
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 30-4.010 Definitions

PURPOSE: This rule defines the special terms used in 9 CSR 30-4.020–9 CSR 30-4.190 regarding the certification standards for mental health agencies.

(1) The terms defined in section 630.005, RSMo are incorporated by reference for use in this chapter as though set out in this rule.

(2) Unless the context clearly requires otherwise, the following terms as used in this chapter shall mean—

(A) Admission, the time when an agency has completed its screening and intake process and has decided to accept an applicant to receive its services;

(B) Agency, an entity responsible for the delivery of mental health services to an identified target population;

(C) Assessment, evaluation of a client's strengths, weaknesses, problems and needs;

(D) Facility, the physical premises used by an agency to provide mental health services;

(E) Initial referral or recording initial demographic information referral to an appropriate service, or both prior to intake screening;

(F) Intake evaluation, the initial clinical interview for determining the level of psychological and social functioning, the need for treatment or additional evaluation service or the development of a treatment plan;

(G) Mental health professionals, one (1) of the following:

1. A professional counselor licensed under Missouri state law to practice counseling;

2. An individual possessing a master's or doctorate degree in counseling, psychology, family therapy or related field, with one (1) year's experience, under supervision, in treating problems related to mental illness;

3. A pastoral counselor with a degree equivalent to the Master of Science Degree in Divinity from an accredited program with specialized training in mental health services. One (1) year of experience, under supervision, in treating problems related to mental illness may be substituted for specialized training;

4. A physician licensed under Missouri state law to practice medicine or osteopathy and with specialized training in mental health services. One (1) year of experience, under supervision, in treating problems related to mental illness may be substituted for specialized training;

5. A psychiatrist that is a licensed physician, who in addition, has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program certified as equivalent by the department;

6. A psychologist licensed under Missouri state law to practice psychology;

7. A psychiatric nurse, a registered professional nurse licensed under Chapter 335, RSMo with at least two (2) years of experience in a psychiatric or substance abuse treatment setting, or a master's degree in psychiatric nursing; and

8. A social worker with a master's degree in social work from an accredited program and with specialized training in mental health services. One (1) year of experience, under supervision, may be substituted for training;

(H) Outpatient program, a program providing emergency services, intake screening, psychotherapy, counseling, aftercare and information/education in a nonresidential setting for mentally disordered and mentally ill clients;

(I) Program, an array of services for the mentally disordered or mentally ill in a setting organized to carry out specific procedures; that is, residential, day treatment and outpatient.

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.*

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

9 CSR 30-4.020 Procedures to Obtain Certification

PURPOSE: This rule describes the procedure to obtain certification from the Department of Mental Health for mental health agencies as authorized by section 630.655, RSMo.

(1) Under section 630.655, RSMo, the department shall certify each agency's level of service, treatment or rehabilitation as necessary for the agency to receive state funds or to meet conditions for third-party reimbursement.

(2) Each agency that is certified shall comply with all requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Abuse Programs, 9 CSR 10-7.130 Procedures to Obtain Certification.

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.*

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

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

PURPOSE: This rule defines terms and explains usage rules for those terms used in certification procedures and standards developed under section 630.655, RSMo for community psychiatric rehabilitation programs and certain services serving persons with serious mental illnesses and disorders.

(1) The terms defined in section 630.005, RSMo are incorporated by reference for use in 9 CSR 30-4.031–9 CSR 30-4.047.

(2) As used in 9 CSR 30-4.031–9 CSR 30-4.047, unless the context clearly indicates otherwise, the following terms shall mean:

(A) Administrative agent—an agency and its approved designee(s) authorized by the Division of Comprehensive Psychiatric Services (CPS) as an entry and exit point into the state mental health service delivery system for a geographic service area defined by the division;

(B) Admission—the process described in 9 CSR 30-4.042;

(C) Advanced practice nurse—as set forth in section 335.011, RSMo, a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for

advanced practice nurses established by the board of nursing;

(D) Affiliate—an organization or person providing psychiatric rehabilitation services through subcontract on behalf of a community psychiatric rehabilitation (CPR) provider;

(E) Applicant—an entity which has applied to the division for certification as a CPR provider;

(F) Brief evaluation—activities including screening, assessment, development and revision of an individual treatment plan, for the purposes of establishing client eligibility in a defined level of care;

