Rules of
Department of Mental Health
Division 30—Certification Standards
Chapter 3—Substance Use Disorder Treatment Programs

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 30—Certification Standards
Chapter 3—Substance Use Disorder 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(Rescinded October 30, 2001)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 Rescinded: Filed Feb. 28, 2001, effective October 30, 2001.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(Rescinded October 30, 2001)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 Rescinded: Filed Feb. 28, 2001, effective October 30, 2001.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(Rescinded July 30, 2018)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 Rescinded: Filed Jan. 12, 2018, effective July 30, 2018.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(Rescinded October 30, 2001)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 Rescinded: Filed Feb. 28, 2001, effective October 30, 2001.

9 CSR 30-3.032 Certification of Alcohol and Drug Abuse Programs

PURPOSE: This rule identifies the types of substance abuse programs eligible for certification and the applicable requirements.

(1) Types of Programs. Certification is available for the following types of alcohol and drug abuse programs and services:

(A) Recovery programs including—

1. Detoxification in accordance with a designated level of care. Levels of care include social setting, modified medical, or medical;

2. Outpatient treatment in accordance with designated levels of care. Levels of care include community-based primary treatment, intensive outpatient rehabilitation, and supported recovery;

3. Opioid treatment;

4. Compulsive gambling treatment;

5. Residential treatment;

6. Institutional corrections; and

7. Comprehensive substance treatment and rehabilitation (CSTAR);

(B) Recovery Programs for Specialized Populations. A specialized program for the treatment and rehabilitation of adolescents or women and children must be certified as a CSTAR program;

(C) Offender education and intervention programs including—

1. Substance Abuse Traffic Offender Program (SATOP) offering designated levels of service. For persons age twenty-one (21) and older, levels of service include offender management, offender education, weekend intervention, and clinical intervention. For persons under the age of twenty-one (21), levels of service include offender management, adolescent diversion education, and youth clinical intervention. The department shall also certify regional SATOP training centers.

2. Required Educational Assessment and Community Treatment Program (REACT) offering a Screening and Education level of service;

(D) Prevention program offering designated levels of service. Levels of service include primary prevention, targeted prevention, and prevention resource center.

(2) Applicable Program Standards. The organization must comply with the standards applicable to each program for which certification is being sought.

(3) Other Rules and Standards. In addition to standards for specific programs and services, the organization must comply with other applicable requirements.

(A) The following Core Rules for Psychiatric and Substance Abuse Programs must be met, unless otherwise stipulated in standards for specific programs and services:

1. 9 CSR 10-7.010 Treatment Principles and Outcomes;

2. 9 CSR 10-7.020 Rights, Responsibilities and Grievances;

3. 9 CSR 10-7.030 Service Delivery Process and Documentation;

4. 9 CSR 10-7.040 Quality Improvement;

5. 9 CSR 10-7.050 Research;

6. 9 CSR 10-7.060 Behavior Management;

7. 9 CSR 10-7.070 Medications;

8. 9 CSR 10-7.080 Dietary Services;

9. 9 CSR 10-7.090 Governing Authority and Program Administration;

10. 9 CSR 10-7.100 Fiscal Management;

11. 9 CSR 10-7.110 Personnel;

12. 9 CSR 10-7.120 Physical Plant and Safety;

13. 9 CSR 10-7.130 Procedures to Obtain Certification;

14. 9 CSR 10-7.140 Definitions;

15. 9 CSR 10-5.190 Criminal Record Review; and

16. 9 CSR 10-5.200 Report of Complaints of Abuse and Neglect; and

17. 9 CSR 10-5.220 Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(B) The following Certification Standards for Alcohol and Drug Abuse Programs must be met, unless otherwise stipulated in standards for specific programs and services:

1. 9 CSR 30-3.022 Transition to Enhanced Standards of Care;

2. 9 CSR 30-3.100 Service Delivery Process and Documentation; and

3. 9 CSR 30-3.110 Service Definitions and Staff Qualifications for Service Delivery.

(4) Approval of Programs and Sites by the Department, When Required. For those services funded by the department or provided through a service network authorized by the department, the department shall have authority to determine and approve each proposed program and/or site prior to the actual delivery of services, including the geographic location, plan of service delivery, and facility.

(A) Any organization subject to this approval process shall submit written notice to the department regarding the proposed program and/or site(s). The notice must include the following information:

1. A determination of need identifying the unserved or under-served target population and the substance abuse treatment, rehabilitation, and other intervention needs of that population. The department shall consider

available data, such as current accessibility to and availability of services, prevalence of substance abuse among the target population, applicable emergency room visits and relevant arrest data;

2. A proposed plan of service delivery including, but not limited to, geographic location, facility, services offered, and staffing pattern;

3. A business/capitalization plan demonstrating the organization's financial ability to provide the proposed services to the target population;

4. A description of planning and coordination to meet the needs of the target population in areas such as psychiatric services, housing, etc.; and

5. Documentation of the local community's involvement in and support for the proposed service, such as an advisory committee which includes representatives from the target population and local agencies (such as courts, Board of Probation and Parole, Division of Family Services, mental health providers) with evidence of their involvement via letters of support, minutes of meetings, etc.

(B) An organization which wishes to change its approved program and/or site(s) must obtain approval from the department prior to such change. Any new or different facility must be equal to or better than the original facility.

(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, RSMo Supp. 2002 and 630.050, 630.655 and 631.102, RSMo 2000. 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.*

**Original authority: 302.540, RSMo 1983, amended 1984, 1993, 1996, 2001, 2002; 630.050, RSMo 1980, amended 1993, 1995; 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 October 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 October 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 October 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 Service Delivery Process and Documentation

PURPOSE: This rule describes requirements in the delivery and documentation of services for those programs certified under 9 CSR 30-3.120 through 9 CSR 30-3.199.

(1) Other Requirements. In addition to the requirements of this rule, a program must also comply with 9 CSR 10-7.030 Service Delivery Process and Documentation that is applicable to both substance abuse and psychiatric programs.

(2) Available Services. Assessment, individual counseling, group education and counseling, community support and family therapy shall be available to each person participating in substance abuse treatment and rehabilitation in accordance with the individual's clinical needs. Day treatment shall be provided if indicated by the person's level of care.

(3) Services to Family Members. Services shall be available to family members of those persons participating in substance abuse treatment and rehabilitation.

(A) Available services shall include family therapy and individual and group codependency counseling. Groups may include both family members and primary clients when indicated by the goals, content and methods of the group.

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

(C) The program shall not be required to establish a client record for a family member, if group education is the only service provided to the family member and if this service is funded by the department or provided through a service network authorized by the department. However, the program shall be required to maintain documentation of group education services and the participating family members.

