history, including duration, patterns, and consequences of use;
H. Current psychiatric symptoms;
I. Family, social, legal, vocational and educational status, and functioning;
J. Current use of resources and services from other community agencies; and
K. Personal strengths, including family and other natural supports, social, peer, and recovery history.

5. The recovery support program shall actively coordinate other services and make appropriate referrals to ensure the safety and well-being of individuals with severe substance use, mental illness, physical health conditions, or other basic needs.

(C) Individualized Recovery Plan. The individualized recovery plan shall reflect the person's unique needs and goals with a focus on integration and inclusion in his/her community, building healthy relationships with family and other natural supports systems, and accessing other community supports. Services may begin before the assessment is completed and the recovery plan is fully developed.

1. Each individual participating in a recovery support program shall actively participate in the creation of a recovery plan within thirty (30) days of admission to the recovery support program. A qualified substance abuse professional and other member(s) of the individual's recovery team shall also participate in development of the recovery plan.
2. The recovery plan shall guide ongoing service delivery and shall be signed by the individual.
3. The recovery plan shall be based on the individual's initial screening and assessment as well as an assisted self-assessment of his or her goals and the strengths and capacities that he or she will use or rely upon to achieve these goals.
4. Service needs beyond the scope of the recovery support program that are being addressed by referral to or coordination with another community organization shall be included in the recovery plan.
5. Progress toward achievement of recovery goals shall be reviewed on a periodic basis to ensure the plan reflects current issues and maintains relevance for the individual. Each individual shall directly participate in regular reviews and updates of their recovery plan and shall sign the review.

(9) Organized Record System. Each recovery support program shall have an organized record system for each individual that receives recovery support services.

(A) Records shall be maintained in a manner that ensures confidentiality and security. The organization shall abide by all local, state, and federal laws and regulations concerning the confidentiality of records.

(B) If records are maintained on a computer system, there shall be a backup process in place to safeguard records in the event of operator or equipment failure and to ensure security from inadvertent or unauthorized access.

(C) The recovery support program shall retain individual records for at least six (6) years from the date of service or until all litigation, adverse audit findings, or both, are resolved.

(D) The recovery support program shall assure ready access to all records, including computerized records, by authorized staff and other authorized parties including department staff.

(10) Documentation. Services funded by the department shall be entered in the department-approved electronic record system. Services documented shall be legible, clear, complete, accurate, and recorded in a timely fashion not to exceed twenty-four (24) hours from service delivery with indelible ink, print, or approved electronic record system.

(A) Entries shall be dated and authenticated by the staff member providing the service, including name and title. Any errors on paper documentation shall be marked through with a single line, initialed, and dated.

(B) There shall be documentation of services provided and results accomplished.

(C) Individual service notes and group logs shall include:

1. Description of the specific service provided;
2. The date and actual time (beginning and ending times) the service was rendered;
3. Name and title of the person who rendered the service;
4. The setting in which the service was rendered;
5. The relationship of the services to the recovery plan; and
6. Description of the individual's response to the service provided.

(D) Where applicable, the record shall also include documentation of referrals to other services or community resources and the outcome of those referrals, signed authorization to release confidential information, missed appointments and efforts to re-engage the individual, urine drug screening or other toxicology reports, and crisis or other significant events that may impact the recovery process.

AUTHORITY: section 630.050, RSMo Supp. 2013, and section 630.055, RSMo 2000. Original rule filed on April 4, 2016, effective Oct. 30, 2016.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.055, RSMo 1980.*

9 CSR 30-3.400 Social Setting Detoxification
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.410 Modified Medical Detoxification
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.420 Medical Detoxification Services
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.500 Residential Programs
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original

rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.510 Adolescent Program
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1994. Original rule filed May 6, 1985, effective Sept. 1, 1985. Amended: Filed Dec. 16, 1988, effective March 15, 1989. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.600 Outpatient Programs
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.610 Methadone Treatment
(Moved to 9 CSR 30-3.132)

9 CSR 30-3.611 Compulsive Gambling Treatment
(Moved to 9 CSR 30-3.134)

9 CSR 30-3.620 Information and Referral Program
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed May 13, 1983, effective Sept. 13, 1983. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.621 Central Intake Program
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed Sept. 15, 1994, effective Feb. 26, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.630 Prevention Programs
(Moved to 9 CSR 30-3.300)