(G) CPR director—director of CPR program;

(H) Chemical restraints—as defined in section 630.005, RSMo, drugs which are prescribed or administered in an emergency to restrain temporarily an individual who presents a likelihood of serious physical harm to him/herself or to others;

(I) Class I Neglect—failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any client when the failure presents either imminent danger to the health, safety or welfare of a client or a substantial probability that death or physical injury would result;

(J) Class II Neglect—failure of an employee to provide reasonable or necessary services to a client or resident according to the individualized treatment plan or to identified acceptable standards of care;

(K) Client—a generic term that includes any individual requesting and receiving CPR services which may include not only the person receiving services but also a legal guardian, unless the context clearly indicates otherwise;

(L) Clinical privileges—authorization to a staff person to provide specific client care and treatment service within well-defined limits based on that individual's license (if applicable), education, training, experience, competence, clinical judgment and generally accepted standards of treatment or care;

(M) Clinical review—a review conducted by mental health professionals identified by the division to determine client eligibility and authorize reimbursement for services determined to be clinically appropriate for a specific client as required by the division;

(N) Community psychiatric rehabilitation center (CPR provider or CPR program)—an organization which provides or arranges for, at the minimum, the following core services: intake and annual evaluations, crisis intervention and resolution, medication services, consultation services, medication administration, community support and psychosocial rehabilitation in a nonresidential setting for

individuals with serious mental illness in conjunction with standards set forth in 9 CSR 30-4.031-9 CSR 30-4.047;

(O) Community support—as defined in 9 CSR 30-4.043(2)(G);

(P) Community support assistant—an individual with a high school diploma or equivalent and applicable training as required by the department;

(Q) Consultation services—as defined in 9 CSR 30-4.043(2)(C);

(R) Crisis intervention and resolution—as defined in 9 CSR 30-4.043(2)(A);

(S) Critical intervention—actions prescribed by an individual's treatment plan, to intercede on behalf of a client's safety in critical situations or circumstances that pose a risk of serious harm to a client or to a client's ability to live outside of an institution or a more restrictive setting than his/her current residence;

(T) Department—the Department of Mental Health;

(U) Director—director of the Department of Mental Health;

(V) Division—the Division of Comprehensive Psychiatric Services of the Missouri Department of Mental Health;

(W) Eligible client—an individual found to have serious mental illness according to specific diagnostic, disability and durational criteria as set out in 9 CSR 30-4.042(4) and satisfying the admission criteria described in 9 CSR 30-4.042;

(X) Facility—the physical plant or site used by a CPR provider to provide mental health services;

(Y) Improper clinical practices—a level of performance or behavior which constitutes a repeated pattern of negligence or which constitutes a continuing pattern of violations of laws, rules, or regulations enforced by the appropriate professional licensing, funding or certifying entity;

(Z) Intake/annual evaluation—as defined in 9 CSR 30-4.035(7) and (18);

(AA) Intensive community psychiatric rehabilitation (CPR)—as defined in 9 CSR 30-4.045;

(BB) Mechanical restraint—any device, instrument or physical object used to restrict an individual's freedom of movement except when necessary for orthopedic, surgical and other medical purposes;

(CC) Medication administration—as defined in 9 CSR 30-4.043(2)(D);

(DD) Medication administration support—as defined in 9 CSR 30-4.043(2)(E);

(EE) Medication aide—an individual as defined in 13 CSR 15-13.030 who administers medications;

(FF) Medication services—as defined in 9 CSR 30-4.043(2)(B);

(GG) Medical technician—an individual as defined in 13 CSR 15-13.020 who administers medications;

(HH) Mental health professional—any of the following:

1. A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one (1) year of experience, under supervision, in treating problems related to mental illness or specialized training;

2. A psychiatrist, a physician licensed under Missouri law who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program identified as equivalent by the department;

3. A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services;

4. A professional counselor licensed under Missouri law to practice counseling and with specialized training in mental health services;

5. A clinical social worker licensed under Missouri law with a master's degree in social work from an accredited program and with specialized training in mental health services;

6. A psychiatric nurse, a registered professional nurse licensed under Chapter 335, RSMo with at least two (2) years of experience in a psychiatric or substance abuse treatment setting or a master's degree in psychiatric nursing;

7. An individual possessing a master's or doctorate degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling or family therapy or related field who has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional;