(4) Services to Women. A program that lacks certification as a specialized program for women and children must meet the following requirements in order to provide services to women:

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

(B) Have staff with experience and training in the treatment of women.

(5) Services to Adolescents. A program that lacks certification as a specialized program for adolescents must meet the following requirements in order to provide services to adolescents—

(A) Offer groups specifically for adolescents;

(B) Have staff with experience and training in the treatment of adolescents;

(C) Maintain an affiliation agreement and demonstrate an effective working relationship with a certified adolescent program; and

(D) Obtain clinical utilization review authorization that the adolescent may participate in services. Services are limited to the supported recovery level, unless otherwise

authorized by clinical utilization review.

(6) Assessment. Each person with a substance abuse problem shall have an assessment by a qualified substance abuse professional in order to ensure an appropriate level of care and an individualized plan.

(A) The assessment shall be completed within seventy-two (72) hours for residential clients or the first three (3) outpatient visits.

1. The seventy-two (72)-hour period for residential clients does not include weekends and holidays observed by the state of Missouri.

2. The initial treatment plan for the individual must also be completed within this designated time period.

(B) If there is a history of prior services in a substance abuse treatment program or a psychiatric facility, a request for prior treatment records shall be made upon written consent of the client or legal guardian to access the department's client tracking registration admissions and commitments system.

(7) Diagnosis. Eligibility for services shall include a diagnosis of substance abuse or dependency including all five (5) axis as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

(A) A face-to-face diagnostic interview shall be conducted as part of the assessment by a licensed physician, licensed psychologist, licensed clinical social worker, or licensed professional counselor.

(B) A diagnostician must also have at least one (1) year experience in treating persons with substance disorders.

(8) Transportation and Supports. Transportation shall be provided or arranged by the program to promote participation in treatment and rehabilitation services and to access other resources and supports in the community. Supports that are funded by the department (such as housing or child care) shall meet contractual and other applicable regulatory requirements.

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

(A) Each person shall actively participate in the program schedule, with individualized scheduling and services based on the person's treatment goals, level of care, and physical, mental, and emotional status.

(B) Group sessions shall address therapeutic issues relevant to the needs of persons served. Some of these scheduled group sessions may not be applicable to or appropriate for all persons and should be attended by each individual on a designated or selective basis. Examples of designated or selective groups may include parenting, budgeting, anger management, domestic violence, co-occurring disorders, relapse intervention track, etc.

(10) Therapeutic Setting. Services shall be provided in a therapeutic, alcohol and drug-free setting.

(A) Productive, meaningful, age-appropriate alternatives to substance use shall be encouraged for each individual.

(B) Any incident of client use of alcohol or drugs shall be documented in the client's record.

(C) An incident of possession or use of alcohol or drugs may result in termination from the program, particularly in residential settings.

(D) Repeated incidents of possession or use shall result in termination from the program.

(E) The program shall not allow gambling or wagering on its premises or as part of its activities.

(11) Drug Testing. The program should conduct tests to determine and detect a client's use of alcohol and drugs. The program shall identify its goals, policies and procedures regarding drug testing.

(A) The program shall implement written policies and procedures regarding the collection and handling of specimens. 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.

(B) A laboratory which analyzes specimens shall meet all applicable state and federal laws and regulations.

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

(D) Test results shall be addressed with persons served once the results are available, in order to intervene with substance use behavior. Test results and actions taken shall be documented in the client's record.

(12) A qualified diagnostician as defined under section (7) of this rule shall approve the treatment plan.

(13) Reviewing Treatment Goals and Outcomes. The individual treatment plan shall be reviewed on a periodic basis and shall accurately reflect the person's needs and goals. Persons who receive services funded by the department or through a service network authorized by the department shall participate in continuing reviews of their progress and outcomes and updates of their plans within the following time frames:

(A) Ten (10) days for residential treatment and community-based primary treatment;

(B) Thirty (30) days for intensive outpatient rehabilitation;

(C) Ninety (90) days for other levels of care.

(14) Clinical Utilization Review. Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;

2. Service authorization beyond any specified maximum amount or cost;

3. Admission of adolescents into adult programs; and

4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by the division.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by the division regarding the utilization of particular services and total service costs; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff. Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

(16) Procedures for Clinical Utilization

Review. Procedures shall be made available to all affected programs and services.

(A) Reviews shall be completed in a timely manner not to exceed three (3) working days from the time a request is received.

(B) To the extent feasible, a review request from a provider shall be made prior to the delivery of services.

1. No request made more than ninety (90) days after service provision shall be accepted or authorized by the department.

2. The provider is fully responsible for sending all pertinent information and documentation related to a clinical utilization review request.

(C) It is the responsibility of the provider to request a review regarding the appropriateness of admission and treatment services, if a provider considers a client to meet some but not all admission criteria or if any reasonable question may exist or be raised about client eligibility for services.

(D) The department may require or initiate clinical utilization review of any situation related to client eligibility.

(E) Service authorization for a client may be continued, increased, reduced, or discontinued in accordance with a clinical utilization review decision.

(F) When a review determines that services have been inappropriate, unnecessary, or delivered to a client who does not meet eligibility and admission criteria, all service authorization for the client may be discontinued and any other necessary action may be taken.

(G) The department shall establish procedures for the review and appeal of an adverse clinical utilization review action. The provider may deliver services to the client during a review or appeal period, with the understanding that such services may not be authorized or funded. A provider or client may—

1. Request further review of an adverse action. The request must be in writing, identify the clinical factors warranting further review, and be received or postmarked within fifteen (15) days of the initial clinical utilization review action; and

2. Appeal any clinical utilization review decision to discontinue all service authorization for the client.

A. The appeal must be in writing, identify the reason for the appeal, and be received or postmarked within thirty (30) days of receiving notice that service authorization has been discontinued.

B. The department shall designate an Appeal Panel to make a final determination in the matter. The panel shall include one (1) or more representatives who are not staff members of the department and shall include at least one (1) member who is a substance abuse treatment provider.

C. Unless otherwise determined by the panel, its final decision shall be based on information available at the time of the initial clinical utilization review action.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. ***

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

***Pursuant to Executive Orders 20-04, 20-10, and 20-12, 9 CSR 30-3.100, paragraph (6)(A)2. was suspended from April 23, 2020 through December 30, 2020.*

9 CSR 30-3.110 Service Definitions and Staff Qualifications

PURPOSE: This rule defines and describes services provided at treatment and rehabilitation programs certified under 9 CSR 30-3.

(1) Other Requirements. Services shall be provided in accordance with applicable program rules. Limitations on group size that are specified in this rule shall apply to those services funded by the department or provided through a service network authorized by the department.

(2) Available Services. Individual counseling, group education and counseling, community support, and family therapy shall be available to each person participating in substance abuse treatment and rehabilitation in accordance with the individual's clinical needs. Day treatment shall be provided if indicated by the person's level of care.

