



Rules of
Department of Mental Health
Division 30—Certification Standards
Chapter 4—Mental Health Programs

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**Title 9—DEPARTMENT OF
MENTAL HEALTH**
Division 30—Certification Standards
Chapter 4—Mental Health Programs

**9 CSR 30-4.005 Eligibility Criteria and
Admission Criteria for Community Psychi-
atric Rehabilitation Programs**

PURPOSE: This rule establishes criteria and procedures for admission of eligible individuals to a community psychiatric rehabilitation (CPR) program.

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

(1) The department designates the minimum geographic boundaries for CPR service areas throughout the state. Exceptions to the designated service areas may be granted by the department.

(A) The CPR program shall operate within its designated service area and provide services to eligible individuals to the extent adequate program capacity allows.

(B) Policies and procedures shall ensure eligible individuals have access to CPR services throughout the twelve (12) months of the year and to other services/resources beyond the scope of the program.

(C) Community support services shall be available to meet individual needs, which may include evenings and weekends.

(D) Community support and crisis intervention services shall be available to eligible individuals in their home and other locations apart from the CPR offices/facilities.

(E) Policies and procedures shall ensure eligible individuals are not required to visit a pre-selected site to receive needed services, other than medication, physician consultation, and psychosocial rehabilitation (PSR). Individuals shall have a choice in the location where they receive CPR services, to the extent program capacity and the treatment plan allows.

(2) The CPR program shall have written policies and procedures defining its service delivery process, including screening, eligibility determination, admission, assessment, treat-

ment and recovery planning, and discharge for individuals served.

(A) Policies and procedures shall ensure admission to services within ten (10) business days of the date of eligibility determination for individuals with serious mental illness or serious emotional disturbance.

(B) Individuals shall not be denied admission to a CPR program based on eligibility for Medicaid benefits or other sources of reimbursement for services.

(3) Policies and procedures shall ensure all CPR services are provided under the direction of a physician/physician extender and are medically necessary and reasonable for the treatment of the individual's mental illness or disorder.

(A) Emergency and crisis intervention services shall be provided prior to completion of the initial comprehensive assessment for individuals determined to need immediate assistance.

(B) A physician/physician extender must be available for emergency and crisis intervention services twenty-four (24) hours per day, seven (7) days per week.

(4) The CPR program shall implement written policies and procedures to ensure eligible individuals are admitted to treatment within ten (10) days of the date of eligibility determination.

(A) CPR services shall be prioritized for individuals who—

1. Have been discharged from inpatient psychiatric hospitalization programs within the last ninety (90) days;

2. Are residents of supervised or semi-independent apartments, psychiatric group homes, or community residential programs;

3. Have been committed by court order under provisions of section 632.385, RSMo;

4. Have been conditionally released under section 552.040, RSMo;

5. Are homeless or considered homeless in accordance with the following criteria:

A. Persons who are sleeping in places not meant for human habitation such as cars, parks, sidewalks, and abandoned buildings;

B. Persons who are sleeping in emergency shelters or doubled up (unable to maintain their housing situation and forced to stay with a series of friends and/or extended family members, paying no rent, and uncertain as to how long they will be able to stay);

C. Persons who are from transitional or supportive housing for homeless persons who originally came from streets or emergency shelters;

D. Persons who are being evicted within the week from a private dwelling unit,

no subsequent residence has been identified, and they lack the resources and support networks needed to obtain access to housing;

E. Persons who are being discharged within the week from facilities in which they have been a resident for more than ninety (90) consecutive days, no subsequent residence has been identified, and they lack the resources and support networks needed to obtain access to housing; and

F. Persons who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing;

6. Are having a current episode of acute crisis or being referred from the crisis system;

7. Have used a hospital emergency room related to a psychiatric illness two (2) or more times during the prior year;

8. Have attempted suicide;

9. Are high utilizers of Medicaid services with co-occurring behavioral health and other chronic health conditions; and

10. Children and adolescents at risk of disruption from a preferred living environment due to symptoms of a serious emotional disturbance.

(5) The CPR program may refuse admission when an individual poses an imminent threat of harm to self or others, or the program is operating at full capacity (a level previously determined by organizational leadership). The program shall implement policies and procedures to monitor capacity.

(6) Eligibility criteria for admission to a CPR program shall include:

(A) Disability—there is clear evidence of serious and/or substantial impairment in the individual's ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by the eligibility determination and comprehensive assessment:

1. Social role functioning/family life—the ability to sustain functionally the role of a worker, student, homemaker, family member, or a combination of these; and

2. Daily living skills/self-care skills—the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling individual finances, using community resources, performing household chores), learning ability/self-direction, and activities appropriate to the individual's age, developmental level, and social role functioning.

(B) Diagnosis—a licensed diagnostician certifies a primary diagnosis based on the *Diagnostic and Statistical Manual of Mental*



Disorders Fifth Edition (DSM-5) published by and available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901 or the *International Classification of Diseases Tenth Revision (ICD-10)* published by and available from the World Health Organization, 525 23rd Street N.W., Washington, DC 20037. The diagnosis may coexist with other psychiatric diagnoses. Specific diagnoses for eligibility can be found in the MO HealthNet *CPR Provider Manual* published by and available from the Missouri Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500. The referenced documents do not include any later revisions or updates.

(C) Duration—rehabilitation services shall be provided for individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following:

1. Received psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);
2. Experienced an occurrence of continuous residential care, other than hospitalization, for a period long enough to disrupt the normal living situation;
3. Exhibited the psychiatric disability for one (1) year or more; or
4. Treatment of the psychiatric disorder has been or will be required for longer than six (6) months.

(D) For adults and children age six (6) and above a functional assessment may be used to establish eligibility for CPR services, including results from a standardized assessment prescribed by the department.

(E) Individuals currently enrolled in a CPR program for youth are automatically eligible for admission to an adult CPR program when the transfer is determined to be clinically appropriate and documented in the record.

(7) Children and youth under the age of eighteen (18) may be provisionally admitted to a CPR program based on the following:

(A) Disability—there is clear evidence of serious and/or substantial impairment in the child's ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by the eligibility determination and comprehensive assessment:

1. Social role functioning/family life—the child is at risk of out-of-home or out-of-school placement; and
2. Daily living skills/self-care skills—the child is unable to engage in personal care, such as grooming and personal hygiene, and

in community living such as performing school work or household chores, learning, self-direction or activities appropriate to the individual's age, developmental level, and social role functioning.

(B) Diagnosis—if a child is exhibiting behaviors or symptoms consistent with a non-established CPR eligible diagnosis, he/she may be provisionally admitted for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR diagnosis is appropriate without an opportunity to observe and evaluate the child's behavior, mood, and functional status. In such cases documentation must clearly support the individual's level of functioning based on disability as defined in subsection (7)(A) of this rule.

(C) Duration—there must be documented evidence of the child's functional disability as defined in subsection (A) of this section for a period of ninety (90) days prior to provisional admission.

(D) Provisional admission shall not exceed ninety (90) days. Immediately upon completion of the ninety (90) days, or sooner if the individual has been determined to have an eligible diagnosis as indicated in subsection (A) of this section, the diagnosis must be documented and he/she may continue to receive services in the program.

(E) If a child who was provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging follow-up services needed. Arrangements for follow-up services must be documented in the discharge summary.

(F) All admission documentation is required for those provisionally admitted with the exception of the comprehensive assessment which may be deferred for ninety (90) days.

(8) The CPR program shall ensure individuals receive the most appropriate care and treatment available. Transferring an individual to another service, from a community program to a hospital, hospital to a community program, or to another CPR program consistent with individual needs, may be considered to obtain necessary care and treatment.

(A) Written procedures shall ensure exchange of information within five (5) days when an individual is referred or transferred to another service component within the organization or to an outside provider for services. Policies and procedures must ensure—

1. Applicable records, portions of records, and other information are readily

transferable and handled in compliance with state and federal confidentiality regulations; and

2. Timely follow-up is made with the alternate CPR program or service provider.

(B) Policies and procedures stipulate the conditions under which referrals are made, such as the need for special services not provided by the current CPR program or the need for ancillary services which will contribute to the well-being of the individual.

(C) Policies and procedures shall assure continuity of care among referring providers including prior inpatient hospitalization, residential support, and outpatient psychiatric and/or substance use disorder treatment.

(D) A current resource directory of area community service agencies must be readily available to individuals and family members/natural supports for referral purposes and upon request by the public.

(9) The CPR program shall coordinate with providers of inpatient psychiatric care to assure continuity of services for eligible individuals returning to the community. This includes active participation of community support staff in discharge planning for the individual.

(A) Policies and procedures shall ensure individuals engaged in CPR have a documented consultation with a community support specialist within five (5) days of discharge from inpatient psychiatric care, including active follow-up within five (5) days for individuals who fail to keep their appointment.

(10) The CPR program shall implement written policies and procedures to ensure individuals who miss a scheduled appointment for services or whose absence is unanticipated are contacted by a community support specialist or other staff person providing their services/supports. The procedures shall establish time frames for contacting individuals, consistent with clinical needs and the seriousness of their disability, not to exceed forty-eight (48) hours.

(11) The CPR program shall provide equal opportunity to individuals with disabilities in accordance with the Americans with Disabilities Act.

(12) The program shall have policies and procedures to ensure individuals determined ineligible for CPR services are referred to other programs and services in the community for which they may be eligible.



(13) The CPR program shall only admit individuals who will benefit from services available. Individuals who have not received services for a six- (6-) month period should be discharged from the program.

(14) The CPR program shall participate in coordination and liaison activities with the adult and juvenile justice systems to—

(A) Promote effective relationships with local law enforcement systems (including courts) through training, education, and consultation;

(B) Educate law enforcement and court officials, juvenile officers, and probation/parole personnel about services offered by the CPR program; and

(C) Provide CPR services, as capacity allows, to persons with serious mental illness who are on probation/parole or in forensic aftercare by working with probation/parole and juvenile officers and department forensic case monitors within the limits of confidentiality.

(15) The CPR program shall participate in coordination and liaison activities with federal, state, and local public assistance agencies, housing agencies, and employment/vocational support agencies to—

(A) Promote effective relationships through training, education, and consultation;

(B) Educate staff about services offered by the CPR provider; and

(C) Assist individuals in seeking public benefits to expedite the application process and maintain/regain their eligibility for assistance within the limits of confidentiality.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016.* This rule originally filed as 9 CSR 30-4.042. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Emergency amendment filed Feb. 15, 1994, effective March 6, 1994, expired April 10, 1994. Emergency amendment filed April 21, 1994, effective May 2, 1994, expired Aug. 29, 1994. Amended: Filed April 21, 1994, effective Oct. 30, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Emergency amendment filed June 30, 2000, effective July 11, 2000, expired Feb. 22, 2001. Amended: Filed June 30, 2000, effective Jan. 30, 2001.

Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed July 31, 2002, effective March 30, 2003. Amended: Filed March 15, 2010, effective Sept. 30, 2010. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Moved to 9 CSR 30-4.005 and amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.

*Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.

9 CSR 30-4.010 Definitions (Rescinded November 30, 2019)

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Emergency amendment filed July 2, 1992, effective July 12, 1992, expired Nov. 8, 1992. Emergency amendment filed July 6, 1993, effective July 16, 1993, expired Nov. 12, 1993. Amended: Filed July 6, 1993, effective March 10, 1994. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed July 31, 2002, effective March 30, 2003. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.020 Procedures to Obtain Certification (Rescinded November 30, 2019)

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.025 Implementation of Certification Authority for Certain Programs

Emergency rule filed Nov. 6, 1985, effective Nov. 16, 1985, expired March 7, 1986.

9 CSR 30-4.030 Certification Standards Definitions (Rescinded November 30, 2019)

AUTHORITY: sections 630.055 and 632.050, RSMo 2000, and section 630.050, RSMo Supp. 2011. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency

amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Emergency amendment filed Feb. 15, 1994, effective March 6, 1994, expired April 10, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed July 31, 2002, effective March 30, 2003. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.031 Procedures to Obtain Certification for Centers (Rescinded November 30, 2019)

AUTHORITY: sections 630.050, 630.655 and 632.050, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 16, 1993, effective Aug. 26, 1993, expired Dec. 23, 1993. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Emergency amendment filed Dec. 9, 1993, effective Dec. 24, 1993, expired April 22, 1994. Amended: Filed Aug. 16, 1993, effective April 9, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.032 Administrative Structure for Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets out responsibilities and authority of the director of a community psychiatric rehabilitation (CPR) program.

(1) Each organization that is certified or deemed certified as a CPR program by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.090



Governing Authority and Program Administration.

(2) A CPR program director shall be appointed whose qualifications, authority, and duties are defined in writing. The director shall have responsibility and authority for all operating elements of the CPR program, including all administrative and service delivery staff. If the CPR program director is not a qualified mental health professional (QMHP) as defined in 9 CSR 10-7.140, a clinical supervisor who is a QMHP shall be designated by the agency to monitor and supervise all clinical aspects of the program. If the agency is certified to provide services to children and youth, the CPR program director shall have at least two (2) years of supervisory experience with children and youth. If the CPR program director does not meet these requirements, the agency shall identify a clinical supervisor for children and youth services who is a QMHP who has responsibility for monitoring and supervising all clinical aspects of the program and meets the above requirements.

(3) The CPR program shall maintain a policy and procedure manual for all aspects of its operations including, but not limited to:

(A) Personnel and staff development in accordance with 9 CSR 30-4.034;

(B) Admission criteria, referral process, and transfer of records in accordance with 9 CSR 30-4.005;

(C) Provision of core and optional CPR services as specified in 9 CSR 30-4.043; and

(D) Specialized programs and/or services as specified in department contracts.

AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed April 29, 2019, effective Nov. 30, 2019.*

*Original authority: 630.655, RSMo 1980.

9 CSR 30-4.033 Fiscal Management of Community Psychiatric Rehabilitation Programs

(Rescinded November 30, 2019)

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended:

Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.034 General Staffing Requirements for Community Psychiatric Rehabilitation Programs

PURPOSE: This rule specifies requirements for caseload size, clinical privileging, and core competencies for staff working in CPR programs.

(1) Each organization that is certified or deemed certified as a CPR program by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.110 Personnel.

(2) Qualified Staff. The program director shall ensure an adequate number of qualified professionals are available to provide community psychiatric rehabilitation (CPR) services.

(A) Caseload size may vary according to the acuity, symptom complexity, and needs of individuals served. An individual being served or his or her parent/guardian has the right to request an independent review by the CPR director if they believe individual needs are not being met. If the CPR director deems it necessary, caseload size or other changes may be implemented.

(B) The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by persons served.

(C) The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

(3) The program shall have and implement a process for granting clinical privileges to practitioners to deliver CPR services.

(A) Each treatment discipline shall define clinical privileges based upon identified and accepted criteria approved by the governing body.

(B) The process shall include periodic review of each practitioner's credentials, performance, education, and the like, and the renewal or revision of clinical privileges at least every two (2) years.