8. An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting;

9. An advanced practice nurse—as set forth in section 335.016, RSMo, a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for

advanced practice nurses established by the board of nursing; and

10. A psychiatric pharmacist as defined in 9 CSR 30-4.030;

(II) Psychiatric pharmacist—a registered pharmacist in good standing with the Missouri Board of Pharmacy who is a board-certified psychiatric pharmacist (BCPP) through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psychopharmacy residency where the service has been supervised by a board-certified psychiatric pharmacist;

(JJ) Physical abuse—in accordance with 9 CSR 10-5.200;

(KK) Physical restraint—physical holding of a client which restricts a client's freedom of movement to restrain temporarily in an emergency a client who presents a likelihood of serious physical harm to him/herself or to others;

(LL) Psychosocial rehabilitation—as defined in 9 CSR 30-4.043(2)(I);

(MM) Research—experiments, including intervention or interaction with clients, whether behavioral, psychological, biomedical or pharmacological and program evaluation as set out in 9 CSR 60-1.010(1);

(NN) Seclusion—placement alone in a locked room for any period of time;

(OO) Sexual abuse—in accordance with 9 CSR 10-5.200;

(PP) Time-out—temporary exclusion or removal of a client from the treatment or rehabilitation setting, used as a behavior modifying technique as prescribed in the client's individual treatment plan and for periods of time not to exceed fifteen (15) minutes each; and

(QQ) Verbal abuse—in accordance with 9 CSR 10-5.200.

AUTHORITY: sections 630.050, 630.055 and 632.050, RSMo 2000. 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.

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 630.055, RSMo 1980; 632.050, RSMo 1980.*

9 CSR 30-4.031 Procedures to Obtain Certification for Centers

PURPOSE: This rule describes procedures to obtain certification from the Department of Mental Health for community psychiatric rehabilitation programs.

(1) Under section 630.050, RSMo, the department shall certify each community psychiatric rehabilitation (CPR) provider's rehabilitation program services as a condition of participation in the community psychiatric rehabilitation program.

(2) 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 10-7.130 Procedures to Obtain Certification.

(3) To be eligible for certification as a CPR provider, an organization must meet one (1) of the following requirements:

(A) Performs the required functions described in section 1916(c)(4) of the Public Health Service Act;

(B) Meets the eligibility requirements for receipt of federal mental health block grant funds;

(C) Has a current and valid purchase of service contract with the Division of Comprehensive Psychiatric Services pursuant to 9 CSR 25-2;

(D) Is designated by the Division of Comprehensive Psychiatric Services under the authority of section 632.050, RSMo to serve as an entry and exit point for the public mental health service delivery system; or

(E) Has been certified at least once prior to November 7, 1993, and has maintained certification continuously since November 7, 1993.

(4) The department shall certify, as a result of a certification survey, each Community Psychiatric Rehabilitation (CPR) Program as designated and eligible to serve children and youth under the age of eighteen (18).

(5) To be eligible to serve children and youth under the age of eighteen (18) a certified community psychiatric rehabilitation (CPR) provider shall meet each of the following requirements:

(A) Have a current and valid purchase of service contract with the Division of Comprehensive Psychiatric Services (CPS) pursuant to 9 CSR 25-2;

(B) Must meet the eligibility requirements for receipt of federal mental health block grant funds;

(C) Must provide a comprehensive array of psychiatric services to children and youth including but not limited to:

1. Crisis intervention mobile response;
2. Screening and assessment;
3. Medication services; and
4. Intensive case management consistent with state plan approved services; and

(D) Have experience and expertise in delivering a division approved home-based crisis intervention program of psychiatric services for children and youth.

(6) A certified community psychiatric rehabilitation (CPR) provider may serve transitional age youth (age sixteen (16) and older) meeting the diagnostic eligibility requirements in 9 CSR 30-4.042(4)(B) in each designated CPS service area without the certification required in 9 CSR 30-4.031(4) and (5) if it is documented in the client record that it is clinically and developmentally appropriate to serve the individual in an adult program.

(7) The following forms are included herein:

- (A) MO 650-1722; and
- (B) MO 650-0231.