(3) Services to Family Members. Services shall be available to family members of those persons participating in substance abuse treatment and rehabilitation funded by the department or provided through a service network authorized by the department.

(A) Available services shall include family therapy and individual and group codependency counseling.

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

(4) Services shall be designed and organized to promote peer support and to orient clients and family members to self-help groups.

(5) Individual Counseling. Individual counseling is a structured, goal-oriented therapeutic process in which an individual interacts on a face-to-face basis with a counselor in accordance with the individual's rehabilitation plan in order to resolve problems related to substance abuse which interfere with the person's functioning.

(A) Key service functions of individual counseling may include, but are not limited to:

1. Exploration of an identified problem and its impact on functioning;

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

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

4. Decision making; and

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

(B) Individual counseling shall only be performed by a qualified substance abuse professional, an associate counselor, or an intern/practicum student as described in 9 CSR 10-7.110(5).

(6) Family Therapy. Family therapy is a planned, face-to-face, goal-oriented therapeutic interaction with a qualified staff member in accordance with an individual rehabilitation plan. The purpose of family therapy is to address and resolve problems in family interaction related to the substance abuse problem and recovery.

(A) One (1) or more family members must be present at all family therapy sessions. In any calendar month, for fifty percent (50%) of a client's family therapy, the primary client must be present, in addition to one (1) or more members of the client's family.

1. Family members below the age of twelve (12) may be counted as one (1) of the required family members when the child can be shown to have the requisite social and verbal skills to participate in and benefit from the service.

2. Documentation of family therapy shall identify the family member(s) present and their relationship to the client.

(B) Key service functions of family therapy may include, but are not limited to:

1. Utilization of generally accepted principles of family therapy to influence family interaction patterns;

2. Examination of family interaction styles and identifying patterns of dysfunctional behavior;

3. Development of a need or motivation for change in family members;

4. Development and application of skills and strategies for improvement in family functioning; and

5. Generalization and stabilization of change to promote healthy family interaction

independent of formal helping systems.

(C) Family therapy may be provided in either the office or home setting. Family therapy shall not include driving time to and from the home setting.

(D) Family therapy shall be performed by a person who—

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

2. Is certified by the American Association of Marriage and Family Therapists; or

3. Has a doctoral degree or master's degree in psychology, social work or counseling and has at least one (1) year of supervised experience in family counseling and has specialized training in family counseling; or

4. Has a doctoral degree or master's degree in psychology, social work or counseling and receives close supervision from an individual who meets the requirements of paragraph 1., 2., or 3. of subsection (5)(D); or

5. Is a degreed, qualified substance abuse professional who receives close supervision from an individual who meets the requirements of paragraph 1., 2., or 3. of subsection (5)(D).

(7) Codependency Counseling. Codependency counseling is a planned, face-to-face, goal-oriented therapeutic interaction with an individual or a group to address dysfunctional behaviors and life patterns associated with being a member of a family in which an individual has a substance abuse problem and is currently participating in treatment for substance abuse.

(A) Codependency counseling—

1. Shall be provided only to a person who is a member of a client's family; and

2. May be provided on an individual or a group basis.

(B) Key service functions may include, but are not limited to:

1. Exploration of the substance abuse problem and its impact on family functioning;

2. Development of coping skills and self-responsibility for changing dysfunctional patterns of relationships;

3. Examination of attitudes and feelings and long-term consequences of living with a person with a substance abuse problem;

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

5. Productive and functional decision-making; and

6. Generalization of newly learned information and behavior to other life situations in order to promote improved family or personal functioning.

(C) The usual and customary size of group codependency counseling sessions shall not exceed twelve (12) family members in order to promote participation, disclosure and feedback.

1. In no event shall the size of a group codependency counseling session that includes only family members exceed an average of twelve (12) persons per calendar month.

2. The program may structure some sessions to include both family members and primary clients up to a maximum of twenty (20) persons.

3. Primary clients participating in such sessions shall be considered, for funding purposes, to have received either day treatment or group counseling, depending on the client's level of care.

(D) Individual and group codependency counseling shall be provided by a person who meets requirements as a—

1. Family therapist; or

2. Qualified substance abuse professional with training in family recovery.

(8) Codependency counseling with children services shall be delivered in an age-appropriate manner. Group codependency services shall be provided in groups with similar ages and developmental issues.

(A) Assessments, individual counseling and group counseling services provided to children under age twelve (12) shall be provided by—

1. A social worker, counselor, psychologist or physician licensed in Missouri who has at least one (1) year of full-time experience in the assessment and treatment of children; or

2. A graduate of an accredited college or university with a master's degree in social work, psychology, counseling, psychiatric nursing or closely related field, who has at least two (2) years of full-time equivalent experience in the treatment and assessment of children.

(B) Group codependency services of an educational nature 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) Codependency counseling for family members below the age of five (5) may only be given when the child can be shown to have the requisite social and verbal skills to participate in and benefit from the service.

(9) Group Counseling. Group counseling is face-to-face, goal-oriented therapeutic interaction among a counselor and two (2) or more clients as specified in individual rehabilitation plans designed to promote clients' functioning and recovery through personal disclosure and interpersonal interaction among group members.

(A) Key service functions of group counseling may include, but are not limited to:

1. Facilitating individual disclosure of issues which permits generalization of the issue to the larger group;

2. Promoting positive help-seeking and supportive behaviors;

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

4. Developing motivation and action by group members through peer pressure, structured confrontation and constructive feedback.

(B) The usual and customary size of group counseling sessions shall not exceed twelve (12) clients in order to promote client participation, disclosure and feedback. In no event shall the size of group counseling sessions exceed an average of twelve (12) clients per calendar month.

(C) Group counseling services shall be provided by a qualified substance abuse professional, an associate counselor, or an intern/practicum student as described in 9 CSR 10-7.110(5).

(10) Group Education. Group education consists of the presentation of general information and application of the information to participants through group discussion in accordance with individualized rehabilitation plans which is designed to promote recovery and enhance social functioning.

(A) Key service functions of group education may include, but are not limited to:

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

2. Presentation of audiovisual materials which are educational in nature with required follow-up discussion;

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

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

(B) The usual and customary size of group educational sessions shall not exceed thirty (30) clients in order to promote client participation. In no event shall the size of group education sessions exceed an average of thirty (30) clients per calendar month.

(C) Group education services shall be provided by an individual who—

1. Is suited by education, background or experience to teach the information being presented;

2. Demonstrates competency and skill in educational techniques;

3. Has knowledge of the topic(s) being taught; and

4. Is present with clients throughout the group education session.

(D) In addition, staff who provide information about human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) shall have completed a department approved or comparable training program.