(C) Initial granting and renewal of clinical privileges shall be based on—

1. Well-defined written criteria for qualifications, clinical performance, and ethical

practice related to the goals and objectives of the program;

2. Verified licensure, certification, or registration, if applicable;

3. Verified training and experience;

4. Recommendations from the agency's program, department service, or all of these, in which the practitioner will be or has been providing service;

5. Evidence of current competence;

6. Evidence of health status related to the practitioner's ability to discharge his/her responsibility, if indicated; and

7. A statement signed by the practitioner that he/she has read and agrees to be bound by the policies and procedures established by the provider and governing body.

(D) Renewal or revision of clinical privileges shall also be based on—

1. Relevant findings from the CPR program's quality assurance activities; and

2. The practitioner's adherence to the policies and procedures established by the CPR program and its governing body.

(E) As part of the privileging process, the CPR program shall establish procedures to—

1. Afford a practitioner an opportunity to be heard, upon request, when denial, curtailment, or revocation of clinical privileges is planned;

2. Grant temporary privileges on a time-limited basis; and

3. Ensure that non-privileged staff receive close and documented supervision from privileged practitioners until training and experience are adequate to meet privilege requirements.

(4) Direct care staff and staff providing supervision to direct care staff shall complete training in the service competency areas listed below.

(A) Competent staff shall—

1. Operate from person-centered, person-driven, recovery-oriented, and stage-wise service delivery approaches that promote health and wellness;

2. Develop cultural competence that results in the ability to understand, communicate with, and effectively interact with people across cultures;

3. Deliver services according to key service functions that are evidence-based and best practices;

4. Practice in a manner that demonstrates respect and understanding of the unique needs of persons served;

5. Use effective strategies for engagement, re-engagement, relationship-building, and communication; and

6. Be knowledgeable of mandated reporting requirements for abuse and neglect



of children and reporting requirements related to abuse, neglect, or financial exploitation of senior citizens and individuals who are disabled.

(B) Staff providing supervision to community support specialists must have additional training or experience in order to be knowledgeable in the supervision competency areas listed below. Competent supervisors—

1. Practice in a manner that demonstrates use of management strategies that focus on individual outcomes, care coordination, collaboration, and communication with other service providers both within and external to the organization;

2. Ensure new and existing staff are competent by providing training/supervision, guidance and feedback, field mentoring, and oversight of services to individuals served by the team;

3. Ensure processes exist for tracking and review of data such as missed appointments, hospitalization and follow-up care, crisis responsiveness and follow-up, timeliness and quality of documentation, and need for outreach and engagement; and

4. Monitor and review services, interventions, and contacts with individuals served to ensure services are implemented according to individualized treatment plans or crisis prevention plans, evaluate the effectiveness and appropriateness of services in achieving recovery/resiliency outcomes in areas such as housing, employment, education, leisure activities and family, peer and social relationships.

(C) New staff shall job shadow their supervisor and/or experienced staff in a position equivalent to their qualifications and skill level.

(D) Staff shall receive ongoing and regular clinical supervision.

(E) A written plan shall be developed indicating how competencies will be measured and ensured for all staff providing direct services and staff providing supervision including, but not limited to, some combination of the following:

1. Testing;
2. Observation/field supervision;
3. Clinical supervision/case discussion;
4. Quality review of case documentation;
5. Use of relevant findings from quality assurance activities;
6. Satisfaction with services as conveyed by individuals served and family members/natural supports;
7. Stakeholder/interagency satisfaction with services; and
8. Treatment outcomes for individuals and family members/natural supports.

(F) Demonstrated competency must be documented within the first six (6) months of employment with the CPR program.

(G) Staff shall participate in at least thirty-six (36) clock hours of relevant training during any two (2) year period. A minimum of twelve (12) clock hours of training must be completed annually.

(H) Documentation of all orientation, training, job shadowing, and supervision activities must be maintained and available for review by department staff or other authorized representatives.

(I) Documentation of training must include the topic, date(s) and length, skills targeted/objective of skill, certification/continuing education units (as applicable), location, and name, title, and credentials of instructor(s).

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Emergency amendment filed Feb. 15, 1994, effective March 6, 1994, expired April 10, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Emergency amendment filed June 15, 1994, effective June 25, 1994, expired Oct. 21, 1994. Amended: Filed June 15, 1994, effective Oct. 30, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed July 31, 2002, effective March 30, 2003. Amended: Filed May 12, 2010, effective Nov. 30, 2010. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Amended: Filed April 29, 2019, effective Nov. 30, 2019.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*

9 CSR 30-4.035 Eligibility Determination, Assessment, and Treatment Planning in Community Psychiatric Rehabilitation Programs

PURPOSE: This rule specifies the eligibility determination, comprehensive assessment, functional assessment, treatment planning, and documentation requirements for commu-

nity psychiatric rehabilitation (CPR) programs.

(1) Each organization that is certified or deemed certified as a CPR program by the department shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

(2) Eligibility Determination. Eligibility determination may be completed to expedite the admission process and requires confirmation of an eligible diagnosis as evidenced by a signature from a licensed diagnostician or a physician/physician extender. Physician extender includes a licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist, and APRN. The licensed diagnostician or physician/physician extender is accountable for the stated diagnosis.

(A) The following mental health professions are approved to render diagnoses:

1. Physician (includes psychiatrist, psychiatry resident, assistant physician, and physician assistant);
2. Psychologist (licensed or provisionally licensed);
3. Advanced Practice Registered Nurse (APRN);
4. Professional Counselor (licensed or provisionally licensed);
5. Marital and Family Therapist (licensed or provisionally licensed);
6. Licensed Clinical Social Worker (LCSW); and
7. Licensed Master Social Worker (LMSW) under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker. LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis.

(B) The professions listed in paragraphs (2)(A)1. to 7. are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. Individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

(C) The signature/date from a licensed diagnostician or physician/physician extender is required prior to delivery of CPR services. The signature can be obtained as follows:

1. Consultation with the organization's licensed diagnostician (licensed psychologist, licensed professional counselor, LCSW) or a physician/physician extender; or



2. Consultation with an unlicensed qualified mental health professional (QMHP) with sign-off by the organization's licensed diagnostician or a physician/physician extender; or

3. Written confirmation of an eligible diagnosis received from a physician for a psychiatric hospitalization within ninety (90) days of discharge.

(D) CPR services are billable to the department beginning on the date eligibility determination is completed.

(E) Documentation of eligibility determination must include, at a minimum:

1. Presenting problem and referral source;

2. Brief history of previous psychiatric/addiction treatment including type of admission;

3. Current medications;

4. Current mental health symptoms supporting the diagnosis;

5. Current substance use;

6. Current medical conditions;

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

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

9. Initial treatment recommendations;

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

11. Signature, date, and title of staff completing the eligibility determination, except when the diagnosis is established as specified in paragraph (2)(C)3. of this rule.

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

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

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

(4) Initial Comprehensive Assessment. A comprehensive assessment must be completed within thirty (30) days of eligibility determination or date of admission if eligibility determination was not completed.

(A) Documentation of the initial comprehensive assessment must include, at a minimum:

1. Basic information (demographics,

age, language spoken);

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

3. Risk assessment (suicide, safety, risk to others);

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

5. Mental health treatment history;

6. Mental status;

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

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

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

10. Functional assessment using an instrument approved by the department for individuals whose diagnosis requires a functional score to support admission, and if required by the department as part of the initial comprehensive assessment for all individuals (challenges, problems in daily living, barriers);

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

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

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

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

15. Spiritual beliefs/religious orientation;

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

17. Need for and availability of social, community, and natural supports/resources

such as friends, pets, meaningful activities, leisure/recreational interests, self-help groups, resources from other agencies, interactions with peers including child/youth and family;

18. Legal involvement history;

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

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

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

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

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

24. Diagnosis;

25. Individual's expression of service preferences;

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

27. Signature and date of the staff person completing the assessment.

(5) Annual Assessment. An annual assessment must be completed for individuals engaged in CPR services.

(A) Documentation of the annual assessment must include, at a minimum:

1. Identification of sections of the clinical assessment being updated, such as check boxes;

2. Updated narrative for each section of the previous assessment that has changed;

3. Clinical formulation (interpretive summary);

4. Diagnosis change/update;

5. Individual's expression of service preferences;

6. Assessed needs/treatment recommendations; and

7. Signature and date of the staff person completing the assessment, community support supervisor (unless they are completing the assessment), and a licensed diagnostician or physician/physician extender.

(6) Initial Treatment Plan. An individual treatment plan must be developed within forty-five (45) days of completion of eligibility determination or date of admission to CPR if eligibility determination was not completed.

(A) The treatment plan shall be developed collaboratively with the individual or parent/guardian and a QMHP, the individual's



community support supervisor, if different from the QMHP, and a physician/physician extender.

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

1. Identifying information;
2. Goals as expressed by the person served and family members/natural supports, as appropriate, that are measurable, achievable, time-specific with start date, strength/skill based and include supports/resources needed to meet goals and potential barriers to achieving goals;
3. Specific treatment objectives, including a start date, that are understandable to the individual served, sufficiently specific to assess progress, responsive to the disability or concern, and reflective of age, development, culture, and ethnicity;
4. Specific interventions including action steps, modalities, and services to be used, duration and frequency of interventions, who is responsible for the intervention, and action steps of the individual served and family members/natural supports;
5. Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CPR program to be addressed through referral/services with another organization;
6. Anticipated discharge and continuing recovery planning which includes but is not limited to criteria for service conclusion, how will the individual served and/or parent/guardian and clinician know treatment goals have been accomplished; and
7. Signature and date of the QMHP/community support supervisor.

A. Physician/physician extender signature and date must be obtained within ninety (90) days of completion of the eligibility determination after a consultation or case review. The physician/physician extender signature certifies treatment is needed and services are appropriate, as described in the treatment plan, and does not recertify the diagnosis.

B. A licensed psychologist may approve (sign and date) the treatment plan when the person served is not currently receiving prescribed medications to treat a mental health condition and the clinical recommendations do not include a need for prescribed medications to treat a mental health condition.

(7) Treatment Plan Review. If a functional assessment is not completed, the treatment plan must be reviewed with each individual

every ninety (90) days to assess the continued need for services and progress achieved during the past ninety (90) days.

(A) The treatment plan shall reflect the individual's current strengths, needs, abilities, and preferences in the goals and objectives that have been established or continued based on the review.

(B) The treatment plan shall be updated to reflect the current needs and goals of the individual and must be documented in the individual's record and may be recorded in—

1. A progress note which specifies updates made to the treatment plan; or
2. A treatment plan review conducted quarterly.

(C) Treatment plan reviews shall be completed, signed, and dated by a QMHP, community support supervisor, or community support specialist.

(8) Annual Treatment Plan. Treatment plans must be updated annually for individuals engaged in CPR services to reflect current goals, needs, and progress in treatment.

(A) The plan is updated collaboratively with the individual or parent/guardian, community support supervisor, community support specialist, and physician/physician extender.

1. A licensed psychologist may take the place of the physician/physician extender when the person served is not currently receiving prescribed medications to treat a mental health condition and the clinical recommendations do not include a need for prescribed medications to treat a mental health condition.

(B) Documentation for completion of the annual treatment plan must include at a minimum:

1. Updates related to the annual assessment and periodic updates to the functional assessment or treatment plan;
2. Signature and date of community support supervisor;
3. Signature and date of community support specialist; and
4. Signature and date of physician/physician extender or licensed psychologist.

(9) Functional Assessment. A department-approved functional assessment must be completed for individuals whose diagnosis requires a functional score to support admission, and if required by the department as part of the initial comprehensive assessment. The functional assessment shall be updated in accordance with the timeframes established by the department to assess current level of functioning, progress toward treatment objectives, and appropriateness of continued ser-

vices. The treatment plan shall be revised to incorporate the results of the initial functional assessment and subsequent updates.

(A) Documentation of the initial functional assessment and regular updates shall include, at a minimum:

1. Barriers, issues, or problems conveyed by the individual, parent/guardian, family members/natural supports, and/or staff indicating the need for focused services;
2. A brief explanation of any changes or progress in the daily living functional abilities in the prior ninety (90) days; and
3. A description of the changes for the treatment plan based on information obtained from the functional assessment.

(B) Documentation of the findings from the functional assessment includes any of the following:

1. A narrative section with the treatment plan that includes the functional update content requirements;
2. A narrative section on the functional assessment with the content requirements; or
3. A progress note in the individual record documenting the content requirements.

(C) Completed functional assessments must be available to department staff and other authorized representatives for review/audit purposes upon request.

(D) For individuals receiving services in a community residential program, the functional assessment must be completed a minimum of every ninety (90) days and documented in the individual record.

(10) Crisis Prevention Plan. If a potential risk for suicide, violence, or other at-risk behavior is identified during the assessment process, and any time during the individual's time in services, a crisis prevention plan shall be developed with the individual.

(A) Documentation for completion of the crisis prevention plan shall include, at a minimum, factors that may precipitate a crisis, a hierarchical list of self-care and self-help strategies identified by the individual to regain a sense of control to return to their level of functioning before the crisis or emergency, and a hierarchical list of staff interventions that may be used when a critical situation occurs.

(11) Discharge. When individuals are discharged from CPR services, a discharge summary must be prepared and entered in the individual record in accordance with 9 CSR 10-7.030.

(12) Data. The CPR program shall provide data to the department, upon request, regarding



characteristics of individuals served, services, costs, or other information in a format specified by the department.

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

AUTHORITY: section 630.655, RSMo 2016.* Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed March 15, 2010, effective Sept. 30, 2010. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Amended: Filed April 29, 2019, effective Nov. 30, 2019. ** Amended: Filed March 9, 2022, effective Sept. 30, 2022.

*Original authority: 630.655, RSMo 1980.

**Pursuant to Executive Order 21-09, 9 CSR 30-4.035, sections (3) and (5) was suspended from April 23, 2020 through December 31, 2021.

9 CSR 30-4.036 Research by a Community Psychiatric Rehabilitation Program
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.037 Client Environment in a Community Psychiatric Rehabilitation Program
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.038 Client Rights for Community Psychiatric Rehabilitation Programs
(Rescinded November 30, 2019)

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.039 Service Provision
(Rescinded November 30, 2019)

AUTHORITY: sections 630.655 and 632.050, RSMo 2000, and section 630.050, RSMo Supp. 2011. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Emergency amendment filed Feb. 15, 1994, effective March 6, 1994, expired April 10, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.040 Quality Assurance
(Rescinded November 30, 2019)

AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.041 Medication Procedures at Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets out procedures to safely record, store and administer medications at a community psychiatric rehabilita-

tion program facility site or in off-site situations.

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. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Each agency that is certified shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Abuse Programs, 9 CSR 10-7.070 Medications.

(2) The community psychiatric rehabilitation (CPR) provider shall make available to all staff, consultation with a registered nurse or physician to check medication procedures.

(3) A physician shall review and evaluate medications at least every six (6) months, except as specified in the client's individualized treatment plan. Face-to-face contact with the client and review of relevant documentation in the client record, such as progress notes and treatment plan reviews, shall constitute the review and evaluation.

(4) The CPR provider shall develop all medication policies and procedures in conjunction with a psychiatrist.

(5) The following forms are included herein:
(A) Form number MO 650-6250; and
(B) Form number MO 650-1485.