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
BUREAU OF QUALITY IMPROVEMENT
1706 E. ELM ST., P.O. BOX 596, JEFFERSON CITY, MO 65102
APPLICATION FOR LICENSURE
AND/OR CERTIFICATION

FOR DMH USE ONLY
DATE RECEIVED BY DMH INITIAL RENEWAL BOI OR RC
VENDOR NO. LICENSE/CERTIFICATE NO. EXPIRATION DATE

Main application form with sections for: NAME OF APPLICANT OR AGENCY, EMPLOYER TAX ID NO., PHONE, MAILING ADDRESS, CITY, ZIP CODE, COUNTY, NAME OF FOSTER PARENT OR AGENCY DIRECTOR, SOCIAL SECURITY NUMBER, CONVICTION OF FELONY BY ANY PERSON TO LICENSED OR CERTIFIED UNDER THIS APPLICATION, LICENSING, CERTIFYING OR ACCREDITING BODY, FACILITY TYPE, LICENSE NUMBER, ISSUANCE DATE, EXPIRATION DATE, NAME OF BUSINESS OR GOVERNING BODY PRESIDENT, ADDRESS, CITY, STATE, ZIP, PHONE NUMBER, RESIDENTIAL FACILITIES AND PROGRAMS TO BE LICENSED OR CERTIFIED UNDER THIS APPLICATION. PLEASE LIST EACH PREMISES INDIVIDUALLY. (Repeating sections for facility details)