(11) Community Support. Community support consists of specific activities with or on behalf of a particular client in accordance with an individual rehabilitation plan to maximize the client's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting client independence and responsibility.

(A) Key service functions of community support include:

1. Participating in the interdisciplinary team meeting in order to identify strengths and needs related to development of the individual's rehabilitation plan;

2. Attending periodic meetings with designated team members and the client, whenever feasible, in order to review and update the rehabilitation plan;

3. Contacting clients who have unexcused absence from the program in order to re-engage the person and promote recovery efforts;

4. Arranging and referring for services and resources and, when necessary, advocating to obtain the services and quality of services to which the person is entitled;

5. Monitoring service delivery by providers external to the program and ensuring communication and coordination of services;

6. Locating and coordinating services and resources to resolve a crisis;

7. Providing experiential training in life skills and resource acquisition;

8. Providing information and education to an individual in accordance with the person's rehabilitation plan; and

9. Planning for discharge.

(B) The following activities shall not be considered a community support unit of service:

1. Reviewing a client's record to ensure that documentation is complete or to conduct quality assurance or other program evaluation;

2. Preparing documentation for the department's management information system or for the client's record, such as progress notes, assessment reports, rehabilitation plans and updates, and initial service plans;

3. Preparing and making clinical utilization review requests;

4. Administering client medications or observing client's self-administer medications;

5. Collecting and processing urine or other specimens for purposes of drug testing;

6. Transporting clients to and from the program;

7. Transporting clients to appointments or other locations in the community, unless the presence of the community support worker is required to resolve an immediate crisis or to address a clearly documented need which the client has previously demonstrated an inability to resolve on his/her own;

8. Routinely visiting the client in the home, unless such visit(s) is clearly and directly related to the rehabilitation plan goals;

9. Meetings with other program staff, except scheduled meetings to develop the initial treatment plan and scheduled treatment plan reviews; and

10. Discussions with the client regarding treatment issues that would be more appropriately addressed by individual counseling, group counseling or education, or other available services.

(C) A client must be reasonably involved in other treatment and rehabilitation services in order to be eligible for community support on an ongoing basis.

(D) The program's staffing pattern and arrangements to provide community support services shall be responsive to the needs, goals and outcomes expected for clients.

(E) Community support services shall be provided by a person who has a bachelor's degree from an accredited college or university in social work, psychology, nursing or a closely related field, or an intern/practicum student as described in 9 CSR 10-7.110(5). Equivalent experience may be substituted on the basis of one (1) year for each year of required educational training.

(12) Day Treatment. Day treatment consists of a comprehensive package of services and therapeutic structured activities provided consistent with an individual rehabilitation plan which are designed to achieve and promote recovery from substance abuse and improve functioning.

(A) Key service functions of day treatment include, but are not limited to, the following:

1. Activities to address the person's immediate need to abstain from substance use;

2. Activities and structure which provide a meaningful, constructive alternative to substance abuse;

3. Activities which promote individual responsibility for recovery;

4. Activities that enhance life skills;

5. Activities that address functional skills;

6. Activities that enhance the use of personal support systems; and

7. Activities which promote development of interests and hobbies to constructively use leisure time.

(B) Required service components which will be used to achieve key service functions of day treatment include:

1. Individual counseling;

2. Group counseling;

3. Group education; and

4. Supervision of clients in structured programming to promote and reinforce a substance-free lifestyle including, but not limited to, organized recreational activities, skill building, structured self-study sessions, promotion of self-help and peer support activities.

(C) The ratio of clients to staff for day treatment shall not exceed the maximum established elsewhere in this rule for group counseling and education.

(13) Ratio of Qualified Substance Abuse Professionals. A majority of the program's staff who provide individual and group counseling shall be qualified substance abuse professionals.

(14) Supervision of Associate Counselors. If an associate counselor provides individual or group counseling, the person shall be registered with and recognized by the Missouri Substance Abuse Counselor's Certification Board, Inc. or by an appropriate board of professional registration within the Department of Economic Development. All counselor functions performed by an associate counselor shall be performed pursuant to the supervisor's control, oversight, guidance and full professional responsibility.

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

(B) Documentation which must be countersigned includes assessments, treatment plans and updates, and discharge summaries.

(15) Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a qualified substance abuse professional who has—

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

(B) Four (4) or more years employment

experience in the treatment and rehabilitation of persons with substance abuse problems.

(16) Credentials for Supervisor of Community Support Workers. A community support worker shall be supervised by an individual with—

(A) A master's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least one (1) year of full-time equivalent experience in providing community support services; or

(B) A bachelor's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least two (2) years of full-time equivalent experience in providing community support services; and

(C) Demonstrated competencies in the areas of supervision and substance abuse treatment and rehabilitation by virtue of experience and/or training.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed Sept. 25, 2002, effective May 30, 2003.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 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 Program

PURPOSE: This rule describes the specific functions, policies and practices required for a methadone treatment program.

(1) Eligibility for Certification and Service Delivery. Prior to delivering opioid treatment services, an agency must apply for and receive provisional certification from the department.

(A) The agency must document the need for new services and must demonstrate community acceptance of the proposed site(s).

1. Determination of the need for new services shall be at the department's sole discretion as the designated state authority responsible for opioid treatment. The determination of need shall be based on applicable data, such as waiting lists, emergency room visits, arrest data, and federal drug use forecasting data.

2. A new site cannot be located within fifty (50) miles of an existing opioid treatment site, unless otherwise indicated by a determination of need.

3. Community acceptance must be solicited within a one (1)-mile radius of any proposed new site. Assurance must be provided to the department of community acceptance, as well as letters of support from local authorities.

(B) An agency applying for provisional certification as an opioid treatment program in the state of Missouri must have provided other certified alcohol and drug services within the state for two (2) years prior to the application. Agencies responding to a department-funded request for proposal will be exempt from this requirement.

(C) In order to be certified as an opioid treatment program, the program shall comply with applicable local, state and federal laws and regulations including those under the

jurisdiction of the Food and Drug Administration and the Drug Enforcement Administration.

(2) Treatment Goals and Performance Outcomes. Opioid treatment services shall be organized to achieve key goals and performance outcomes.

(A) Key goals shall include—

1. Developing positive and stable functioning in the community with reduced criminal activity and improved employment status;

2. Reducing or eliminating the use of illicit drugs;

3. Stabilizing emotional and behavioral functioning;

4. Improving social and family relationships; and

5. Improving health status and reducing the spread of infectious disease.

(B) Performance outcomes related to these goals shall be measured in a consistent manner. Measures shall include, but are not limited to—

1. Increasing employment and productive activities. Clients should be involved in employment or other productive activities. For those persons who have been in opioid treatment for six (6) months or longer, seventy percent (70%) shall be working, attending job training or school, be a homemaker, or have a medically documented disability; and

2. Reducing or eliminating the use of illicit drugs. Random drug screening shall be used to measure the program's effectiveness in helping clients' progress toward this goal.