(6) The following publication is incorporated by reference:
(A) *United States Pharmacopeia Standards.*



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
**ABNORMAL INVOLUNTARY MOVEMENT
SCALE (AIMS)**

INSTITUTION NAME

Current Medications	<hr/> <hr/> <hr/> <hr/>	
Facial And Oral Movements	1. Muscle of Facial Expression - e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing.	Circle One 0 1 2 3 4
	2. Lips and Perioral Area - e.g., puckering, pouting, smacking.	0 1 2 3 4
	3. Jaw - e.g., biting, clenching, chewing, mouth opening, lateral movement.	0 1 2 3 4
	4. Tongue - Rate only increase in movement both in and out of mouth, NOT inability to sustain movement.	0 1 2 3 4
Extremity Movements	5. Upper (Arms, Wrists, Hands, Fingers) - Include choreic movements, (i.e., rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex serpentine). Do NOT include tremor (i.e., repetitive, regular, rhythmic)	0 1 2 3 4
	6. Lower (Legs, Knees, Ankles, Toes) - e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4
Trunk Movements	7. Neck, Shoulder, Hips - e.g., rocking, twisting, squirming, pelvic gyrations.	0 1 2 3 4
Global Judgments	8. Severity of Abnormal Movements.	0 1 2 3 4
	9. Incapacitation Due to Abnormal Movements.	0 1 2 3 4
	10. Patient's Awareness of Abnormal Movements - Rate only patient's report.	0 1 2 3 4
Dental Status	11. Current problems with teeth and/or dentures.	No Yes
	12. Does patient usually wear dentures?	No Yes
PHYSICIAN SIGNATURE:		DATE:

MO 650-6250 (10-92)

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)



ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS

Complete Examination Procedures (below) before making ratings.

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously.

- CODES:**
- 0 - NONE
 - 1 - MINIMAL, MAY BE EXTREME NORMAL
 - 2 - MILD
 - 3 - MODERATE
 - 4 - SEVERE

EXAMINATION PROCEDURES

Either before or after completing the Examination Procedure, observe the patient unobtrusively at rest (e.g., in waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask patient whether there is anything in his/her mouth (i.e., gum, candy, etc.), and if there is, to remove it.
2. Ask patient about the current condition of his/her teeth. Ask if he/she wears dentures. Do teeth or dentures bother patient now? Remove them.
3. Ask patient whether he/she notices any movement in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.
4. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at entire body for movements while in this position.)
5. Ask patient to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
6. Ask patient to open mouth. (Observe tongue at rest within mouth/look for fasciculations.) Do this twice.
7. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend patient's left and right arms (one at a time). Note any rigidity and **RATE SEPARATELY.**
10. Ask patient to stand up. (Observe in profile. Observe all body areas, again, hips included.)
11. Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth.)
12. Have patient walk a few paces, turn and walk back to chair. (Observe hands and gait.) Do this twice.



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
**ABNORMAL INVOLUNTARY
MOVEMENT SCALE**

DATE	
DIAGNOSIS	CURRENT MEDICATIONS
_____	_____
_____	_____
_____	_____

INSTRUCTIONS

Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g., in waiting room). The chair to be used in this examination should be a hard, firm one without arms.

After observing the patient, he may be rated on a scale of 0 (none), 1 (minimal), 2 (mild), 3 (moderate) and 4 (severe) according to the severity of symptoms.

Ask the patient whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is to remove it.

Ask patient about the *current* condition of his/her teeth. Ask patient if he/she wears dentures. Do teeth or dentures bother patient *now*?

Ask patient whether he/she notices any movement in mouth, face, hands, or feet. If yes, ask to describe and to what extent they *currently* bother patient or interfere with his/her activities.

- 0 1 2 3 4 Have patient sit in chair with hands on knees, legs slightly apart and feet flat on floor. (Look at entire body for movements while in this position.)
- 0 1 2 3 4 Ask patient to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
- 0 1 2 3 4 Ask patient to open mouth. (Observe tongue at rest within mouth). Do this twice.
- 0 1 2 3 4 Ask patient to protrude tongue. (Observe abnormalities on tongue movement.) Do this twice.
- 0 1 2 3 4 Ask the patient to tap thumb, with each finger, as rapidly as possible for 10-15 seconds; separately with right hand, then with left hand. (Observe facial and leg movements.)
- 0 1 2 3 4 Flex and extend patient's left and right arms. (One at a time.)
- 0 1 2 3 4 Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
- 0 1 2 3 4 + Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs and mouth.)
- 0 1 2 3 4 + Have patient walk a few paces, turn and walk back to chair. (Observe hands and gait.) Do this twice.

COMMENTS

RATED BY _____

MO 650-1485 (5-90)



AUTHORITY: section 630.655, RSMo 2000. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed July 31, 2002, effective March 30, 2003.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-4.042 Eligibility Criteria and Admission Criteria for Community Psychiatric Rehabilitation Programs (Moved to 9 CSR 30-4.005)

9 CSR 30-4.043 Service Provision, Staff Qualifications, and Documentation Requirements for Community Psychiatric Rehabilitation Programs

PURPOSE: This rule specifies the core and optional psychiatric treatment services, staffing requirements, and documentation requirements for community psychiatric rehabilitation (CPR) programs.

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

(1) CPR programs shall comply with requirements set forth in department Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

(A) Service delivery and documentation requirements specific to the CPR program are included in this rule.

(2) Core Services. At a minimum, CPR programs shall directly provide the following core services, or ensure the services are available through a subcontract as specified in 9 CSR 10-7.090(6):

(A) Eligibility determination (to expedite the admission process, if necessary), in accordance with 9 CSR 30-4.005;

(B) Initial comprehensive assessment, in accordance with 9 CSR 30-4.035;

(C) Annual assessment, in accordance with 9 CSR 30-4.035;

(D) Treatment planning, in accordance

with 9 CSR 30-4.035;

(E) Community support, in accordance with 9 CSR 30-4.047;

(F) Crisis Prevention and Intervention—face-to-face emergency or telephone intervention available twenty-four (24) hours a day, on an unscheduled basis, to assist individuals in resolving a crisis and providing support and assistance to promote a return to routine, adaptive functioning. Services must be provided by a qualified mental health professional (QMHP), licensed mental health professional (LMHP), qualified addiction professional (QAP), or community support specialist with population-specific experience providing community support services in accordance with the key service functions specified in 9 CSR 30-4.047(5)(B). Nonmedical staff providing crisis prevention and intervention must have immediate, twenty-four (24) hour telephone access to consultation with a physician/physician extender. Minimum service functions shall include, but are not limited to—

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

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

3. Identifying maladaptive reactions exhibited by the individual;

4. Evaluating potential for rapid regression;

5. Attempting to resolve the crisis; and

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

7. Documentation must include—

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

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

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

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

E. The individual's disposition; and

F. Planned follow-up by staff;

(G) Integrated Treatment for Co-Occurring Disorders (ITCD), in accordance with 9 CSR 30-4.0431;

(H) Medication Administration—assures the appropriate administration and continuing effectiveness of medication(s) being prescribed for the individual served. Services must be provided by a physician, assistant physician, physician assistant, registered professional nurse (RN), licensed practical nurse (LPN), advanced practice registered nurse (APRN), psychiatric resident, or psychiatric pharmacist. Key service functions shall include—

1. Administering therapeutic injections of medication (subcutaneous or intramuscular);

2. Monitoring lab tests/levels including consultation with the physician(s), individual served, and community support specialist;

3. Coordinating medication needs with the individual served and his or her family members/natural supports, as appropriate, and pharmacy staff, including the use of indigent drug programs (does not include routine placing of prescription orders and refills with pharmacies);

4. Setting up medication boxes;

5. Delivering medication to the individual's home;

6. Educating the individual about medications;

7. Recording the individual's initial histories and vital signs;

8. Ensuring medication is taken as prescribed;

9. Monitoring side effects of medication including the use of standardized evaluations; and

10. Monitoring prescriber's orders for treatment modifications and educating the individual served;

(I) Medication Services—goal-oriented interaction with the individual served regarding the need for medication and management of a medication regimen. A physician/physician extender shall provide this service, subject to the guidelines and limitations promulgated for each specialty in statutes and administrative rules.

1. Individuals requiring or requesting medication shall be seen by a qualified staff person within fifteen (15) days, or sooner if clinically indicated. All efforts shall be made to ensure established psychotropic medications are continued without interruption. Medication services must occur at least every six (6) months for individuals taking psychiatric medications. Key service functions shall include, but are not limited to—

A. Review of the individual's presenting condition;

B. Mental status exam;

C. Review of symptoms and medication side effects;

D. Review of the individual's functioning;

E. Review of the individual's ability to self-administer medication;

F. Education on the effects of medication and its relationship to the individual's mental illness and choice of medication; and

G. Prescription of medications when indicated.

2. Documentation for medication services must include, at a minimum:



A. A description of the individual's presenting condition;

B. Pertinent medical and psychiatric findings;

C. Observations and conclusions;

D. Any side effects of medication as reported by the individual;

E. Actions and recommendations regarding the individual's ongoing medication regimen; and

F. Pertinent information reported by family members/natural supports regarding a change in the individual's condition or an unusual or unexpected occurrence in his or her life, or both;

(J) Metabolic Syndrome Screening—identifies risk factors for obesity, hypertension, hyperlipidemia, and diabetes. The screening is required annually for adults and children/youth who are receiving antipsychotic medication.

1. Services must be provided by an RN or LPN. Key service functions shall include, but are not limited to:

A. Taking and recording vital signs;

B. Conducting lab tests to assess lipid levels and blood glucose levels and/or HgbA1c, or arranging and coordinating lab tests to assess lipid levels and blood glucose levels and/or HgbA1c;

C. Obtaining results of recently completed lab tests from other health care providers to assess lipid levels and blood glucose levels and/or HgbA1c; and

D. Recording the results of the metabolic screening on a form/tool approved by the department.

2. Metabolic syndrome screening is limited to no more than one (1) screening every ninety (90) days, per individual. If the lab tests are conducted by a nurse, an analyzer approved by the department must be used.

3. Documentation must reflect completion of the Metabolic Syndrome Screening and Monitoring Tool and a summary progress note;

(K) Physician Consultation/Professional Consultation—medical services provided by a physician, assistant physician, physician assistant, APRN, psychiatric resident, or a psychiatric pharmacist. The service is intended to provide direction to treatment and consists of a review of an individual's current medical situation either through consultation with one (1) staff person, or a team discussion(s) related to a specific individual. This service cannot be substituted for supervision or face-to-face intervention with the individual. Key service functions shall include, but are not limited to:

1. An assessment of the individual's presenting condition as reported by staff;

2. Review of the treatment plan through consultation;

3. Participant-specific consultation with staff especially in situations which pose a high risk of psychiatric decompensation, hospitalization, or safety issues; and

4. Participant-specific recommendations regarding high risk issues and, when needed, to promote early intervention; and

(L) Psychosocial Rehabilitation for Adults, in accordance with 9 CSR 30-4.046.

(3) Optional Services. In addition to the core services defined in section (2) of this rule, the following optional services may be provided directly by the CPR program, or through a subcontract as specified in 9 CSR 10-7.090(6):

(A) Adult Inpatient Diversion, in accordance with 9 CSR 30-4.045;

(B) Assertive Community Treatment (ACT), in accordance with 9 CSR 30-4.032;

(C) Children's Inpatient Diversion, in accordance with 9 CSR 30-4.045;

(D) Co-Occurring Individual Counseling, a structured, goal-oriented therapeutic process in which an individual interacts with a qualified provider in accordance with their treatment plan to resolve problems related to their documented mental illness and substance use disorder that interferes with functioning.

1. Services involve the use of evidence-based practices such as motivational interviewing, cognitive behavior therapy, and relapse prevention.

2. Counseling provided to the individual's family is for the direct benefit of the individual served in accordance with their needs and treatment goals, and for the purpose of assisting in the individual's recovery.

3. Services must be provided by a QMHP or QAP;

(E) Co-Occurring Group Counseling—goal-oriented therapeutic interaction between a counselor and two (2) or more individuals as specified in individual treatment plans to promote self-understanding, self-esteem, and resolution of personal problems related to the individual's documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. This service utilizes evidence-based practices.

1. Services must be provided by a QMHP or QAP;

2. Group size shall not exceed ten (10) individuals;

(F) Co-Occurring Group Rehabilitative Support—informational and experiential services to assist individuals, family members, and others identified by the individual as a

primary natural support, in the management of substance use and mental health disorders.

1. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and substance use disorders. This includes integrating affective and cognitive aspects in order to enable the individuals served, as well as family members/natural supports, to cope with the illness and understand the importance of their individual plan of care.

2. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms, and precursors to crisis, crisis planning, community resources, recovery management, and medication action, interaction, and side effects.

3. The service includes use of evidence-based practices such as promotion of participation in peer self-help, brain chemistry and functioning, the latest research on illness causes and treatments, medication education and management, symptom management, behavior management, stress management, improving daily living skills, and independent living skills.

4. Group size is limited to twenty (20) individuals.

5. Services must be provided by staff who have documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QAP;

(G) Day Treatment for Children/Youth—an intensive array of services provided to children/youth in a highly structured and supervised environment designed to reduce symptoms of a psychiatric disorder and maximize the individual's functioning so they can attend school and interact in their community and family setting. Services are individualized based on individual needs and include a multidisciplinary approach to care under the direction of a physician. The provision of educational services must comply with the Individuals with Disabilities Education Act and section 167.126, RSMo.

1. Hours of operation are based on program capacity, staffing availability, space requirements, and as specified by the department.

2. Eligibility criteria includes—

A. For children six (6) years of age and older, the individual must be at risk of inpatient or residential placement as a result of a serious emotional disturbance (SED);

B. For children five (5) years of age or younger, the individual must exhibit one (1) or more of the following:

(I) Has been expelled from multiple day care/early learning programs due to emotional or behavioral dysregulation in relation



to SED or diagnosis based on the 2021 edition of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-5™, Version 2.0), published by and available from ZERO TO THREE, 2445 M Street NW, Suite 600, Washington, DC 20037, telephone (202) 638-1144 or (800) 899-4301. The document incorporated by reference does not include any later amendments or additions;

(II) Is at risk for placement in an acute psychiatric hospital or residential treatment center as a result of a SED; or

(III) Has a score in the seriously impaired functioning level on the standardized functional tools approved by the department for this age range.

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

A. Providing integrated treatment combining education, counseling, and family interventions;

B. Promoting active involvement of the parent/guardian in the program;

C. Consulting and coordinating with the individual's/family's private service providers, as applicable, to establish and maintain continuity of care;

D. Coordinating and sharing information with the individual's school, including discharge planning, consistent with the Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act (HIPAA);

E. Requesting screening and assessment reports from the individual's school to determine any special education needs;

F. Planning the individualized educational needs with the individual's school; and

G. Providing other core services as prescribed by the department.

4. For programs serving children three (3) to five (5) years of age, services must be provided by a team of at least one (1) QMHP and one (1) appropriately certified, licensed, or credentialed ancillary staff. For programs serving school-age children, services must be provided by a team consisting of at least one (1) QMHP and two (2) appropriately certified, licensed, or credentialed ancillary staff. Ancillary staff include—

A. Occupational therapists;

B. Physical therapists;

C. Assistant behavior analysts;

D. Individuals with a bachelor's degree in child development, psychology, social work, or education;

E. Individuals with an associate's degree, or two (2) years of college, and two (2) years of experience in a mental health or child-related field; and

F. Individuals meeting the qualifica-

tions of a community support specialist with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions for community support services as specified in 9 CSR 30-4.047.