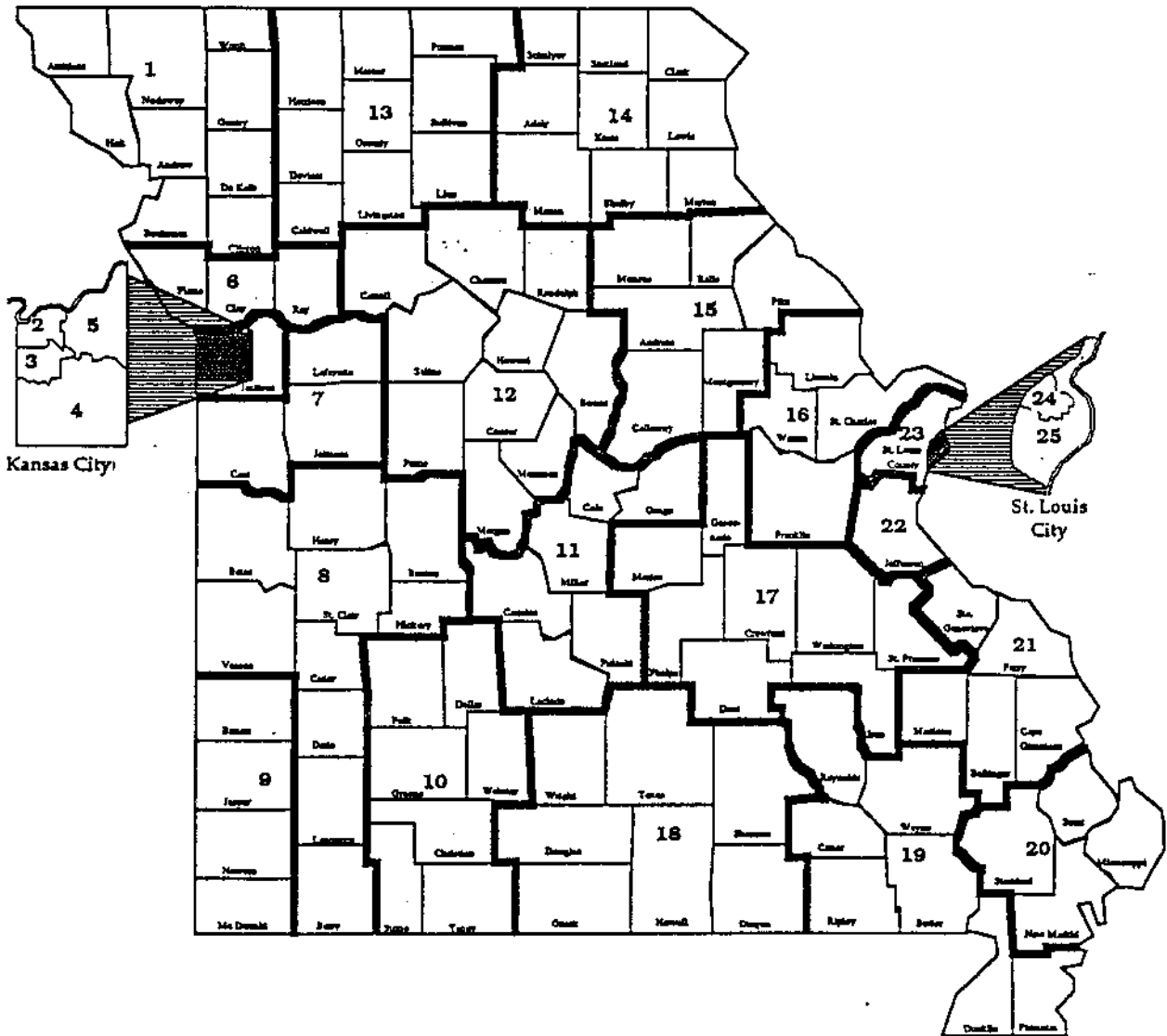


ADDENDUM: LISTING OF RESIDENTIAL FACILITIES AND PROGRAMS					(RESIDENTIAL FACILITIES AND PROGRAMS TO BE LICENSED OR CERTIFIED UNDER THIS APPLICATION. PLEASE LIST EACH PREMISES INDIVIDUALLY.)
NAME OF FACILITY					
ADDRESS	CITY	COUNTY	ZIP	PHONE	
NAME OF CONTACT PERSON				PHONE	
TYPE OF FACILITY <input type="checkbox"/> CPRC <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DAY PROGRAM <input type="checkbox"/> FOSTER <input type="checkbox"/> RESPITE <input type="checkbox"/> ISL <input type="checkbox"/> OTHER RESIDENTIAL					
NAME OF OTHER LICENSURE, CERTIFICATION OR ACCREDITATION		LICENSE OR CERTIFICATION NUMBER		EXPIRATION DATE	
CAPACITY OF CURRENT ENROLLMENT		REQUESTED CAPACITY	TYPE OF RESIDENT OR CLIENT SERVED <input type="checkbox"/> M/MD <input type="checkbox"/> MR/DD		
NAME OF FACILITY					
ADDRESS	CITY	COUNTY	ZIP	PHONE	
NAME OF CONTACT PERSON				PHONE	
TYPE OF FACILITY <input type="checkbox"/> CPRC <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DAY PROGRAM <input type="checkbox"/> FOSTER <input type="checkbox"/> RESPITE <input type="checkbox"/> ISL <input type="checkbox"/> OTHER RESIDENTIAL					
NAME OF OTHER LICENSURE, CERTIFICATION OR ACCREDITATION		LICENSE OR CERTIFICATION NUMBER		EXPIRATION DATE	
CAPACITY OF CURRENT ENROLLMENT		REQUESTED CAPACITY	TYPE OF RESIDENT OR CLIENT SERVED <input type="checkbox"/> M/MD <input type="checkbox"/> MR/DD		
NAME OF FACILITY					
ADDRESS	CITY	COUNTY	ZIP	PHONE	
NAME OF CONTACT PERSON				PHONE	
TYPE OF FACILITY <input type="checkbox"/> CPRC <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DAY PROGRAM <input type="checkbox"/> FOSTER <input type="checkbox"/> RESPITE <input type="checkbox"/> ISL <input type="checkbox"/> OTHER RESIDENTIAL					
NAME OF OTHER LICENSURE, CERTIFICATION OR ACCREDITATION		LICENSE OR CERTIFICATION NUMBER		EXPIRATION DATE	
CAPACITY OF CURRENT ENROLLMENT		REQUESTED CAPACITY	TYPE OF RESIDENT OR CLIENT SERVED <input type="checkbox"/> M/MD <input type="checkbox"/> MR/DD		
NAME OF FACILITY					
ADDRESS	CITY	COUNTY	ZIP	PHONE	
NAME OF CONTACT PERSON				PHONE	
TYPE OF FACILITY <input type="checkbox"/> CPRC <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DAY PROGRAM <input type="checkbox"/> FOSTER <input type="checkbox"/> RESPITE <input type="checkbox"/> ISL <input type="checkbox"/> OTHER RESIDENTIAL					
NAME OF OTHER LICENSURE, CERTIFICATION OR ACCREDITATION		LICENSE OR CERTIFICATION NUMBER		EXPIRATION DATE	
CAPACITY OF CURRENT ENROLLMENT		REQUESTED CAPACITY	TYPE OF RESIDENT OR CLIENT SERVED <input type="checkbox"/> M/MD <input type="checkbox"/> MR/DD		
NAME OF FACILITY					
ADDRESS	CITY	COUNTY	ZIP	PHONE	
NAME OF CONTACT PERSON				PHONE	
TYPE OF FACILITY <input type="checkbox"/> CPRC <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DAY PROGRAM <input type="checkbox"/> FOSTER <input type="checkbox"/> RESPITE <input type="checkbox"/> ISL <input type="checkbox"/> OTHER RESIDENTIAL					
NAME OF OTHER LICENSURE, CERTIFICATION OR ACCREDITATION		LICENSE OR CERTIFICATION NUMBER		EXPIRATION DATE	
CAPACITY OF CURRENT ENROLLMENT		REQUESTED CAPACITY	TYPE OF RESIDENT OR CLIENT SERVED <input type="checkbox"/> M/MD <input type="checkbox"/> MR/DD		