A. The following aggregate results shall be expected from random drug screening conducted each month—

(I) For all clients tested, seventy percent (70%) shall be free of all drugs; and

(II) For those clients tested who have been in opioid treatment for one (1) consecutive year or longer, eighty percent (80%) shall be free of opiates.

B. In calculating these performance outcomes, the following categories of clients may be exempted—

(I) Persons admitted to the program within the past ninety (90) days;

(II) Persons undergoing administrative withdrawal due to program infraction(s) or other circumstance; and

(III) Persons undergoing withdrawal against medical advice.

(C) If a program does not meet a performance outcome listed in subsection (2)(B) of this rule for three (3) consecutive months, it shall be considered a significant deficiency related to quality of care. The department shall—

1. Place the program on administrative review, require submission of a written plan of correction, and monitor performance for at least ninety (90) days; or

2. Issue conditional certification under the provisions of 9 CSR 10-7.130.

(3) Medical Director. The program shall have a medical director who is a physician licensed in Missouri. Responsibilities of the medical director include, but are not limited to:

(A) Ensuring that clients meet admission criteria and receive the required physical examination and laboratory testing;

(B) Prescribing methadone with client input; and

(C) Reviewing and signing the client's initial treatment plan and the comprehensive treatment plan on an annual basis.

(4) Services. The program shall provide a range of treatment and rehabilitation services to address the therapeutic needs of persons served.

(A) Services shall include:

1. Individual counseling, group education, and counseling, family therapy, community support;

2. Medical evaluations;

3. Use of methadone for medically supervised withdrawal from narcotics and for ongoing opioid treatment.

A. Medically supervised withdrawal means the dispensing of methadone in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incidental to withdrawal from the continuous or sustained use of narcotics and in order to bring the individual to a drug-free state within a one hundred eighty (180)-day time period.

B. Ongoing opioid treatment means the dispensing of methadone for more than one hundred eighty (180) days in the treatment of an individual for dependence on heroin or other morphine-like drug; and

4. Medical director shall insure that dosage is appropriate to the patient's need.

(B) While eventual withdrawal from the use of all drugs, including methadone, may be an appropriate treatment goal, some clients may remain in opioid treatment for relatively long periods of time.

1. Periodic consideration shall be given to withdrawing from continued opioid treatment, when appropriate to the individual's progress and goals.

2. Such consideration and decisions shall be determined by the client and the program staff as part of an individualized treatment planning process.

(C) The program shall offer services at least six (6) days per week. Services shall be available during early morning or evening so that clients who are employed or otherwise involved in productive, daily activities can access services.

(D) Programs in the same geographical area shall work together to maximize hours of operation and treatment accessibility.

(5) Admission Criteria. The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of the Division of Alcohol and Drug Abuse; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge

or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

(6) Admission and Assessment Protocol. The opioid treatment program shall—

(A) Verify the applicant is not currently enrolled in another methadone program;

(B) Obtain the applicant's signature on a consent to treatment, ensuring that the client understands the risks and benefits of opioid treatment and the possibility of administrative detoxification for infractions of program rules;

(C) Conduct a complete medical history and physical examination to determine symptoms of withdrawal and the possibility of infectious disease; and

(D) Obtain laboratory testing to determine—

1. Blood count and differential and chemical profile;

2. Serological test for sexually transmitted disease;

3. Routine and microscope urinalysis;

4. Pregnancy test;

5. Toxicology screening for drugs;

6. Intradermal Purified Protein Derivative (PPD) test, administered and interpreted by medical staff; and

7. A chest X-ray, pap smear, or screening for sickle cell disease if the examining medical personnel request these tests.

(E) A complete medical history, physical examination, and laboratory testing shall not be required for a client 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.

(7) Continued Placement and Utilization Criteria. The program shall utilize a structured approach in providing treatment and rehabilitation services and shall use established criteria for determining client progress. Client progress and movement between the structured phases of treatment shall be based on the following criteria:

(A) Absence of the use of alcohol and other drugs, except as medically prescribed;

(B) Social, vocational, legal, family, emotional and behavioral functioning;

(C) Program attendance as scheduled; and

(D) Other individual goals and accomplishments related to the client's treatment plan.

(8) Phases of Treatment. The program shall utilize six (6) structured phases of treatment and rehabilitation to indicate client progress and to establish requirements regarding client attendance and service participation. The requirements listed below for each phase are minimum requirements and the frequency and extent of treatment and rehabilitation services shall be adjusted, based on individual client needs.

(A) Phase I consists of a minimum ninety (90)-day period in which the client attends the program for observation of opioid treatment daily or at least six (6) days a week. Take-home dosage is limited to a single dose each week.

1. During the initial ninety (90) days, the client shall participate in at least four (4) hours of counseling per month with at least two (2) of the hours being individual counseling.

2. During the initial ninety (90) days, the treatment plan shall be reviewed and updated on at least a monthly basis.

3. Prior to client moving to Phase II or receiving take-home medication, the client shall demonstrate a level of stability as evidenced by absence of alcohol and other drug abuse, regularity of program attendance, absence of significant behavior problems, absence of recent criminal activities, and employment, actively seeking employment or attending school if not retired, disabled, functioning as a homemaker, or otherwise economically stable.

(B) Phase II is designated for clients who have been admitted more than ninety (90) days, but less than two hundred seventy (270) days and who have successfully met Phase I criteria.

1. During the first ninety (90) days of Phase II, the program may issue no more than two (2) take-home doses of methadone at a time.

2. The client shall participate in at least two (2) hours of counseling per month during the first three (3) months of Phase II, with at least one (1) of the hours being individual counseling.

3. During the second ninety (90) days of Phase II, the client shall participate in at least one (1) hour of individual counseling per month, and the program may issue no more than three (3) take-home doses of methadone plus closed and holiday days.

4. The treatment plan shall be reviewed and updated at least every three (3) months during Phase II.

(C) Phase III is designated for clients who have been admitted more than nine (9) months but less than one (1) year and who have successfully met progressive Phase II criteria.

1. During Phase III, the program may issue no more than six (6) take-home doses of methadone plus closed and holiday days.

2. The client shall participate in at least one (1) hour of individual counseling per month during Phase III.

3. The treatment plan shall be reviewed and updated at least every six (6) months during Phase III, or more frequently if circumstances warrant.

(D) Phase IV is designated for clients who have been admitted more than one (1) year but less than two (2) years and who have successfully met progressive Phase III criteria.