5. Documentation must include relevant information reported by family members/natural supports regarding a change in the individual's condition or an unusual or unexpected occurrence in their life;

(H) Evidence-Based Practices for Children and Youth, in accordance with 9 CSR 30-4.045;

(I) Family Assistance—services focus on development of home and community living skills and communication and socialization skills for children and youth, including coordination of community-based services. Staff must have a high school diploma or equivalent and two (2) years of experience working with children who have a SED or have experienced abuse and neglect. Staff must also complete training approved by/provided by the department and be supervised by a QMHP. Key service functions shall include, but are not limited to:

1. Modeling appropriate behaviors and coping skills for the child;

2. Exposing the child to activities that encourage positive choices, promote self-esteem, support academic achievement, and develop problem-solving skills for home and school;

3. Teaching appropriate social skills through hands-on experiences; and

4. Mentoring appropriate social interactions with the child or resolving conflict with peers;

(J) Family Support—provides a support system for parents/caregivers of an individual twenty-five (25) years of age and younger who has a SED. Activities are directed and authorized by the individualized treatment plan. Services must be provided by a family member of an individual twenty-five (25) years of age and younger who has or had a behavioral or emotional disorder. The family member must have a high school diploma or equivalent certificate, complete training required by the department, and be supervised by a QMHP. Key service functions shall include, but are not limited to:

1. Providing information and support to the parents/caregivers so they have a better understanding of the individual's needs and options to be considered as part of treatment;

2. Assisting the parents/caregivers in understanding the planning process and importance of their voice in the development and implementation of the individualized treatment plan;

3. Providing support to empower the parents/caregivers to be a voice for the individual and family in the planning meeting;

4. Working with the family to highlight the importance of individualized planning and the strengths-based approach;

5. Assisting the family in understanding the roles of various providers and the importance of the team approach;

6. Discussing the benefits of natural supports within the family and community;

7. Introducing methods for problem-solving and developing strategies to address issues needing attention;

8. Providing support and information to parents and caregivers to shift from being the decision maker to the support person as the individual becomes more independent;

9. Connecting families to community resources;

10. Empowering parents, caregivers, and individuals served to become involved in activities related to planning, developing, implementing, and evaluating programs and services; and

11. Connecting parents, caregivers, and individuals served to others with similar lived experiences to increase their support system;

(K) Individual Professional PSR and Group Professional PSR—mental health interventions provided on an individual or group basis. A skills-based approach is utilized to address identified behavioral problems and functional deficits related to a mental disorder that interfere with an individual's personal, family, or community adjustment. Maximum group size is one (1) professional to eight (8) individuals. This service cannot be provided to individuals under the age of five (5). Services must be provided by the following staff who complete training required by the department:

1. A professional counselor licensed or provisionally licensed under Missouri law with specialized training in mental health services;

2. A licensed clinical social worker or master social worker licensed under Missouri law with specialized training in mental health services;

3. A licensed, provisionally licensed, or temporarily licensed psychologist under Missouri law with specialized training in mental health services; or

4. A marital and family therapist licensed or provisionally licensed under Missouri law with specialized training in mental health services.

(L) Intensive CPR, in accordance with 9 CSR 30-4.045;

(M) Metabolic Syndrome Screening—optional service for individuals not receiving



antipsychotic medications and, if provided, must be in accordance with subsection (2)(J) of this rule;

(N) Peer Support—assists individuals in their recovery from a behavioral health disorder in a person-centered, recovery-focused manner. Individuals direct their own recovery and advocacy processes to develop skills for coping with and managing their symptoms, and identify and utilize natural support systems to maintain and enhance community living skills. Services are directed toward achievement of specific goals defined by the person served and specified in the individual treatment plan.

1. Peer support services shall be provided in a manner that reflect the core competencies, principles, and values identified in the publication, *Core Competencies for Peer Workers in Behavioral Health Services*, 2018, developed by and available from the Substance Abuse and Mental Health Services Administration (SAMHSA), 5600 Fishers Lane, Rockville, MD 20857, (877) 726-4727, hereby incorporated by reference and made a part of this rule. This rule does not incorporate any subsequent amendments or additions to this publication.

2. Services are provided by Certified Peer Specialists who have at least a high school diploma or equivalent certificate, complete applicable training and testing required by the department, and are supervised by a QMHP. Certified Peer Specialists are part of the individual's treatment team and participate in staff meetings/discussions related to services, but they cannot be assigned an independent caseload. The Certified Peer Specialist Code of Ethics must be followed. Job duties include, but are not limited to:

- A. Starting and sustaining mutual support groups;
- B. Promoting dialogues on recovery and resilience;
- C. Teaching and modeling skills to manage symptoms;
- D. Teaching and modeling skills to assist in solving problems;
- E. Supporting efforts to find and maintain paid employment;
- F. Using the stages in recovery concept to promote self-determination; and
- G. Assisting peers in setting goals and following through on wellness and health activities.

3. Certified Peer Specialists use the power of peers to support, encourage, and model recovery and resilience from behavioral health disorders in ways that are specific to the needs of each individual. Services may be provided on an individual or group

basis and are designed to assist individuals in achieving the goals and objectives on their individual treatment plan or recovery plan. Activities emphasize the opportunity for individuals to support each other as they move forward in their recovery. Interventions may include, but are not limited to:

- A. Sharing lived experiences of recovery, sharing and supporting the use of recovery tools, and modeling successful recovery behaviors;
- B. Helping individuals recognize their capacity for resilience;
- C. Helping individuals connect with other peers and their community at large;
- D. Helping individuals who have behavioral health disorders develop a network for information and support;
- E. Assisting individuals in making independent choices and taking a proactive role in their treatment;
- F. Assisting individuals in identifying strengths and personal resources to aid in their recovery; and
- G. Helping individuals set and achieve recovery goals;

(O) Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR), in accordance with 9 CSR 30-4.046;

(P) Psychosocial Rehabilitation for Youth, in accordance with 9 CSR 30-4.046; and

(Q) Professional Parent Home-Based Services and Treatment Family Home-Based Services (ICPR for Children/Youth in Residential Settings), in accordance with 9 CSR 30-4.045.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Emergency amendment filed Aug. 27, 1993, effective Sept. 8, 1993, expired Nov. 7, 1993. Emergency amendment filed Oct. 28, 1993, effective Nov. 7, 1993, expired March 6, 1994. Emergency amendment filed Feb. 15, 1994, effective March 6, 1994, expired April 10, 1994. Amended: Filed Aug. 27, 1993, effective April 9, 1994. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Emergency amendment filed Aug. 11, 1999, effective Aug. 22, 1999, expired Feb. 17, 2000. Amended: Filed Aug. 11, 1999, effective Feb. 29, 2000. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.*

**Original authority: 630.050, RSMo 1980, amended 1993, 995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*

9 CSR 30-4.0431 Integrated Treatment for Co-Occurring Disorders (ITCD) in Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets forth standards and regulations for the provision of ITCD in community psychiatric rehabilitation programs (CPR) for adults.

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

(1) ITCD is integrating substance use disorder treatment with community psychiatric rehabilitation for individuals with co-occurring psychiatric and substance use disorders. ITCD is a practice based on evidence and research for individuals with serious mental illness and substance use disorders.

(2) Organizations certified or deemed certified by the department as CPR programs may offer further specialized treatment for co-occurring psychiatric and substance use disorders and shall use the *Integrated Treatment for Co-Occurring Disorders: The Evidence* resource KIT published in 2010 by the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Publication No. SMA-08-4366, Rockville, MD 20009. This publication may be downloaded at <https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>. The resource KIT incorporated by reference with this rulemaking does not include any later amendments or additions.

(3) The agency shall have policies approved by the governing body as defined in 9 CSR 10-7.090 that are consistent with the provision of effective evidence-based interventions to guide the co-occurring services and be consistent with the ITCD model of treatment.



(4) Admission Criteria. Persons meeting criteria for ITCD must meet admission criteria as defined in 9 CSR 30-4.005 and must have a co-occurring substance use disorder.

(A) Individuals shall receive screening for both mental health and substance use disorders.

(B) If individuals present with both mental health and substance use identified service needs, the individuals shall receive an integrated assessment identifying service needs as well as stage of readiness for change.

(5) Personnel and Staff Development. ITCD shall be delivered by a multidisciplinary team responsible for coordinating a comprehensive array of services available to the individual through CPR with the amount and frequency of service commensurate with the individual's assessed need.

(A) The multidisciplinary team shall include but is not limited to the following:

1. A physician/physician extender (physician extender includes licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist, and advanced practice registered nurse (APRN);

2. A registered professional nurse (RN);

3. A qualified mental health professional (QMHP);

4. Additional staff sufficient to provide community support and retain the responsibility for acquisition of appropriate housing and employment services;

5. A qualified co-occurring disorders specialist is defined as a person who demonstrates substantial knowledge and skill regarding substance use disorders by being one (1) of the following:

A. A physician or QMHP in Missouri or an individual who meets the applicable training and credentialing required by the Missouri Credentialing Board for any of the following accreditations (Qualified Addiction Professional):

(I) Certified Alcohol and Drug Counselor (CADC);

(II) Certified Reciprocal Alcohol and Drug Counselor (CRADC);

(III) Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC);

(IV) Certified Criminal Justice Addictions Professional (CCJP);

(V) Registered Alcohol Drug Counselor-Provisional (RADCP);

(VI) Registered Alcohol Drug Counselor (RADC);

(VII) Co-Occurring Disorders Professional (CCDP); or

(VIII) Co-Occurring Disorders Professional-Diplomat (CCDP-D); and

B. The QMHP or QAP shall also have

one (1) year of training or supervised experience in substance use disorder treatment. If they have less than one (1) year of experience in providing co-occurring disorder treatment, they shall be actively acquiring twenty-four (24) hours of training in co-occurring disorders content and receive supervision from experienced co-occurring disorders staff as approved by the department.

(B) The multidisciplinary treatment team shall meet regularly to discuss each individual's progress and goals and provide insights and advice to one another.

(C) Multidisciplinary team members shall receive ongoing training in ITCD and have a training plan that addresses specific ITCD criteria, including co-occurring disorders, motivational interviewing, stage-wise treatment, cognitive behavioral interventions, and substance use disorders treatment.

(D) The number of integrated treatment teams is determined by the needs and number of individuals being supported.

(E) Only qualified staff shall provide integrated treatment for co-occurring disorder services. Qualified staff for each service are—

1. Individual counseling, group counseling, and assessment, a QMHP, or a QAP who meets the co-occurring counselor competency requirements established by the department; and

2. Group psychosocial rehabilitation services, eligible providers shall have documented education and experience related to the topic presented and either be, or be supervised by, a QMHP or QAP who meets co-occurring counselor competency requirements established by the department.

(6) Treatment.

(A) ITCD shall be delivered according to the ITCD model and criteria specified by the department. Services are time unlimited with the intensity modified according to level of need and degree of recovery; include outreach efforts and interventions to promote physical health, especially related to substance use; and target specific services to individuals who do not respond to treatment.

(B) In addition to eligible CPR services, integrated treatment for co-occurring disorder services include the following:

1. Co-occurring individual counseling. A structured goal-oriented therapeutic process in which an individual interacts with a counselor in accordance with the individual's treatment plan in order to resolve problems related to the individual's documented mental and substance use disorders that interfere with functioning. Individual co-occurring counseling involves the

use of practices such as motivational interviewing, cognitive behavioral therapy, harm reduction, and relapse prevention. Individual co-occurring counseling may include interaction with one (1) or more members of the individual's family or other natural supports for the purpose of assessment or supporting the individual's recovery;

2. Co-occurring group counseling. Goal-oriented therapeutic interaction among a counselor and two (2) or more individuals as specified in individual treatment plans designed to promote individual self-understanding, self-esteem, and resolution of personal problems related to the individual's documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. Group size shall not exceed ten (10) individuals;

3. Co-occurring group psychosocial rehabilitation services. Informational and experiential services designed to assist individuals, family members, and others identified by the individual as a primary natural support, in the management of the substance use and mental health disorders. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and substance use disorders. This includes integrating affective and cognitive aspects in order to enable the individuals receiving services, family members, and other natural supports to cope with the illness and understand the importance of their individual plan of care. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms, understanding of the precursors to crisis, crisis planning, community resources, recovery management, and medication action, interaction, and side effects. Group size shall not exceed twenty (20) individuals;

4. Co-occurring assessment supplement. Individuals who present with both substance use and mental health identified service needs must receive additional assessments to document the co-occurring disorders and assess the interaction of the co-occurring disorders over time;

5. The agency shall arrange for referrals for withdrawal management/detoxification or hospitalization services when appropriate;

6. The agency shall provide housing and vocational services consistent with the ITCD model; and

7. Other services as appropriate.

(C) Staff shall help individuals in the engagement and persuasion stages recognize the consequences of their substance use, resolve ambivalence related to their addiction,



and introduce them to self-help principles. Individuals in the active treatment or relapse prevention stage shall receive co-occurring individual and/or group counseling and be assisted in connecting with self-help programs in the community.

(D) Families and other natural supports shall receive education and, as appropriate, be involved in counseling.

(7) Records.

(A) An integrated treatment plan shall be developed by the multi-disciplinary team, including input from the integrated treatment specialist, and shall include participation of the individual receiving services.

(B) The treatment plan shall address mental health and substance use disorder treatment strategies that involve building both skills and supports for recovery.

(C) Interventions shall be consistent with, and determined by, the individual's identified stage of treatment.

(8) Performance Improvement. The agency's performance improvement plan shall include monitoring its compliance with the ITCD program model and identifying and measuring satisfaction and outcomes of individuals served. Fidelity improvement shall be included as part of the agency's overall performance improvement efforts.

(9) The team shall participate in fidelity reviews and fidelity improvement activities conducted by the department.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Sept. 2, 2008, effective April 30, 2009. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*

9 CSR 30-4.0432 Assertive Community Treatment (ACT) in Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets forth standards and regulations for the provision of ACT services in community psychiatric rehabilitation programs for adults.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This

material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Assertive Community Treatment (ACT) is a transdisciplinary team model used to deliver comprehensive and flexible treatment, support, and services to adults or transition-age youth who have the most severe symptoms of a serious mental illness or severe emotional disturbance and who have the greatest difficulty with basic daily activities.

(2) Organizations certified or deemed certified as Community Psychiatric Rehabilitation (CPR) providers by the department may offer ACT services and shall use the *Assertive Community Treatment: How to Use the Evidence-Based Practice KIT* published in 2008 by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Publication No. SMA-08-4344, Rockville, MD 20008. This publication may be downloaded at <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4345>. Agencies shall also use *A Manual for ACT Start-Up* by Deborah J. Allness, M.S.S.W. and William H. Knoedler, M.D., published in 2003 by National Alliance for the Mentally Ill (NAMI), 3803 N. Fairfax Drive, Suite 100, Arlington, VA 22203, (703) 524-7600. The documents incorporated by reference with this rule do not include any later amendments or additions.