SERVICE AREAS

Please shade in counties served by your agency and, on the back portion of this page, outline any plans for expansion.





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.*

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

9 CSR 30-4.032 Administration

PURPOSE: This rule sets out responsibilities and authority of the governing body and director of a community psychiatric rehabilitation program.

(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 10-7.090 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 as defined in 9 CSR 30-4.030, then the agency shall identify a clinical supervisor who is a qualified mental health professional who has responsibility for monitoring and supervising all clinical aspects of the program. If the agency is certified to provide services to children and youth, then 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 qualified mental health professional who has responsibility for monitoring and supervising all clinical aspects of the program and meets the above requirements.

(3) The CPR provider shall maintain a policy and procedure manual for all aspects of its operations. CPR program plans, policies and procedures shall include descriptions, details and relevant information about—

- (A) The philosophy, types of services and organization of the CPR provider;
- (B) Goals and objectives;
- (C) Organization and methods of personnel utilization;

(D) Relationship among components within the organization and with agencies outside of the program;

(E) Location of service sites;

(F) Hours and days of operation of each site;

(G) The outreach plan for all services offered;

(H) Infection control procedures, addressing at least those infections that may be spread through contact with bodily fluids;

(I) The scope of volunteer activities;

(J) Safety precautions and procedures for clients, volunteers, employees and others;

(K) Staff communication with the governing body;

(L) The on-site use of tobacco, alcohol and other substances;

(M) Emergency policies and procedures by staff, volunteers, clients, visitors and others for—

- 1. Medical emergencies;
- 2. Natural emergencies, such as earthquakes, fires, severe storms, tornado or flood;
- 3. Behavioral crisis;
- 4. Abuse or neglect of clients;
- 5. Injury or death of a client; and
- 6. Arrest or detention of a client;

(N) Policies and procedures which address commonly occurring client problems such as missed appointments, appearing under the influence of alcohol or drugs, broken rules, suicide attempts, loitering, accidents, harassment and threats; and

(O) Relevant information about service provision for children and youth addressing any and all aspects of subsections (A) through (N) of this rule.

(4) The governing body shall establish a formal mechanism to solicit recommendations and feedback from clients, client family members and client advocates regarding the appropriateness and effectiveness of services, continuity of care and treatment. The CPR provider shall document issues raised, including recommendations made by clients, client family members and client advocates; actions taken by the governing body, director and CPR program staff; an implementation plan and schedule to resolve issues cited.

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. Emergency amendment filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Amended: Filed Dec. 28, 2001, effective July 12, 2002.*

**Original authority: 630.655, RSMo 1980.*

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

PURPOSE: This rule prescribes fiscal policies and procedures for community psychiatric rehabilitation programs.

(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 10-7.100 Fiscal Management.

(2) Unless prohibited by law, an independent public accountant shall conduct an annual audit of the community psychiatric rehabilitation (CPR) provider's fiscal operations.

(A) The CPR provider shall make the audit available to staff who have responsibility for budget and management.

(B) The audit shall report, according to the methods, policies and procedures established by the department, individual unit costs for each service provided by the CPR provider.

(C) The governing body shall review and approve the audit.

(D) The CPR provider shall correct or resolve adverse audit findings following approval by the governing body.