1. During Phase IV, the program may issue two (2) week take-home doses plus closed and holiday days.

2. The client shall participate in at least one (1) hour of individual counseling per month during this phase.

3. The treatment plan shall be reviewed and updated at least every six (6) months during this phase.

(E) Phase V is designated for clients who have been admitted for more than two (2) years.

1. During Phase V, the program may issue one (1) month maximum take-home doses.

2. The client shall participate in at least one (1) hour of individual counseling per month during this phase.

3. The treatment plan shall be reviewed and updated at least every six (6) months during this phase.

(F) Phase VI is designated for clients who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A client may enter this phase at any time in the treatment

and rehabilitation process.

1. During Phase VI, the medical director determines take-home doses based on stability.

2. During Phase VI, the counselor determines the frequency of counseling sessions with input from the client. At the onset of Phase V, the client may require an increased level of counseling and other support services.

3. The counselor and patient develop an after care plan prior to the successful completion of treatment.

(9) Program Rules. In order to remain in the program and to successfully progress through the phases of treatment and rehabilitation, a client shall demonstrate progress and shall comply with program rules.

(A) An infraction of program rules by a client may result in administrative medical withdrawal from methadone and termination from the program.

(B) For the purpose of these standards, an infraction means threats of violence or actual bodily harm to staff or another client, disruptive behavior, community incidents (loitering, diversion of methadone, sale or purchase of drugs), continued unexcused absences from counseling and other support services, involvement in criminal activities and other serious rule violations.

(C) A client who either relapses or ceases to meet the progressive phase criteria for which they have been granted may, at the discretion of the medical director, be moved to a phase that the medical director determines is necessary to reestablish stability.

(D) Administrative medical withdrawal shall be scheduled in such a way as to minimize the psychological and physical effects of such withdrawal. Administrative medical withdrawal shall be completed in a manner appropriate to the client's level of medication and the circumstances justifying such action. Programs may facilitate a transfer to another program or referral to a medical facility in lieu of administrative medical withdrawal.

(10) Safety and Health. The program shall establish and implement policies, procedures, and practices which ensure access to its services and which address the safety and health of its clients. The provider shall—

(A) Ensure continued opioid treatment in the event of emergency or natural disaster;

(B) Ensure treatment to persons regardless of sero status, HIV-related conditions, acquired immunodeficiency syndrome (AIDS), or tuberculosis (TB);

(C) Provide information and education to clients regarding HIV and AIDS;

(D) Provide or arrange HIV testing and pre-test and post-test counseling for clients;

(E) Provide or arrange testing for tuberculosis and sexually transmitted diseases upon admission and at least annually thereafter;

(F) Provide medical evaluations to clients upon admission and at least annually thereafter;

(G) Utilize infection control procedures consistent with Occupational Safety and Health Administration guidelines;

(H) Arrange for medical care to clients during pregnancy, when necessary, and document the arrangements made and the client's compliance.

(11) Staff Training. All direct service and medical staff shall receive training relevant to service delivery in an opioid treatment setting. Each staff member shall participate in fourteen (14) clock hours of such training during a two (2)-year period.

(12) Drug Testing. The program shall use drug testing as a performance measure and as a clinical tool for the purpose of diagnosis and treatment planning.

(A) Each sample shall be analyzed for opiates, methadone, marijuana, cocaine, barbiturates, and benzodiazepines. Testing shall include other drugs as may be indicated by a client's use patterns. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must include any such drugs.

(B) Drug testing shall be done upon admission, and random drug testing of each client shall be conducted at least eight (8) times during a twelve (12)-month period.

(C) Following admission, the results of a single drug test shall not be the sole basis to determine significant treatment decisions.

(D) A program with thirty percent (30%) or more of its client population having positive drug test results shall be placed on administrative review and the agency shall develop an action plan to bring its program into compliance with this performance expectation.

(13) Take-Home Doses. The program shall implement practices in accordance with the principle that take-home doses of methadone is a privilege given only to those individuals who will benefit from it and who have demonstrated responsibility in taking methadone as prescribed.

(A) The requirement of time in treatment as outlined elsewhere in this rule is a minimum reference point after which a client may be considered for take-home medication privileges. The time reference does not mean that a client in treatment for a particular time has a specific right to take-home medication.

(B) Programs must educate the client regarding safe transportation and storage of methadone as well as emergency procedures in case of accidental ingestion.

(C) Before take-home privileges are allowed, the client must have a lock box for transportation of methadone and home storage.

(D) The program shall have policies that address the responsibilities of patients granted take-home medications. The policies shall include methods of assuring client's appropriate use and storage of medication.

(E) The program shall have policies in place addressing the return of take-home bottles. Policies shall include bottles returned with labels intact and consequences of unreturned bottles.

(F) Regardless of time in treatment, the medical director, in his/her reasonable judgment, may deny or rescind the take-home medication privileges of a client.

(14) Methadone Storage and Security. The program shall ensure the security of its methadone supply and shall account for all methadone.

(A) The program shall meet the requirements of the Drug Enforcement Administration.

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

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

(D) The program shall implement written policies and procedures to ensure positive identification of the client before methadone is administered.

(E) The program shall implement written policies and procedures regarding the recording of client medication intake and a daily methadone inventory.

(15) Emergency Medication. The medical director may, based on his/her reasonable judgment, grant emergency take-home doses of methadone based on emergency circumstances related to medical, criminal justice, family or employment. The circumstances and basis for the action must be documented in the client record and should address the concerns outlined in section (13). Take-home doses for in-state emergencies is limited to a maximum of three (3) doses and out-of-state is limited to a maximum of five (5) doses. Additional take-home doses must be authorized through the exception request process.

(16) Vacation Medication. The program medical director may, based on his/her reasonable judgment grant vacation take-home doses of methadone for up to two (2) weeks per calendar year. The circumstances and basis for the action must be documented in the client record and should address the concerns outlined in section (13). Additional take-home medication must be authorized through the exception request process.

AUTHORITY: sections 630.655 and 631.102, RSMo 2000. 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.*

**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 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) 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 education 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.*

**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 special requirements for service delivery as Comprehensive Substance Treatment and Rehabilitation (CSTAR).

(1) Levels of Care. A CSTAR program shall provide the following levels of care on a nonresidential basis in accordance with requirements for outpatient programs:

(A) Primary treatment;

(B) Intensive outpatient treatment; and
(C) Supported recovery.

(2) Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements, when the department determines that 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 in order to qualify for Medicaid reimbursement of substance abuse 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 client meets rehabilitation plan goals and criteria for discharge; or

2. Transition the client to another provider such that there is continuity of clinically appropriate treatment services.

(4) Missed Appointments. If an individual fails to appear at a scheduled program activity, staff shall promptly initiate efforts to contact the person and maintain active program participation.