(3) Agencies providing ACT services shall comply with requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.010 through 9 CSR 10-7.140.

(4) The agencies providing ACT services shall have policies approved by the governing body as defined in 9 CSR 10-7.090 that are consistent with the provision of effective evidence based interventions to guide the ACT services and be consistent with the ACT model of treatment.

(5) Personnel and Staff Development. ACT shall be delivered by a transdisciplinary team (team) responsible for coordinating a comprehensive array of services. The team shall

include, but is not limited to, the following disciplines:

(A) The team shall have adequate prescribing capacity by meeting one (1) of the following:

1. A psychiatrist, physician assistant, psychiatric resident, or an advanced practice nurse who shall be available sixteen (16) hours per week to no more than fifty (50) individuals to assure adequate direct psychiatric treatment;

2. A combination of a psychiatrist, physician assistant, psychiatric resident, and an advanced practice nurse equaling sixteen (16) hours per week shall be available to no more than fifty (50) individuals; or

3. In a service area designated as a Mental Health Professional Shortage Area, the psychiatrist, physician assistant, or psychiatric resident shall be available ten (10) hours per week to no more than fifty (50) individuals; or an advanced practice nurse shall be available sixteen (16) hours per week to no more than fifty (50) individuals;

(B) The ACT team prescriber shall attend at least two (2) team meetings per week either face-to-face or by teleconference;

(C) A registered nurse with six (6) months of psychiatric nursing experience who shall work with no more than fifty (50) individuals on a full-time basis;

(D) A team leader who is a licensed or provisionally licensed qualified mental health professional (QMHP) as defined in 9 CSR 10-7.140 that is full time with one (1) year of supervisory experience and a minimum of two (2) years experience working with adults and/or transition-age youth with a serious mental illness or severe emotional disturbance in community settings;

(E) The team shall have adequate substance use disorder treatment capacity by meeting one (1) of the following:

1. A co-occurring disorder specialist who is a qualified addiction professional (QAP) as defined in 9 CSR 10-7.140 with one (1) year of training or supervised experience in substance use disorder treatment shall be assigned to no more than fifty (50) individuals; or

2. A QAP who has less than one (1) year of experience in integrated treatment for co-occurring disorders shall be actively acquiring twenty-four (24) hours of training in that area and shall receive supervision from staff with experience in integrated treatment for co-occurring disorders;

(F) The team shall have adequate employment and education specialization capacity by meeting one (1) of the following:

1. An employment and education specialist who qualifies as a community support



specialist as defined in 9 CSR 10-7.140 with one (1) year of experience and training in supported employment shall be available to no more than fifty (50) individuals; or

2. If the employment and education specialist is not assigned to a team full-time or is assigned to a team with less than fifty (50) individuals, the employment and education specialist shall attend at least two (2) team meetings per week;

(G) The team shall include a peer specialist who is self-identified as currently or formerly receiving mental health services; is assigned full-time to a team and participates in the clinical responsibilities and functions of the team in providing direct services; and serves as a model, a support, and a resource for the team members and individuals being served. Peer specialists, at a minimum, shall meet the qualifications of a Certified Peer Specialist as defined in 9 CSR 10-7.140;

(H) The team shall include a program assistant. The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including, but not limited to, the following:

1. Managing medical records;
2. Operating and coordinating the management information system; and
3. Triage telephone calls and coordinating communication between the team and individuals receiving ACT services;

(I) Other team members may be assigned to work exclusively with the team and must qualify as a community support specialist or a qualified mental health professional as defined in 9 CSR 10-7.140; and

(J) In addition to training required in 9 CSR 30-4.034, team members shall receive ongoing training relevant to ACT services.

(6) Team Operations.

(A) The team shall function as the primary provider of services for the purpose of recovery from serious mental illness or severe emotional disturbance and/or substance use disorders and shall have responsibility to help adults or transition-age youth meet their needs in all aspects of living in the community.

(B) The team shall meet face-to-face at least five (5) times per week to review the status of each individual via the daily communication log, staff report, services, and contacts scheduled per treatment plans and triage.

(C) The team members shall be available to one another throughout the day to provide consultation or assistance.

(D) The ACT specialists shall cross-train

their teammates to help each member develop knowledge and skills for each specialty area.

(7) Eligibility Criteria. Adults or transition-age youth who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive behavioral health services. Individuals shall have at least one (1) of the diagnoses as specified by the department, meet one (1) or more of the conditions specified in this rule, and meet all other CPR admission criteria as defined in 9 CSR 30-4.005.

(A) The diagnosis may coexist with other psychiatric diagnoses.

(B) For adults or transition-age youth exhibiting extraordinary clinical needs, the team may apply to the department to approve admission to ACT services.

(C) Individuals must meet one (1) or more of the following conditions to receive ACT services:

1. Recent discharge from an extended stay of three (3) months or more in a state hospital for an adult or an extended stay in a residential facility for transition-age youth (ages 16-25);
2. High utilization of two (2) admissions or more per year in an acute psychiatric hospital and/or six (6) or more per year for psychiatric emergency services;
3. Have a co-occurring substance use disorder greater than six (6) months duration;
4. Exhibit socially disruptive behavior with high risk of involvement in the justice system including arrest and incarceration;
5. Reside in substandard housing, is homeless, or at imminent risk of becoming homeless;
6. Experience the symptoms of an initial episode of psychosis within the past two (2) years (hallucinations, delusions or false beliefs, confused thinking, or other cognitive difficulties) leading to a significant decrease in overall functioning; or
7. Other indications demonstrating that the adult or transition-age youth has difficulty thriving in the community.

(8) Admission Process.

(A) The team shall develop a process for identifying adults or transition-age youth who are appropriate for ACT services.

(B) When the team receives a referral for ACT services, the team leader shall confirm the individual meets the ACT eligibility criteria.

(C) The team leader shall arrange an admission meeting that includes current providers of services, the team leader, and the individual. The meeting may also include,

but is not limited to, the following:

1. Family members, significant others, natural supports or guardians, if the individual grants permission;

2. Team members who will be working with the newly enrolled individual; and/or

3. The team psychiatrist.

(D) At the admission meeting, team members shall introduce themselves and explain the ACT program.

(E) When the individual decides he or she accepts ACT services, the team shall immediately open a record and schedule initial service contacts with the individual for the next few days.

(F) An initial assessment shall be completed on the day of admission. The initial assessment shall be based on information obtained from the individual, referring treatment provider, and family/natural supports or other supporters who participate in the admission process and shall include, but not be limited to, the following:

1. The individual's mental and functional status;
2. The effectiveness of past treatment; and
3. The current treatment, rehabilitation, and support service needs.

(G) The initial treatment plan shall be completed on the day of admission, include initial needs and interventions, be used to support recovery, and be used by the team as a guide until the comprehensive assessment and treatment plans are completed.

(H) The team shall ensure the individual receiving services participates in the development of the treatment plan and signs the plan. The individual's parent/legal guardian also participates and signs the plan. The individual's signature is not required if signing would be detrimental to the individual's well-being. If the individual does not sign the treatment plan, the team shall insert a progress note in the case record explaining the reason the individual did not sign the treatment plan.

(I) The team's physician/physician extender shall approve the treatment plan. A licensed psychologist, as a team member, may approve the treatment plan only in instances when the individual is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications.

(9) Comprehensive Assessment and Treatment Planning.

(A) To be in compliance with this standard, the team shall follow a systematic process including admission, comprehensive and ongoing assessment, and continuous



treatment planning utilizing the assessment and treatment planning protocol and components included in the publication, *A Manual for ACT Start-Up* and in the fidelity protocol specified by the department.

(B) The team shall conduct the comprehensive ACT assessment as they are working with the individual in the community delivering services outlined in the initial treatment plan.

(C) The comprehensive ACT assessment provides a guide for the team to collect information including the individual's history, including trauma history, past treatment, and to become acquainted with the individual and their family members. This assessment enables the team to individualize and tailor ACT services to ensure courteous, helpful, and respectful treatment. The comprehensive assessment includes, but is not limited to:

1. Psychiatric history, mental status, and diagnosis;
 2. Physical health;
 3. Use of drugs and/or alcohol;
 4. Education and employment;
 5. Social development and functioning;
 6. Activities of daily living;
 7. Family structure and relationships;
- and
8. Functional assessment approved by the department.

(D) Team members, with supervision from the team leader, shall complete their respective sections of the comprehensive assessment within thirty (30) days of admission.

(E) The assessment is ongoing throughout the course of ACT treatment and consists of information and understanding obtained through day-to-day interactions with the individual, the team, and others, such as landlords, employers, family, friends, and others in the community.

(F) The comprehensive assessment is a daily and ongoing process that is continuously updated and documented as information changes or is received.

(G) Treatment plans shall be developed utilizing information obtained from the comprehensive assessment.

(H) Treatment plans shall contain objective goals based on the individual's preferences and shall be person-specific.

(I) Treatment plans shall contain specific interventions and services that will be provided, by whom, for what duration, and location of the service.

(J) The comprehensive treatment plan shall be developed within forty-five (45) days of admission.

(K) The treatment plan shall be revised or re-written every six (6) months.

(10) Service Provision.

(A) ACT services shall be delivered seven (7) days per week, including evenings and holidays based upon individual needs.

(B) At least two (2) hours of direct ACT services shall be available on each day of the weekend and on holidays.

(C) A team member shall be on call twenty-four (24) hours per day, seven (7) days per week.

(D) The team shall be available to individuals on an ACT team who are in crisis twenty-four (24) hours a day, seven (7) days a week. The team is the first-line crisis evaluator and responder. If another crisis responder screens calls, there is minimal triage. When the team is contacted, the team shall determine the need for team intervention and whether that be by telephone or face-to-face, with back-up by the team leader and ACT team prescriber.

(E) Individualized, practical crisis prevention plans shall be available to staff who are on call.

(F) Individuals shall be offered services on a time unlimited basis, with less than ten percent (10%) dropping out annually, excluding those who graduate from services.

(G) The team shall provide goal driven services for all individuals enrolled in ACT including, but not limited to:

1. Psychopharmacologic treatment;
 2. Nursing;
 3. Integrated treatment for co-occurring disorders;
 4. Supported employment and education;
 5. Peer support;
 6. Crisis intervention;
 7. Psychiatric rehabilitation and skills training to improve functioning;
 8. Wellness management and recovery;
 9. Empirically supported psychotherapy;
- and
10. Supportive housing.

(H) The team shall have a process to manage emergency funds for individuals served.

(I) The ratio for clinical staff to individuals served, excluding the psychiatrist, shall be no more than one to ten (1:10).

(J) The ratio for clinical staff to individuals served shall be no more than one to thirteen (1:13) if the team continues to demonstrate outcomes in areas such as employment, housing, and hospitalizations comparable to teams with lower caseloads.

(K) The clinical team shall be of sufficient, absolute size to consistently provide necessary staffing diversity and coverage, based on team caseload size.

(L) At a minimum, individuals shall be contacted face-to-face by the team an average

of two (2) hours per week.

(M) For individuals who refuse services, the team shall attempt to engage individuals with at least two (2) face-to-face contacts per month for a minimum of six (6) months.

(N) Individuals who are experiencing severe, emergent, or acute symptoms shall be contacted multiple times daily by the team.

(O) At a minimum, seventy-five percent (75%) of team contacts shall occur out of the office.

(P) Individuals shall have direct contact with more than two (2) team members per month.

(Q) Individuals with co-occurring disorders shall be provided integrated mental health and substance use disorder treatment.

(R) The team shall monitor and, when needed, provide supervision, education, and support in the administration of psychiatric medications for all individuals.

(S) The team shall monitor symptom response and medication side-effects.

(T) The team shall educate individuals and families about symptom management and early identification of symptoms.

(U) The team shall have an average of one (1) or more contacts per month with family and support systems in the community, including landlords and employers, after obtaining the individual's permission.

(V) The team shall actively and assertively engage and reach out to family members, natural supports, and significant others to include, but not be limited to, the following:

1. Establishing ongoing communication and collaboration between the team, family members/natural supports, and others;
2. Educating the family/natural supports about mental illness or severe emotional disturbance and/or substance use disorder and the family's role in treatment;
3. Educating the family/natural supports about symptoms management and early identification of symptoms indicating onset of illness; and
4. Providing interventions to promote positive interpersonal relationships.

(W) At a minimum, the team supports, facilitates, or ensures the individual's access to the following services:

1. Medical and dental services;
2. Social services;
3. Transportation; and
4. Legal advocacy.

(X) Inpatient admissions shall be jointly planned with the team and the team, at a minimum, shall make weekly contact with individuals while hospitalized.

(Y) The team shall coordinate discharge planning in cooperation with hospital staff.



(11) Transition to Less Intensive Services.

(A) The team shall conduct regular assessment of the need for ACT services.

(B) The team shall use explicit criteria or markers for the need to transfer to a less intensive service option.

(C) Transition shall be gradual and individualized, with assured continuity of care.

(D) The team shall monitor the individual's status following transition based on individual need.

(E) There shall be an option to return to the team, as needed.

(F) A transition plan shall be developed incorporating graduated step down in intensity and including overlapping team meetings as needed to facilitate the transition of the individual.

(G) The individual shall be engaged in the next step of treatment and rehabilitation.

(H) Documentation of transition to less intensive services shall include a systematic plan to maintain continuity of treatment at appropriate levels of intensity to support the individual's continued recovery and have easy access to return to the ACT team if needed.

(I) A discharge summary shall include, but is not limited to, the following:

1. Dates of admission and transition to less intensive services;
2. Reason for admission and referral source;
3. Diagnosis or diagnostic impression;
4. Description of services provided and outcomes achieved, including any prescribed medication, dosage, and response;
5. Reason for or type of transition or discharge from the team; and
6. Medical status and needs that may require ongoing monitoring and support.

(J) An aftercare plan shall be completed prior to transition to less intensive services or discharge from the team. The plan shall identify services, designated provider(s), or other planned activities designed to promote further recovery.

(12) Records.

(A) The ACT provider shall implement policies and procedures to assure routine monitoring of individual records for compliance with applicable standards.

(B) All staff contacts with individuals shall be documented and easily accessible to team members.

(C) Each individual's record shall document services, activities, or sessions that involve the individual including—

1. The specific services rendered;
2. The date and actual time the service was rendered;
3. The name of the team member who

rendered the service;

4. The setting in which the services were rendered;

5. The amount of time it took to deliver the services;

6. The relationship of the services to the treatment regimen described in the treatment plan; and

7. Updates describing the individual's response to prescribed care and treatment.

(D) In addition to documentation required under subsection (12)(C), for medication services, the ACT provider shall provide additional documentation for each service episode, unit, or as clinically indicated, for each service provided to the individual as follows:

1. Description of the individual's presenting condition;
2. Pertinent medical and psychiatric findings;
3. Observations and conclusions;
4. Individual's response to medication, including identifying and tracking over time one (1) or more target symptoms for each medication prescribed;
5. Actions and recommendations regarding the individual's ongoing medication regimen; and
6. Pertinent/significant information reported by family members, natural supports, or significant others regarding a change in the individual's condition, an unusual or unexpected occurrence in the individual's life, or both.