9 CSR 30-3.700 Substance Abuse Traffic Offender Programs
(Moved to 9 CSR 30-3.201)

9 CSR 30-3.710 Definitions
(Rescinded October 30, 2001)

AUTHORITY: sections 302.510, 302.540, 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, RSMo Supp. 1997 and 630.655 and 631.010, RSMo 1994. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed Oct. 4, 1988, effective Oct. 14, 1988, expired Jan. 14, 1989. Amended: Filed Oct. 4, 1988, effective Jan. 14, 1989. Emergency amendment filed April 4, 1989, effective April 14, 1989, expired July 14, 1989. Amended: Filed April 4, 1989, effective July 14, 1989. Emergency amendment filed April 4, 1989, effective April 14, 1989, expired July 14, 1989. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.720 Procedures to Obtain Certification
(Rescinded October 30, 2001)

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, RSMo Supp. 1997 and 630.655 and 631.010, RSMo 1994. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.730 Administration
(Moved to 9 CSR 30-3.202)

9 CSR 30-3.740 Environment
(Rescinded October 30, 2001)

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, RSMo Supp. 1997 and 630.655 and 631.010, RSMo 1994. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

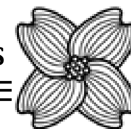
9 CSR 30-3.750 Personnel
(Moved to 9 CSR 30-3.204)

9 CSR 30-3.760 Program Structure
(Moved to 9 CSR 30-3.206)

9 CSR 30-3.770 Client Records
(Rescinded October 30, 2001)

AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, RSMo Supp. 1997 and 630.655 and 631.010, RSMo 1994. Original rule filed Nov. 2, 1987, effective May 15, 1988. Emergency amendment filed May 3, 1994, effective July 1, 1994, expired Oct. 28, 1994. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Emergency amendment filed Oct. 17, 1994, effective Oct. 28, 1994, expired Feb. 24, 1995. Amended: Filed Oct. 17, 1994, effective April 30, 1995. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.780 Curriculum and Training
(Rescinded October 30, 2001)



AUTHORITY: sections 302.540, 577.001, 577.049, 577.520, 577.525, 630.050 and 630.053, RSMo Supp. 1997 and 630.655 and 631.010, RSMo 1994. Original rule filed Nov. 2, 1987, effective May 15, 1988. Amended: Filed April 29, 1998, effective Oct. 30, 1998. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.790 Supplemental Fee
(Moved to 9 CSR 30-3.208)

9 CSR 30-3.800 Required Educational Assessment and Community Treatment Program
(Moved to 9 CSR 30-3.230)

9 CSR 30-3.810 Definitions
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.820 Procedures to Obtain Certification
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Emergency amendment filed Dec. 20, 1995, effective Dec. 30, 1995, expired June 26, 1996. Amended: Filed Dec. 20, 1995, effective June 30, 1996. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.830 Comprehensive Substance Treatment and Rehabilitation Program Description
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.840 Treatment and Rehabilitation Process
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.850 Service Provision
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded and readopted: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Emergency amendment filed Dec. 20, 1995, effective Dec. 30, 1995, expired June 26, 1996. Amended: Filed Dec. 20, 1995, effective June 30, 1996. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.851 Specialized Program for Women and Children
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.852 Specialized Program for Adolescents
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.853 Adolescent Residential Support
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.860 Quality Assurance
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.870 Behavior Management
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.880 Client Records
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.890 Personnel, Staff Qualifications, Responsibilities and Training
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994,

effective Nov. 30, 1994. Amended: Filed June 27, 1995, effective Dec. 30, 1995. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.900 Client Rights
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.910 Research
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.920 Governing Authority and Program Administration
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed May 3, 1994, effective Nov. 30, 1994. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.930 Fiscal Management
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.940 Environment, Safety and Sanitation
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.950 Accessibility
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.960 Dietary Services
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed June 15, 1990, effective Nov. 30, 1990. Amended: Filed July 30, 1998, effective Feb. 28, 1999. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-3.970 Medication Management
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1986. Original rule filed June 15, 1990, effective Nov. 30, 1990. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.