(A) Such efforts should be initiated within forty-eight (48) hours, unless circumstances indicate a more immediate contact should be made due to the person's symptoms and functioning or the nature of the scheduled service.

(B) Efforts to contact the person shall be documented in the individual's record.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 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 Specialized Program for Women and Children

PURPOSE: This rule establishes requirements relative to specialized substance abuse programs for women and children.

(1) Eligibility Criteria. The program shall provide treatment, rehabilitation, and other supports solely to women and their children. Services may be offered on a residential or outpatient basis, in accordance with admission and eligibility criteria for those programs and settings specified elsewhere in these rules.

(A) Priority shall be given to women who are pregnant, postpartum, or have children in their physical care and custody. Postpartum shall be defined as up to six (6) months after delivery.

1. The program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria.

2. 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.

(B) Programs designated for women and children will ensure that treatment occurs in the context of a family systems model. Each program will provide therapeutic activities designed for the benefit of children. Thus, it is important that children should accompany their mother, unless contraindicated by medical, educational, family, legal or other reasons which are documented in the client's record.

(2) Therapeutic Issues Relevant to Women. The program shall address therapeutic issues relevant to women and shall address their specific needs.

(A) Therapeutic issues relevant to women shall include, but are not limited to, parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality.

(B) Residential treatment and community-based primary treatment shall include planned, supervised activities to promote parent-child bonding.

(3) Supervision of Children. Children shall be supervised at all times.

(A) The parent/guardian should be responsible for providing supervision when the child is not attending day care or participating in other scheduled program activities.

(B) Program staff shall assist the parent in providing age-appropriate activities, training and guidance.

(4) Availability of Day Care and Staffing Patterns. The program shall ensure that child care/day care is available for children while the mother participates in treatment and rehabilitation services.

(A) The program shall obtain licensure as a day care center, unless an exception is granted by the department.

(B) If an exception is granted, the program shall nevertheless meet any licensure requirements that the department determines to be appropriate or applicable to the program. The program shall—

1. Employ a full-time staff person to assume responsibility for day care services. The person shall be qualified by having a minimum of a bachelor's degree in early childhood education or closely related field;

2. Maintain a staff-to-child ratio at the following age-related levels:

A. Birth through two (2) years. Groups composed of mixed ages through two (2) years shall have no less than one (1) adult to four (4) children, with no more than eight (8) children in a group;

B. Age two (2) years. Groups composed solely of two (2)-year-olds shall have no less than one (1) adult to eight (8) children, with no more than sixteen (16) children in a group;

C. Ages three through four (3–4) years. Groups composed solely of three (3)- and four (4)-year-olds shall have no less than one (1) adult to ten (10) children;

D. Ages five (5) and up. Groups composed solely of five (5)-year-olds and older shall have no less than one (1) adult to every sixteen (16) children; and

E. Mixed age groups two (2) years and up. Groups composed of mixed ages of children two (2) years of age and older shall have no less than one (1) adult to ten (10) children with a maximum of four (4) two (2)-year-olds. When there are more than four (4) two (2)-year-olds in a mixed group, there shall be no less than one (1) adult to eight (8) children;

3. If a center has an attendance of more than fifty (50) children, the center director or individual in charge shall not be included in staff/child ratios except during naptime or on an emergency substitute basis;

4. If a center has an attendance of more than thirty (30) children at lunch or dinner time, staff shall be provided for meal preparation, serving and cleanup. The staff shall not be included in staff/child ratios during this time; and

5. Individuals employed for clerical, housekeeping, cleaning and maintenance shall not be included in staff/child ratios while performing those duties.

(C) Day care shall not be funded by the division for children who are thirteen (13) or older, unless there has been specific authorization based on clinical utilization review.

(5) Therapeutic Issues Relevant to Children. The program shall address therapeutic issues relevant to children and shall address their specific needs. Age-appropriate activities, training and guidance shall be offered to meet the following goals:

(A) To build self-esteem;

(B) To learn to identify and express feelings;

(C) To build positive family relationships;

(D) To develop decision-making skills;

(E) To understand chemical dependency and its effects on the family;

(F) To learn and practice nonviolent ways to resolve conflict;

(G) To learn safety practices such as sexual abuse prevention; and

(H) To address developmental needs.

(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) Documenting Services to Children. The program shall document any services provided to children, including day care and community support.

(A) The record shall document the child's developmental, physical, emotional, social, educational, and family background and current status.

(B) To determine the need for a child to receive services beyond day care and community support, a trained staff member shall complete an initial screening instrument approved by the department. The screening shall include an interview with at least one (1) parent and the child, whenever appropriate.

(C) If indicated by the screening, a qualified staff member will complete an assessment instrument approved by the department. The assessment will determine the appropriateness of therapeutic services and provide information to guide development of an individual plan. The assessment must be completed before a child receives any services beyond day care and community support.

(D) The child's individual plan and consent for treatment must be signed by the legal guardian.

(8) Staff Training. Service delivery staff and program administration shall demonstrate expertise in addressing the needs of women and children. All service delivery staff shall receive periodic training regarding therapeutic issues relevant to women and children.

(9) Safety and Health. The program shall maintain a safe, healthy environment which is responsive to the physical and medical needs of women and children.

(A) A registered nurse (one (1) full-time equivalent) shall be available within the program.

(B) At least one (1) staff member shall be on duty at all times who has current training in first aid and cardiopulmonary resuscitation for infants, children and adults.

(C) The program shall demonstrate effective working relationship(s) with a physician, hospital, and/or clinic to provide medical care for women, including pregnant and postpartum women, and their children.

(D) 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. Any symptoms of intoxication, impairment or withdrawal.

(E) The program shall ensure that recommendations by a physician or licensed health care provider are implemented regarding medical, physical and nutritional needs.

(F) If a specialized program for women and children provides detoxification services, it shall comply with applicable standards under 9 CSR 30-3.120 Detoxification. 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 facility.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. Original rule filed Feb. 28, 2001, effective Oct. 30, 2001.*

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

9 CSR 30-3.192 Specialized Program for Adolescents

PURPOSE: This rule establishes requirements relative to specialized substance abuse programs for adolescents.

(1) Age Criteria for Adolescents. The program shall provide treatment, rehabilitation, and other services solely to clients between the ages of twelve through seventeen (12–17) years inclusive and their families. Exceptions to these age requirements may be authorized through clinical utilization review for those individuals in which there is justification and documentation of behavior and experience appropriate for the services available.