(E) The ACT team shall update the department-approved functional assessment every ninety (90) days to assess individual functioning, progress toward treatment objectives, and appropriateness of continued services. The treatment plan shall be revised and updated based on the findings from the functional assessment. Documentation in the individual record shall include, but is not limited to:

1. Barriers, issues, or problems identified by the individual, family, guardian, and/or team that identify the need for focused services;
2. A brief explanation of any change or progress in the daily living functional abilities in the prior ninety (90) days; and
3. A description of the changes for the plan of treatment based on information obtained from the functional assessment.

(F) The ACT program also shall include other information in the individual record, if not otherwise addressed in the intake/annual evaluation or treatment plan, including—

1. The individual's medical history, including—
 - A. Medical screening or relevant

results of physical examinations; and

B. Diagnosis, physical disorders, and therapeutic orders;

2. Evidence of informed consent;

3. Results of prior treatment; and

4. Condition at discharge from prior treatment.

(G) Any authorized person making any entry in an individual's record shall sign and date the entry, including corrections to information previously entered in the individual's record.

(H) The ACT program shall implement written procedures to ensure exchange of information within five (5) working days when an individual is referred or transfers to another service component within the organization or to an outside entity for services.

(I) The ACT provider shall provide information, as requested, regarding individual characteristics, services, and costs to the department in a format established by the department.

(13) Performance Improvement. The agency's performance improvement plan shall include monitoring compliance with the ACT standards.

(A) Records shall show evidence that the team monitors hospitalization, housing, employment/education, substance use, and contact with the justice system for all individuals using a tracking form approved by the department and submitted to the department on a quarterly basis.

(B) The agency shall include fidelity improvement as part of its overall performance improvement efforts.

(C) The team shall participate in fidelity reviews and fidelity improvement activities conducted by the department.

(D) Team members or a designee(s) shall meet with the department and stakeholder groups and collaborate as needed.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Original rule filed Aug. 14, 2009, effective March 30, 2010. Amended: Filed April 29, 2019, effective Nov. 30, 2019.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*

9 CSR 30-4.044 Behavior Management
(Rescinded October 30, 2001)

AUTHORITY: section 630.655, RSMo 1994. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Rescinded:



Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.045 Intensive Community Psychiatric Rehabilitation (ICPR)

PURPOSE: This rule sets forth standards and regulations for the provision of ICPR services.

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

(1) Intensive Community Psychiatric Rehabilitation (ICPR). ICPR is separate and distinct from other community psychiatric rehabilitation (CPR) services. The individual treatment plan shall specify interventions and supports to be provided by ICPR staff that are separate from other CPR services (such as community support) to prevent duplication of services.

(A) Services are designed to help individuals who are experiencing a severe psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient setting or a restrictive living setting. ICPR is a comprehensive, time-limited, community-based service for individuals who are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.

(B) ICPR in all settings (children/youth and adult) must be approved by the department prior to implementation. Written proposals shall be submitted to the department and must include the following:

1. The proposed service, setting, and timeline for implementation;
2. Method for determining eligibility for the service;
3. Staffing patterns/staff qualifications, including identification of the qualified mental health professional (QMHP) who supervises the ICPR setting;
4. Evidence that the site(s) is safe;
5. Process for obtaining multidisciplinary input into treatment plans;
6. Type of documentation to be used;
7. Strategy for preventing the duplication of services and supports delivered by residential and community-based CPR staff;
8. Plan for financial separation of room and board from services; and

9. Plan for providing personal spending funds to individuals served.

(C) ICPR is intended for—

1. Persons who would be hospitalized without the provision of intensive community-based intervention;
2. Persons who have extended or repeated hospitalizations;
3. Persons who have psychiatric crisis episodes;
4. Persons who are at risk of being removed from their home or school to a more restrictive environment; and
5. Persons who require assistance in transitioning from a highly restrictive setting to a community-based alternative, including specifically persons being discharged from inpatient psychiatric settings who need intensive CPR services and may require assertive outreach and engagement.

(D) Treatment teams deliver services that will maintain the individual within the family and significant support systems and assist them in meeting basic living needs and age appropriate developmental needs.

(2) Admission Criteria. To be eligible for ICPR, the individual must meet admission criteria as defined in 9 CSR 30-4.005 and at least one (1) of the following criteria:

- (A) Is being discharged from a department facility or bed funded by the department;
- (B) Has had extended or repeated psychiatric inpatient hospitalizations or crisis episodes within the past six (6) months;
- (C) Has received services in multiple out-of-home residential settings due to their mental disorder; or
- (D) Is at risk of being removed from their home, school, or other community living situation.

(3) Staff Requirements. Staff requirements for ICPR in residential settings are as follows:

- (A) Intensive Residential Treatment Settings (IRTS) and Psychiatric Individualized Supported Living (PISL), in accordance with 9 CSR 40-1 and 9 CSR 40-4.001;
- (B) Clustered apartments (CA). Staff shall be available on a full- or part-time basis in accordance with the agency's written proposal approved by the department;

1. Clustered apartment services are provided on-site at the individual's place of residence. Staff providing services shall be located on site, within a five (5) mile radius of the CA, or within a ten (10) minute drive of the CA.

(C) Treatment Family Home-Based Services and Professional Parent Home-Based Services, as specified in section (7) of this rule and 9 CSR 40-6.001.

(4) Treatment for Children/Youth and Adults. All treatment teams shall be supervised by a qualified mental health professional (QMHP). The team coordinates a comprehensive array of services available to the individual through the CPR program as specified in 9 CSR 30-4.043. Other services shall be provided as clinically appropriate to meet individual needs, however, shall not duplicate services being provided on site. Each team shall include:

(A) Staff required to provide specific services identified on the individualized treatment plan;

(B) The individual receiving services and family members or other natural supports, if developmentally appropriate;

(C) ICPR shall include:

1. Multiple face-to-face contacts with the individual on a weekly basis, and may require contact on a daily basis, as required for each service type;

2. Services that are available twenty-four (24) hours per day, seven (7) days per week for programs that require daily services; and

3. Crisis response services that may be coordinated with an existing crisis system;

(D) The amount and frequency of services is based upon the individual's assessed acuity and need;

(E) A crisis prevention plan shall be developed for each individual, including clinical issues that may impact transition to less intensive services;

(F) At a minimum, quarterly treatment plan reviews shall occur to ensure individuals are receiving the appropriate level of services to meet needs and goals; and

(G) Individuals no longer need ICPR when—

1. There is a reduction of severe symptoms; and
2. They are able to function without intensive services; or
3. They choose to no longer receive intensive services.

(5) Documentation Requirements. ICPR services must be documented in accordance with 9 CSR 10-7.030(13), and as specified in this rule.

(A) For individuals currently enrolled in the CPR program, the following documentation is required upon admission to ICPR:

1. Verification they meet admission criteria;
2. Acuity level; and
3. Treatment plan update indicating the higher level of service the individual will be receiving.



(B) For individuals newly admitted directly from the community into ICPR, an intake evaluation must be completed to substantiate acuity and criteria for admission.

1. Each individual shall have a psychiatric evaluation at admission. For individuals discharged from inpatient hospitalization into ICPR, a psychiatric evaluation completed at the facility/hospital may be initially accepted.

2. The comprehensive assessment must be completed within thirty (30) days of admission except for individuals admitted provisionally.

3. Treatment plans shall be developed upon admission and be updated at least quarterly, or more frequently if clinically indicated.

(C) Treatment plans shall be reviewed as required for each service type and documented in the individual record with a summary progress note, including updates to the treatment plan as appropriate.

(D) Upon change from ICPR services, a transition summary must be completed by a QMHP and included in an updated treatment plan.

(6) ICPR for Children and Youth. Services are medically necessary to maintain a child with a Serious Emotional Disturbance (SED) in their natural home, or maintain a child with a serious mental illness or SED in a community setting who has a history of failure in multiple community settings, and/or the presence of ongoing risk of harm to self or others, which would otherwise require long-term psychiatric hospitalization. Clinical interventions are provided by a multidisciplinary treatment team on a daily basis, and the interventions must be available twenty-four (24) hours per day, seven (7) days per week for stabilization purposes. The child's family and other natural supports may receive services when they are for the direct benefit of the child in accordance with their individual treatment plan.

(A) When a child/youth is receiving this service, it is vital that the parent/guardian be actively involved in the program if the individual is to receive the full benefit of the program. Services shall be provided to the child/youth's family and other natural supports when such services are for the direct benefit of the individual, in accordance with their needs and treatment goals identified in the treatment plan, and for assisting in their recovery.

(B) Services shall include, but are not limited to:

1. Medication administration/management of medication;
2. Ongoing behavioral health assessment

and diagnosis;

3. Monitoring to assure individual safety;

4. Individual and group counseling; and

5. Community support.

(C) The ICPR multidisciplinary team shall include the following staff, based on the needs of the individual served:

1. Physician, psychiatrist, child psychiatrist, psychiatric resident, assistant physician, physician assistant, or Advanced Practice Registered Nurse (APRN);

2. QMHP;

3. RN;

4. LPN;

5. Community Support Specialist; and

6. Individuals with a high school diploma, or equivalent certificate, under the direction and supervision of a QMHP.

(D) Services are limited to ninety (90) days. Exceptions may be granted by the department and must be documented in the individual record.

(7) ICPR for Children/Youth in Residential Settings (Treatment Family Home-Based Services and Professional Parent Home-Based Services). Intensive therapeutic interventions are provided to improve the child's functioning and prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting due to a SED.

(A) Services are for children whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting.

(B) Providers must complete extensive, specialized training required by the department and meet department licensure requirements as specified in 9 CSR 40-6.

(C) The provider shall participate in placement and ongoing meetings with the child's CPR treatment team and assist in development of the treatment plan. The provider is responsible for implementing the treatment plan and maintaining contact with the child's natural parent/guardian and completing documentation as required by the department.

(D) Services and supports are individualized and strength-based to meet the needs of the child and family across life domains to promote success, safety, and permanence in the home, school, and community. Therapeutic interventions target the child's serious mental health issues and promote positive development and healthy family functioning.

(E) Children must meet CPR admission criteria and their behavior must be sufficiently under control to live safely in a community setting with appropriate support.

(F) Staff of the CPR program who supervise the child's services must be available twenty-four (24) hours a day, seven (7) days per week to assist the provider if a crisis situation occurs.

(G) Placement, duration, and intensity of services is based on the specific needs of each child as specified in the MO HealthNet *CPR Provider Manual*, hereby incorporated by reference and made a part of this rule and available from the Department of Social Services, 615 Howerton Court, PO Box 6500, Jefferson City, MO 65102-6500, and as specified in the department contract, September 2019. This rule does not incorporate any subsequent amendments or additions to this publication.

(H) A maximum of three (3) children may receive services in a Treatment Family Home (TFH), subject to licensed capacity. One (1) child may be served in a Professional Parent Home (PPH).

(8) Evidence-Based Practices (EBP) for Youth. Services involve proven treatment supports for children and youth to address specific behavioral health needs. The selected EBP is based on individual needs and desired outcomes as identified in the treatment plan.

(A) The EBP must be approved by the department.

(B) Activities associated with the service must include, but are not limited to:

1. Extensive monitoring and data collection;
2. Specific skills-training in a prescribed or natural environment; and
3. Prescriptive responses to a psychiatric crisis and/or frequent contact with the individual and/or family, in addition to the arranged therapy sessions.

(9) ICPR for Adults in Non-Residential Settings. Services are delivered by teams using one (1) of the following methods:

(A) Linking and transitioning individuals from acute or long-term services to less intensive treatment. The time frame for services is approximately ninety (90) days or less, but varies according to individual needs;

(B) Modified Assertive Community Treatment (ACT), as approved by the department. The time frame varies based on individual needs; or

(C) Intensive wrap-around stabilization services for individuals with substantial mental health needs who may otherwise require inpatient hospitalization. The expected period of engagement is approximately ninety (90) days or less, but varies according to individual needs.

(D) Teams may be designated exclusively



for individuals in ICPR or be mixed teams serving individuals in ICPR and rehabilitation services.

(E) A department-approved functional assessment must be completed monthly and documented in the individual record.

(F) Community support services shall not be provided while an individual is receiving ICPR non-residential services.

(10) ICPR for Transition Age Youth in Non-Residential Settings. Services are delivered by transdisciplinary specialty teams using intensive wrap-around stabilization for individuals with substantial mental health and/or co-occurring needs, with the primary diagnosis being a mental disorder.

(A) Services are for individuals who may otherwise require inpatient hospitalization. The period of engagement varies based upon individual needs as specified in the treatment plan.

(B) An initial comprehensive assessment must be completed within thirty (30) days of admission.

(C) An individual treatment plan shall be developed within forty-five (45) days of admission and shall be updated as required by the department.

(11) ICPR for Adults in Residential Settings (IRTS, PISL, Clustered Apartments). Medically necessary services/supports are provided to adults who have a serious mental illness and are transitioning from an inpatient psychiatric hospital to the community, or who are at risk of returning to inpatient care due to their clinical status or need for increased support. Services and supports are provided on site where the individual lives under the supervision of a QMHP. Residential settings are structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services.

(A) Staff providing services/supports must be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalent certificate. Two (2) years of direct health care experience, or a bachelor's degree in behavioral sciences, is preferred.

(B) Staff must be systematically trained to provide intensive interventions and supports to reduce the symptoms of mental illness, and provide de-escalation and intervention techniques to individuals in a psychiatric crisis who are exhibiting behaviors potentially dangerous to themselves or others. A training plan must be in place for each staff person identifying specific topics and frequency of refresher training on each topic, including documentation of course completion.

(C) Support and rehabilitation services

related to activities of daily living and crisis prevention and intervention must be provided.

(D) Documentation must reflect delivery of direct (face-to-face) services and supports such as, daily summary progress notes, group notes, individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, and prompting or reminders.

(12) Children's Inpatient Diversion. A full array of intensive clinical services are provided to children/youth in a highly structured therapeutic setting. Services are designed to restore the child to a prior level of functioning, decrease risk of harm, and prevent transition to a more restrictive setting.

(A) Emergency medical services must be available on site or in close proximity.

(B) A psychiatrist must supervise services which are delivered by a multi-disciplinary treatment team.

(C) Licensed nursing staff must be available on a daily basis.

(D) Licensed occupational and recreational therapists must be available based on individual needs.

(E) The provision of services is limited to certified or deemed-certified CPR programs for children and youth. The service must be accredited by a national accrediting body approved by the department.

(F) There shall be one (1) staff person for every two (2) individuals served during waking hours. The ratio for staff to individuals served may decrease to one (1) staff to six (6) individuals during sleeping hours.

(13) Adult Inpatient Diversion. A full array of intensive clinical services are provided to adults in a highly supervised twenty-four (24) hour, structured therapeutic setting. Services are designed to restore the individual to a prior level of functioning, decrease risk of harm, and prepare for transition to a less restrictive setting.

(A) Emergency medical services must be available on site or in close proximity.

(B) Intensive therapeutic services must be provided in a coordinated effort under the direction of a psychiatrist. Other staff on the treatment team includes licensed nurses, licensed psychologists, social workers, counselors, psychosocial rehabilitation specialists, and other trained supportive staff.

(C) Services shall include, but are not limited to:

1. Nursing;
2. Community support;
3. Psychosocial rehabilitation; and
4. Treatment for co-occurring disorders

and other evidence-based services.

(D) The provision of services is limited to CPR programs for adults. The service must be accredited by a national accrediting body approved by the department.

(E) The staffing ratio for daytime and evening hours shall be one staff to six individuals served (1:6), and one staff to eight individuals served (1:8) during nighttime hours.

AUTHORITY: sections 630.050, 630.655, and 632.050, RSMo 2016. Emergency rule filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Original rule filed Dec. 28, 2001, effective July 12, 2002. Emergency amendment filed June 14, 2010, effective July 1, 2010, expired Feb. 24, 2011. Amended: Filed June 14, 2010, effective Feb. 24, 2011. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*

9 CSR 30-4.046 Psychosocial Rehabilitation (PSR) in Community Psychiatric Rehabilitation Programs

PURPOSE: This rule provides standards for PSR programs operated as part of a community psychiatric rehabilitation (CPR) program.

(1) The Psychosocial Rehabilitation (PSR) program must be accredited by CARF International, The Joint Commission, Council on Accreditation, or other accrediting body recognized by the department. If the PSR program is not accredited, department licensure rules as specified in 9 CSR 40-1 and 9 CSR 40-9 shall apply, as applicable, until accreditation is obtained.

(2) The community psychiatric rehabilitation (CPR) program shall provide or arrange transportation to and from the PSR site, and to/from various locations in the community, to provide individuals with opportunities for off-site training and rehabilitation in realistic settings.

(3) Policies and procedures shall be implemented for intake screening, referral, and assignment of individuals eligible for services.

(A) Intake policies and procedures shall define referral procedures to be followed for persons determined ineligible for PSR services.



(B) The maximum wait time from an individual's initial face-to-face contact with the PSR program to intake screening shall be ten (10) working days, or sooner, if clinically indicated.

(C) The intake screening shall determine the individual's need for PSR, functional strengths and weaknesses, and transportation needs.

(D) PSR services shall be incorporated into the individual's treatment plan within forty-five (45) days of admission to the program.

(4) Policies and procedures shall ensure program staff document measurable progress for individuals engaged in key services.

(A) Key services shall include, but are not limited to—

1. Training/rehabilitation in community living skills;

2. Development of personal support systems through a group modality; and

3. Prevocational training/rehabilitation provided directly by the program or through subcontract, including at a minimum—

A. Interview and job application skills;

B. Therapeutic work opportunities; and

C. Temporary employment opportunities.

(B) Documentation of key services must include—

1. A weekly note summarizing specific services rendered, the individual's involvement in and response to the services, and relationship of the services to the treatment plan;

2. Pertinent information reported by family members or other natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in his or her life; and

3. Daily attendance records, including each individual's actual attendance time and the activity or session attended (this information does not need to be integrated into the individual record). Attendance records must be available to department staff and other authorized representatives for audit and monitoring purposes, upon request.

(5) PSR services shall be structured and may occur during the day, evening, weekend, or a combination of these, to effectively address the rehabilitation needs of individuals served. Services and activities are not limited to the program location/site.

(A) The program shall directly provide or ensure the following services available for individuals served:

1. Opportunities for training and rehabilitation in daily living skills, including activities associated with meal preparation and laundry, at a minimum;

2. Off-site training/rehabilitation in community living skills; and

3. Opportunities for family members/natural supports and advocates to participate in the planning, development, and evaluation of the PSR program.

(6) PSR for Adults. Services are for adults who need age-appropriate, developmentally focused rehabilitation. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to assist individuals in developing personal support systems, social skills, community living skills, and pre-vocational skills that promote community inclusion, integration, and independence.

(A) Key service functions shall include, but are not limited to—

1. Screening to evaluate the appropriateness of the individual's participation in PSR;

2. Addressing individualized program goals and objectives;

3. Enhancing independent living skills;

4. Addressing basic self-care skills; and

5. Enhancing use of personal support systems.

(B) The director of the program must be a Qualified Mental Health Professional (QMHP) with two (2) years of relevant work experience.

(C) All direct care staff must have a high school diploma or equivalent certificate.

(D) Each day program shall have, as a minimum, a daily direct care staff ratio of one (1) staff person for each sixteen (16) individuals served (1:16) unless program needs or the needs of individuals being served require otherwise.

(E) At least one (1) staff person must be on duty at all times when individuals enrolled in PSR are present at the program.

(7) PSR for Children and Youth. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to improve or maintain the child's ability to function as independently as possible within their family and/or in the community. Services are provided according to the individual treatment plan, with an emphasis on community integration, independence, and resiliency. Hours of operation are determined by the program based on capacity, staffing availability, geography, and space requirements, but shall be no more than six (6) hours daily, per child.

(A) The director must be a QMHP with

two (2) years of experience working with children and youth. One (1) full-time mental health professional must be available during the provision of services.

(B) Staffing ratios shall be based on the ages and needs of the children being served. For individuals between the ages of three (3) and eleven (11), the staffing ratio shall be one (1) staff to four (4) participants (1:4). For individuals between the ages of twelve (12) and seventeen (17), the staffing ratio shall be one (1) staff to six (6) participants (1:6).

(C) Other staff of the PSR team shall include the following, based on the needs of individuals served:

1. Registered nurse;

2. Occupational therapist;

3. Recreational therapist;

4. Rehabilitation therapist;

5. Community support specialist;

6. Family support worker; and

7. Certified peer specialist.

(D) Key service functions shall include, but are not limited to:

1. Assisting the child in gaining or regaining skills for community/family living such as personal hygiene, completing age-appropriate household chores, and family, peer, and school activities;

2. Developing interpersonal skills which provide a sense of participation and personal satisfaction (opportunities should be age and culturally appropriate daytime and evening activities which offer the chance for companionship, socialization, and skill building); and

3. Assisting the child and family in developing normative behaviors and expectations of relationships, and providing the opportunity to practice affiliated skills which can be valuable to an individual reestablishing family and personal support relationships.

(E) Group sessions may be provided for parents/guardians to develop and enhance parenting skills. In these situations, the PSR services and expected goals and outcomes must be documented in the child/youth's treatment plan and clearly relate to the treatment and rehabilitation goals of the child or youth.

(8) Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR). Services promote physical and mental wellness, well-being, self-direction, personal empowerment, respect, and responsibility. Services shall be provided in individual and group settings using curriculum approved by the department. Services must be delivered by staff who have completed required training.

(A) The maximum group size shall not exceed eight (8) individuals; however, if there



are other curriculum-based approaches that suggest different group size guidelines, larger groups may be approved by the department.

(B) Services shall be person-centered and strength-based including, but not limited to—

1. Psychoeducation;
2. Relapse prevention; and
3. Coping skills training.

(C) CPR programs must be approved by the department to provide this service.

(D) If a program is accredited by Clubhouse International and submits its accreditation report to the department, it may be deemed as a PSR-IMR program by the department.

(E) Required documentation includes a weekly note summarizing the services rendered and the individual's response to the services, and pertinent information reported by family members or other natural supports regarding a change in the individual's condition, or an unusual/unexpected occurrence in their life, or both.

1. If an individual is participating in PSR-IMR and PSR, a single, weekly summary progress note must clearly address the PSR-IMR and PSR sessions and activities during the week, or two (2) separate summary progress notes must address each type of PSR service provided during the week.

2. Daily attendance records or logs clearly identifying and distinguishing PSR-IMR as the specific type of session/activity, with actual attendance times and description of service, must also be maintained. The attendance records/logs must be available for audit and monitoring purposes, but do not need to be integrated into each clinical record.

AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Dec. 1, 2011, effective June 30, 2012. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-4.047 Community Support in Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets out requirements for community support services provided by a community psychiatric rehabilitation program.

(1) Service Delivery. The community psychi-

atric rehabilitation (CPR) program shall establish an identifiable unit which coordinates and provides community support services for children, youth, families, and/or adults. The unit shall be organized to perform functions within the scope of community support services, including critical interventions.

(2) Policies and Procedures. The CPR program shall implement policies and procedures to provide adequate, appropriate, and effective community support services to individuals. Policies and procedures shall include:

(A) A mechanism to assure the provision of all needed CPR services, as indicated in the individual's current treatment plan;

(B) A mechanism to assure the provision of all needed services in addition to those provided by the CPR program, as indicated in the individual's current treatment plan;

(C) A method for assigning individuals to a community support specialist or team, including:

1. Procedures to assure each individual is afforded an opportunity to express preferences in the selection of a community support specialist; and

2. A mechanism to assure all individuals admitted who need community support are assigned to an active caseload of a community support specialist;

(D) A process to assure an effective transfer and follow-up of an individual between or among community support specialists or community support teams. Staff shall document the rationale for the transfer, the individual's acceptance, and follow-up by the community support specialist in the clinical record;

(E) A process for determining overall increase or decrease in the level of functioning for individuals served through ongoing performance improvement activities;

(F) A method to assure staff providing community support services in the CPR program have the opportunity to participate and contribute to the agency's performance improvement process;

(G) Development of suitable revisions to treatment goal(s) as indicated by growth or deterioration of individual functioning and/or condition; and

(H) Program and aggregate evaluation activities to determine effectiveness of services delivered.

(3) Staff Requirements. The CPR program shall ensure an adequate number of appropriately qualified staff are available to provide community support services and functions.

(A) Qualified staff includes:

1. A qualified addiction professional (QAP) as defined in 9 CSR 10-7.140;

2. A qualified mental health professional (QMHP) as defined in 9 CSR 10-7.140;

3. An individual with a bachelor's degree in a human services field which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science, and rehabilitation counseling;

4. An individual with any four- (4-) year combination of higher education and qualifying experience;

5. An individual with any four- (4-) year degree and two (2) years of qualifying experience;

6. An individual with an Associate of Applied Science in Behavioral Health Support degree from an approved institution; or

7. An individual with four (4) years of qualifying experience.

(B) Qualifying experience must include delivery of services to individuals with mental illness, substance use disorders, or developmental disabilities. Experience must include some combination of the following:

1. Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;

2. Teaching and modeling for individuals how to cope and manage psychiatric, developmental, or substance use disorder issues while encouraging the use of natural resources;

3. Supporting individuals in their efforts to find and maintain employment and/or to function appropriately in family, school, and community settings; and

4. Assisting individuals to achieve the goals and objectives in their individual treatment plan.

(C) It is the responsibility of the CPR program to document how staff meet the qualifications based on the criteria in subsections (3)(A) and (3)(B) of this rule.

(D) Community support specialists must also complete orientation and training required by the department.

(E) Community support specialists must be supervised by—

1. A qualified addiction professional (QAP);

2. A qualified mental health professional (QMHP);

3. Staff possessing a Master's degree in a behavioral health or related field who has completed a practicum or has one (1) year of experience in a behavioral health field; or

4. Staff who meet the qualifications of a community support specialist with at least



three (3) years of population-specific experience providing community support services in accordance with the key service functions specified in paragraphs (5)(B)1. to 8. of this rule.

(F) Community support supervisors who are not a QAP or QMHP must be supervised by a QAP or QMHP.

(4) Monitoring. To the extent the individual is able to participate, periodic observation and monitoring shall take place in his/her home or other community location as stipulated in the individual treatment plan.

(A) Observation and monitoring shall be documented including, but not limited to:

1. Assessment of the individual's mental health status and/or substance use;
2. Safety and home care; and
3. Functional abilities and skill transference related to activities of daily living including educating, demonstrating, observing, and practicing skills in his/her natural environment.

(5) Service Delivery. Community support is a comprehensive service designed to reduce the individual's disability resulting from a mental illness, emotional disorder, and/or substance use disorder and restore functional skills of daily living, principally by developing natural supports and solution-oriented interventions intended to achieve recovery/resiliency as identified in the goals and/or objectives in the individual treatment plan.

(A) This service may be provided to the individual's family/natural supports when such services are for the direct benefit of the individual served, in accordance with needs and goals identified in the treatment plan, to assist in the individual's recovery/resiliency. Most contact occurs in community locations where the individual lives, works, attends school, and/or socializes.

(B) Key service functions of community support shall include, but are not limited to:

1. Developing recovery goals and identifying needs, strengths, skills, resources, and supports and teaching individuals how to use them to support recovery, identifying barriers to recovery, and assisting individuals in the development and implementation of plans to overcome them;

2. Helping individuals restore skills and resources negatively impacted by their substance use disorder and/or co-occurring mental illness or emotional disorder including, but not limited to:

A. Seeking or successfully maintaining employment or volunteering including, but not limited to, communication, personal hygiene and dress, time management, capac-

ity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance;

B. Maintaining success in school including, but not limited to, communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identifying and addressing behaviors that interfere with school performance; and

C. Obtaining and maintaining housing in the least restrictive setting including, but not limited to, issues related to nutrition, meal preparation, and personal responsibility;

3. Supporting and assisting individuals in a crisis to access needed treatment services to resolve the crisis;

4. Continuing recovery planning and discharge planning with individuals who are hospitalized for a medical or behavioral health condition;

5. Assisting individuals, other natural supports, and referral sources in identifying risk factors related to relapse in mental illness and/or substance use disorders, developing strategies to prevent relapse, and advising and otherwise assisting individuals in implementing those strategies;

6. Promoting the development of positive support systems by providing information to family members/natural supports, as appropriate, regarding mental illness, emotional disorders, and/or substance use disorders and ways they can be of support to their family member's recovery. Such activities must be directed toward the primary well-being and benefit of the individual served;

7. Developing and advising individuals on implementing lifestyle changes needed to cope with the side effects of psychotropic medications and/or to promote recovery/resiliency from the disabilities, negative symptoms, and/or functional deficits associated with a mental illness, emotional disorder, and/or substance use disorder; and

8. Advising individuals on maintaining a healthy lifestyle including, but not limited to, recognizing the physical and psychological signs of stress, creating a self-defined daily routine that includes adequate sleep and rest, walking or exercise and appropriate levels of activity and productivity, involvement in creative or structured activities that counteract negative stress responses, learning to assume personal responsibility and care for minor illnesses and knowing when professional medical attention is needed.

(6) Documentation. Documentation must be maintained in the individual record for each community support session, service, or activity in accordance with 9 CSR 10-7.030(13). The following must also be documented:

(A) Phone contacts; and/or

(B) Pertinent/significant information reported by family members/natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in his/her life.

AUTHORITY: section 630.655, RSMo 2016. Original rule filed Jan. 19, 1989, effective April 15, 1989. Amended: Filed Dec. 13, 1994, effective July 30, 1995. Amended: Filed Nov. 10, 2020, effective May 30, 2021.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-4.100 Governing Authority (Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.110 Client Rights (Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.120 Environment (Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.130 Fiscal Management (Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.140 Personnel (Rescinded October 30, 2001)



AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.150 Research
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.160 Client Records
(Rescinded November 30, 2019)

AUTHORITY: sections 630.050 and 630.655, RSMo 2000. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Rescinded: Filed April 29, 2019, effective Nov. 30, 2019.