(2) Other Eligibility Criteria. The level of care and treatment setting for adolescent services shall be based on problem severity ratings in the following domains:

(A) Substance Abuse Patterns/Withdrawal Risk. This includes factors such as recent use patterns (substances used, frequency, amount, method of administration), consequences of use, progression, tolerance, and withdrawal risk;

(B) Physical Health. This includes physical health conditions that require ongoing care and that may be a factor in treatment planning;

(C) Emotional/Behavioral Functioning. This includes factors such as suicidal ideation or plans, aggressiveness, severe conflict with others, recent running away from home; co-occurring psychiatric disorders, and need for continuous supervision;

(D) Acceptance/Resistance. This includes factors such as blaming others, willingness to acknowledge problems, and attempts to stop or cut back substance use;

(E) Abstinence Potential. This includes factors such as substance use in the past thirty (30) days, longest period of abstinence in the past six (6) months, impulsiveness, general ability to follow through with appointments and responsibilities;

(F) Recovery Environment. This includes factors such as non-using friends, involvement in non-using activities, school attendance and performance, geographic access to treatment services, and involvement of other persons or agencies to support recovery; and

(G) Family/Caregiver Functioning. This includes factors such as appropriateness of rules and consequences, availability of supervision, presence of others in the household with active substance abuse, emotional and psychiatric functioning of caregivers, ability and willingness to participate in the treatment and recovery process.

(3) 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 best treated in settings that are programmatically and physically separate from treatment services for adults;

(B) Services shall maintain youth in the family and community setting, whenever clinically feasible;

(C) Services shall support the family and engage the family in a recovery and change process, whenever appropriate. If the parent(s) are not an available and appropriate resource, program staff shall assist in developing alternate social and family support systems for the adolescent;

(D) Services to the family shall be directed to understanding and supporting the youth's recovery process, identifying and intervening with parental substance abuse problems, improving parenting skills and communication skills within the family, and assisting the family in improving its level of functioning;

(E) A cooperative team approach shall be utilized in order to provide a consistent environment and therapeutic milieu;

(F) Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that needs of youth in treatment are met and that services are coordinated. Coordination of service needs are critical with

youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas; and

(G) Service delivery shall address—

1. Recovery issues such as peer relationships, use of leisure time, and abuse and neglect;

2. Skill development such as decision-making and study skills; and

3. Information and education regarding adolescent developmental issues and sexuality.

(4) Living Arrangements. Adolescents may be served from a variety of living arrangements including, but not limited to, the following:

(A) Home of the parent/guardian;

(B) Foster home;

(C) Residential settings operated by the program;

(D) Juvenile detention;

(E) Other supervised living arrangements; or

(F) Independent living.

(5) 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 the family.

(A) This review shall be done by a family therapist.

(B) Refusal by the family for an in-home assessment shall not constitute automatic denial of treatment services for adolescents.

(C) The program shall actively involve family members in the treatment process, unless contraindicated for legal or clinical reasons which are documented in the client record.

(D) Staff shall orient the parent or legal guardian regarding—

1. Treatment philosophy and design;

2. Discipline and any behavioral management techniques 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 family participation.

(E) Staff shall seek family participation in treatment planning, service delivery and continuing recovery planning.

1. Services may include family participation in educational and counseling sessions.

2. Family participation in treatment planning shall be documented in the client record. In the event that the family does not participate, then staff shall document efforts to involve the family and reasons why the family did not participate.

(6) Educational and Vocational Opportunities. The program shall assist the adolescent and parent/guardian as necessary to ensure educational and/or vocational opportunities during treatment.

(7) Privilege System. Any system used by the program to modify behavior by requiring certain behaviors to earn privileges or restricting privileges (that is, step-down program) for failure to comply with requirements shall be defined in writing, stated in behavioral terms to the extent possible, and applied consistently to all clients.

(8) Safety and Health. The program shall maintain a safe, healthy environment which is responsive to the physical and medical needs of adolescents.

(A) Adolescents shall be prohibited from smoking on the premises, grounds and any off-site program functions.

(B) For adolescents receiving residential support, the program must provide or arrange for a history and physical examination performed by a physician licensed in Missouri or a nurse practitioner licensed and authorized to title and practice as an advanced practice nurse pursuant to 335.016, RSMo and who is engaged in a written collaborative practice arrangement as defined by law. Registered nurses may still conduct initial health screenings upon admission to a residential support setting, but this screening does not satisfy the requirement for a history and physical examination as defined above.

(C) The program shall demonstrate effective working relationship(s) with a physician, hospital, and/or clinic to provide medical care for adolescents.

(9) Staff Training and Supervision. Service delivery staff shall—

(A) Have training and demonstrate expertise regarding the treatment of both substance abuse and other disorders related to adolescents; and

(B) Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.

(10) Structured Activities Available to Adolescents Living in a Residential Setting. In addition to treatment services, adolescents living in a residential setting operated by the program shall have their awake time structured in activities, such as academic education, completing assignments, attendance at self-help groups, family visits and positive leisure.

(11) Staffing Patterns in a Residential Facility. The following minimum client to staff ratios shall be maintained at all times adolescents are present in a residential facility—

(A) At a facility with six (6) residents or less, one (1) staff member must be providing supervision of clients during program hours and also during designated client sleeping hours;

(B) At a facility with seven through twelve (7–12) residents, two (2) staff members must be providing supervision of clients during program hours and also during designated client sleeping hours;

(C) At a facility with thirteen through sixteen (13–16) residents, three (3) staff members must be providing supervision of clients during program hours, with a required ratio of two (2) staff during designated client sleeping hours; and

(D) At a foster home funded by the department, a foster parent must provide or arrange for appropriate supervision of the adolescent(s) at all times.

(12) If the adolescent residential support facility serves a coed population, the staffing pattern shall include at least one (1) female and at least one (1) male staff member any time residents are present. If residential support is provided for girls only, a female staff member must be present at all times. If residential support is provided for boys only, a male staff member must be present at all times.

AUTHORITY: sections 630.050, 630.655 and 631.010, RSMo 2000. 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.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 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 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) 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 2018 edition of the *SATOP Provider Manual*, Department of Mental Health, 1706 E. Elm Street, PO Box 687, Jefferson City, Missouri 65102 and incorporated herein by reference. The referenced manual does not include any later amendments or additions.

(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. 2020. 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.*

**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 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) 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 education 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 education sessions shall be facilitated by a SQP or SQI. Group education 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 education 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 and 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 education, 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 SATOP Comparable Program Completion Form and signed money order for the supplemental fee, made payable to Mental Health Earnings Fund, must be submitted to the Department of Mental Health, Controller's Office, PO Box 596, Jefferson City, MO 65102-0596.

1. The form and instructions are available at: www.dmh.mo.gov/ada/satop/completionform.pdf or by calling the department at (573) 522-4020.

(C) Following review of the comparable program, the department will provide notification of the individual's program completion to the 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. 2020. 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.*

**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; 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.053, RSMo 1993, amended 1995, 1996, 2015; 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 statewide 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.