9 CSR 30-4.170 Referral Procedures
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.180 Medication
(Rescinded October 30, 2001)

AUTHORITY: sections 630.050, RSMo Supp. 1993 and 630.655, RSMo 1986. Original rule filed June 14, 1985, effective Dec. 1, 1985. Rescinded: Filed Feb. 28, 2001, effective Oct. 30, 2001.

9 CSR 30-4.190 Outpatient Mental Health Treatment Programs

PURPOSE: This rule prescribes policies and procedures for outpatient mental health treatment programs.

(1) Each agency that is certified by the department as an outpatient mental health treatment program shall comply with all requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, 9 CSR 10-7.010 through 9 CSR 10-7.140.

(A) The agency shall have written policies and procedures defining eligibility for services, screening, admission, and clinical

assessment to assist in the support of each individual.

(B) The program shall maintain reasonable hours to assure accessibility.

(2) The program shall ensure an intake screening and admission assessment is conducted in accordance with 9 CSR 10-7.030 (1) and (2).

(A) The following services shall be provided on an outpatient basis, in accordance with individual needs:

1. Crisis prevention and intervention;
2. Treatment planning;
3. Individual and group counseling;
4. Continuing recovery planning; and
5. Information and education.

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

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

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

(4) Services shall be provided under the direction of an individual treatment plan as specified in 9 CSR 10-7.030(4).

(A) An initial treatment goal shall be developed at intake to address immediate needs during the admission process to the outpatient treatment program.

(B) The admission assessment and treatment plan shall be completed within the first three (3) outpatient visits.

1. Each individual shall participate in the development of their treatment plan.

2. For children and youth, the parent or guardian must participate in the development of the treatment plan and the child/youth shall participate, as appropriate.

(C) Treatment plans shall be reviewed and updated every ninety (90) days to reflect the individual's progress and changes in treatment goals and services.

(D) Treatment plans must be revised and rewritten at least annually to align with the annual assessment to reflect current needs and goals.

(E) Treatment plans shall be approved by a licensed mental health professional as defined in 9 CSR 30-4.035(2)(A).

(5) Individual and group counseling must be delivered by a licensed mental health profes-

sional.

(6) Each agency shall maintain an organized clinical record system in accordance with 9 CSR 10-7.030(13) which ensures easily retrievable, complete, and usable records stored in a secure and confidential manner.

(A) Each agency shall implement written procedures to assure quality of individual records, including a routine review to ensure documentation requirements are being met.

AUTHORITY: sections 630.050 and 630.655, RSMo 2016. Original rule filed June 14, 1985, effective Dec. 1, 1985. Amended: Filed Feb. 28, 2001, effective Oct. 30, 2001. Amended: Filed April 29, 2019, effective Nov. 30, 2019. Amended: Filed March 9, 2022, effective Sept. 30, 2022.*

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

9 CSR 30-4.195 Access Crisis Intervention (ACI) Programs

PURPOSE: This rule sets forth standards and regulations for ACI Programs.

(1) The ACI program is provided or arranged by administrative agents.

(2) The terms defined in section 630.005, RSMo are used in this rule.

(3) Unless the context clearly requires otherwise, the following terms as used in this rule shall mean—

(A) Access Crisis Intervention (ACI)—crisis intervention/referral services provided twenty-four (24) hours per day, seven (7) days per week by telephone hotline or face-to-face mobile response at the location of the crisis or at another location in the community;

(B) Administrative agent—an agency and its approved designee(s) authorized by the Division of Behavioral Health (DBH) as an entry and exit point into the state mental health service delivery system for a geographic service area defined by the department;

(C) Advocate—individual who assists those receiving department-funded services with treatment planning, care issues, and the complaint/grievance and resolution process;

(D) Community outreach/education plan—a plan outlining how individuals receiving services and their family members/natural supports, advocates, state agencies, law enforcement and others in the community will become familiar with the local Access Crisis Intervention System;



(E) Community Psychiatric Rehabilitation Program—a specialized program that provides or arranges for, at a minimum, the following core services: eligibility determination, initial comprehensive assessment, annual assessment, treatment planning, crisis intervention and resolution, medication services, physician/professional consultation services, medication administration, community support, metabolic syndrome screening (for individuals receiving antipsychotic medication), and psychosocial rehabilitation in a nonresidential setting for individuals with serious mental illness or serious emotional disturbances;

(F) Community support—as defined in 9 CSR 30-4.047;

(G) Crisis Intervention Team (CIT)—law enforcement officers with specialized training for response to behavioral health crisis;

(H) Individual served—anyone receiving department-funded services directly from an organization/agency;

(I) Internal agency protocol—a specific method indicating how the agency plans to respond to guidelines set forth by the department;

(J) Mobile crisis response—specialized staff available twenty-four (24) hours per day, seven (7) days per week to assess and intervene face-to-face with individuals where the crisis is occurring or another secure location in the community;

(K) Qualified Mental Health Professional (QMHP)—as defined in 9 CSR 10-7.140;

(L) Risk assessment—the process of assessing dangerousness to self or others;

(M) Residential crisis services—a service used for persons who are at high risk for hospitalization or who are being diverted from hospitalization and can include specific crisis stabilization units, group homes, residential, apartments, motels/hotels, and foster home type settings;

(N) Specialized program—programs operated by an agency that provide specific services to designated eligible individuals enrolled in that program;

(O) Telephone hotline services—a published, centralized, twenty-four (24) hours per day, seven (7) days per week staffed toll-free telephone number to provide direct means of crisis assessment and triage for individuals in crisis, their families/natural supports, and agencies needing assistance; and

(P) Withdrawal management/detoxification—support provided to persons served during withdrawal from alcohol and/or other drugs.

(4) Records and Documentation Require-

ments.

(A) A treatment plan is not required for individuals receiving only telephone hotline or mobile outreach through the ACI program. Evidence of coordination between the ACI staff and the treating staff for individuals currently receiving department-funded services, or those who are in the process of being admitted to a CPR program, must be documented in the individual record.

(B) At a minimum, programs funded for ACI must keep the following records for telephone hotline services when possible to obtain from caller:

1. Date and time of telephone call;
2. Identity of caller, including but not limited to, parent, individual receiving services, law enforcement, judge, hospital, emergency room, mental health professional;
3. Name, address, telephone number, and date of birth;
4. Presenting problem; and
5. Disposition and follow-up.

(C) ACI programs must have a method for retaining hotline data in compliance with 9 CSR 10-7.030.

(D) When a call is received on behalf of another individual who is in crisis, the caller and the individual in crisis must both be identified as recipients of the crisis intervention services provided by the ACI program. For data collection purposes, the identified service recipient is the individual in crisis.

(E) At a minimum, agencies providing ACI services must keep the following records for mobile outreach services when the individual agrees to provide identifying information:

1. Date and time of referral;
2. Date, time and place of face-to-face contact;
3. Person accompanying mobile worker;
4. Person in attendance at face-to-face contact;
5. Name, address, telephone number, date of birth;
6. Presenting problem; and
7. Disposition and follow-up.

(F) The agency must document when the individual does not provide identifying information.

(G) Agencies providing ACI services must submit data reports and documentation to the department in accordance with the department's standardized form and protocol.

(H) Agencies providing ACI services must meet the documentation and confidentiality requirements as defined in 9 CSR 10-7.030.

(5) Treatment.

(A) Each administrative agent must provide or arrange for the delivery of ACI services.

(B) ACI programs must operate or arrange for a twenty-four- (24-) hour per day, seven (7) day per week telephone hotline. Each program shall have a written description of the telephone hotline system including the following:

1. Name of the agency or contractor that operates the hotline;
2. Numbers and qualifications of hotline staff;
3. Written documentation that clinical supervision is provided including, but not limited to: meeting minutes, supervision logs, or peer review processes;
4. Written description of how the telephone hotline is staffed;
5. Written documentation of case reviews and quality assurance activities relating to hotline services;
6. Written documentation of how telephone hotline services are provided to individuals who are deaf, have limited English proficiency, or are from cultural minority groups;
7. Written description of ongoing hotline outreach activities; and
8. Written description of a process for identifying and utilizing community resources in the delivery of telephone hotline service.

(C) Each administrative agent must have a designated agency staff person or persons on call to the ACI system twenty-four (24) hours per day, seven (7) days per week.

(D) If the individual served, advocate, family member/natural support requests to speak with a staff member from a specialized program including, but not limited to, the CPR program's community support specialist and the ACI clinical staff have determined this action is clinically necessary, the ACI hotline staff shall contact the appropriate designated agency staff person.

(E) The ACI hotline staff shall remain in contact with the caller until a successful hand-off contact between caller and designated agency staff person has occurred.

(F) Once contact between the caller and agency staff has occurred, the designated agency staff person shall respond to the caller and/or secure the appropriate requested specialized program personnel involved.

(G) The designated agency staff person shall remain in contact with the caller until a successful hand-off or contact between specialized program personnel and caller has occurred.

(H) Each administrative agent must have a written internal agency protocol in place for how the designated agency staff person will be able to contact staff from specialized programs that require twenty-four (24) hour,



seven (7) day per week crisis intervention as a component of their service menu.

(I) If ACI staff does not follow the procedure listed in subsection (H) of this rule, there must be a written protocol for contacting the ACI supervisor and the specialized program supervisor within twenty-four (24) hours to review the immediate action taken and then reviewed for a performance improvement process within forty-eight (48) hours.

(J) ACI programs must have a written description for resource and referral to the following services:

1. Acute hospitalization;
2. Medical services;
3. Withdrawal management/detoxification services;
4. Priority outpatient scheduling within twenty-four (24) hours or the next working day;
5. Children and youth services; and
6. Psychiatric availability.

(K) ACI programs must operate a twenty-four- (24-) hour per day, seven (7) day per week mobile response system. Each program shall have a written description of the mobile response system including the following:

1. Name of the agency or contractor that operates the mobile response system;
2. Written description of how mobile crisis response teams are staffed twenty-four (24) hours per day, seven (7) days per week;
3. Numbers and qualifications of staff;
4. Written documentation that clinical supervision is provided including, but not limited to: meeting minutes, supervision logs, or peer review processes;
5. Written documentation of case reviews and quality assurance activities relating to mobile response services; and
6. Written documentation of how mobile response services respond to individuals who are deaf, have limited English proficiency, or are from cultural minority groups.

(L) ACI programs shall provide mobile response to known and unknown individuals twenty-four (24) hours per day, seven (7) days per week at the location of the crisis or another secure community location.

(M) Mobile response shall not be provided exclusively in emergency rooms, jails, or mental health facilities.

(N) When a call is referred to mobile response, a phone-only response is appropriate if the clinical needs of the person who is in crisis can be addressed over the phone and/or the crisis has been deescalated.

(O) Each agency providing ACI services must have safety mechanisms in place for mobile response. These may include, but are not limited to:

1. Mobile phones;
2. Risk assessments for phone and continually during contact;
3. Availability of multiple staff to respond for face-to-face contact;
4. Backup availability; and
5. Written protocols for mobile response to be delivered in safe locations when necessary.

(P) In crisis situations in which law enforcement need to be contacted by the ACI staff, the ACI staff must make the initial contact and remain involved until the crisis is resolved, by phone or with the mobile response team.

1. ACI staff shall first contact law enforcement officers trained in crisis intervention, if they are available in the city/county where the crisis situation is taking place and ACI staff have established arrangements to make direct contact with them.

(Q) If the caller is not satisfied, the grievance procedure must be followed as defined in 9 CSR 10-7.020(7).

(6) Performance Improvement.

(A) Each administrative agent must develop a community outreach/education plan that includes details of how the following groups will become familiar with the ACI system:

1. Families/natural supports;
2. Individuals receiving services;
3. Advocates of individuals receiving services;
4. State agencies including, but not limited to, the Department of Social Services, Family Support Division, Children's Division, and Division of Youth Services; the Department of Health and Senior Services, Division of Senior and Disability Services; and the Department of Corrections, Division of Probation and Parole;
5. Emergency responders (law enforcement agencies, 911, paramedics);
6. Primary and secondary schools;
7. Court system including, but not limited to, juvenile, family, mental health, and drug courts;
8. Residential care programs, homeless shelters, public housing;
9. Public health agencies;
10. Community health centers;
11. Primary care medical offices; and
12. General public.

(B) The community outreach/education plan must include the various action steps that will be taken in educating the community as to how to access the ACI system through written material and other means of communication.

(C) The community outreach/education plan must indicate how the components will

be accomplished on an ongoing basis.

(D) Agencies providing ACI services must be able to demonstrate their community awareness and education activities, at least annually, in a report or other format specified by the department which may include, but is not limited to, number of hotline calls, walk-ins, media outreach, and outreach/educational efforts with schools, law enforcement, or other entities in the community.

(E) The telephone number for ACI must be published in local telephone books distributed in each service area and be prominently displayed on agency websites and social media pages.

(F) If the level of crisis services provided by an agency is significantly below the state average or other established benchmarks, this circumstance must be addressed in the performance improvement plan.

(G) Agencies providing ACI services must promptly respond to requests from local institutions of higher education to assist in developing appropriate crisis response systems on college campuses.

(7) Personnel and Staff Development.

(A) Staff providing telephone hotline services must have a bachelor's degree with three (3) years of behavioral health and crisis intervention experience or a master's degree with one (1) year of behavioral health and crisis intervention experience.

1. Staff providing telephone hotline services must be supervised by a QMHP.

2. Staff providing telephone hotline services must have immediate access to a QMHP.

(B) For mobile response, the mobile crisis team shall have at least one (1) QMHP to provide face-to-face crisis intervention for each mobile response.

(C) Each administrative agent shall designate a coordinator for ACI services who must be a QMHP.

(D) The agency shall have written documentation that clinical supervision is provided on a scheduled basis including, but not limited to: meeting minutes, supervision logs, or peer review processes.

(E) For administrative agents that subcontract for hotline services this standard applies. Administrative agents shall have designated staff on call to the ACI system twenty-four (24) hours per day, seven (7) days per week for specialized programs. This designated staff person or persons shall have received crisis intervention training and have experience in responding to crisis situations with individuals and families.



(F) Each agency shall have an ACI Training Plan. The training plan shall include individuals served, families/natural supports, and advocates in the development and implementation of the plan.

(G) Staff providing ACI services shall complete the designated ACI training required by the department at least annually that includes, but is not limited to, the following core competencies as defined by the department:

1. Crisis intervention strategies and techniques;
2. ACI and legal issues;
3. Safety;
4. ACI responsiveness to individuals and families served; and
5. Available resources and services in the community.

(H) ACI staff shall have a working familiarity with the core competencies prior to providing crisis intervention services.

(I) New ACI staff shall be trained and document the demonstration of the core competencies within the first six (6) months of employment.

(J) The administrative agent shall describe how the core competencies will be incorporated into the ACI staff training program on an ongoing basis.

(K) Each agency shall provide a written plan of how it will measure the competencies of the ACI staff. The plan must include at least two (2) measurable outcomes including, but not limited to:

1. Review of case documentation;
2. Review of assessment forms for appropriate interventions; and
3. Question, answer, observation, and feedback by supervisory staff and peers.

(L) New ACI staff must receive clinical supervision and job-shadow the supervisor or experienced crisis workers for a minimum of forty (40) hours prior to providing crisis services.

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**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.055, RSMo 1980.*