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.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-4.034 Personnel and Staff Development

PURPOSE: This rule prescribes personnel policies and procedures for community psychiatric rehabilitation programs.

(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 10-7.110 Personnel.

(2) Only qualified professionals shall provide community psychiatric rehabilitation (CPR) services. Qualified professionals for each service shall include:

(A) For intake/annual evaluations, an evaluation team consisting of, at least, a physician, one (1) other mental health professional, as defined in 9 CSR 30-4.030, and including, for the annual evaluation, the community support worker assigned to each client;

(B) For brief evaluation, an evaluation team consisting of at least, a physician and one (1) other mental health professional, as defined in 9 CSR 30-4.030;

(C) For treatment planning, a team consisting of at least a physician, one (1) other mental health professional as defined in 9 CSR 30-4.030 and the client's community support worker;

(D) For crisis intervention and resolution, any mental health professional as defined in 9 CSR 30-4.030;

(E) For medication services, a physician, psychiatric pharmacist or advanced practice nurse as defined in 9 CSR 30-4.030;

(F) For medication administration, a physician, registered professional nurse (RN), licensed practical nurse (LPN), advanced practice nurse, or psychiatric pharmacist;

(G) For medication administration support, a medication technician or medication aide as defined in 9 CSR 30-4.030;

(H) For community support:

1. A mental health professional or an individual with a bachelor's degree in social work, psychology, nursing or a related field, supervised by a psychologist, professional counselor, clinical social worker, psychiatric nurse or individual with an equivalent degree as defined in 9 CSR 30-4.030. Equivalent experience in psychiatric and/or substance abuse treatment may be substituted on the basis of one (1) year of experience for each year of required educational training; or

2. A community support assistant with a high school diploma or equivalent and applicable training required by the department, supervised by a qualified mental health professional as defined in 9 CSR 30-4.030. A community support assistant may receive assignments and direction from a community support worker; and

(I) For consultation services, a physician, a psychiatric pharmacist or advanced practice nurse as defined in 9 CSR 30-4.030.

(3) The CPR provider shall ensure that an adequate number of appropriately qualified staff is available to support the functions of

the program. The department shall prescribe caseload size and supervisory to staff ratios.

(A) Caseload size may not exceed one (1) community support worker to twenty (20) clients in the rehabilitation level of care and one (1) community support to twelve (12) children and youth in the rehabilitation level of care.

(B) The supervisory to staff ratio in the rehabilitation level of care should not exceed one (1) qualified mental health professional to seven (7) community support workers.

(C) The supervisory to staff ratio in the rehabilitation level of care should not exceed one (1) qualified mental health professional to two (2) community support assistants.

(D) The supervisory to staff ratio in the rehabilitation level of care should not exceed one (1) qualified mental health professional to eight (8) total staff.

(4) The department may issue waivers and exceptions to the staffing patterns promulgated under this section as it deems necessary and appropriate.

(5) Personnel policies and procedures shall comply with all aspects of 9 CSR 10-7.110, shall apply to all staff and volunteers working in the CPR program and shall include:

(A) Requirements for an annual written job performance evaluation for each employee and procedures which provide staff with the opportunity to review the evaluation; and

(B) Client abuse and neglect and procedures for investigating alleged violations.

(6) The provider shall have and implement a process for granting clinical privileges to practitioners.

(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) The provider shall base initial granting and renewal of clinical privileges 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 s/he 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 also shall be based on—

1. Relevant findings from the providers quality assurance activities; and

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

(E) As part of the privileging process, the provider 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 nonprivileged staff receive close and documented supervision from privileged practitioners until training and experience are adequate to meet privilege requirements.

(7) The CPR provider shall establish, maintain and implement a written plan for professional growth and development of personnel.

(A) The CPR provider shall provide orientation within thirty (30) calendar days of employment, documented, for all personnel and affiliates, and shall include, but not be limited to:

1. Client rights and confidentiality policies and procedures, including prohibition and definition of verbal/physical abuse;

2. Client management, for example, techniques which address verbal and physical management of aggressive, intoxicated or behaviorally disturbed clients;

3. CPR program emergency policies and procedures;

4. Infection control;

5. Job responsibilities;

6. Philosophy, values, mission and goals of the CPR provider; and

7. Principles of appropriate treatment, including for staff working with children and youth, principles related to children and youth populations.

(B) Staff who are transferred or promoted to a new job assignment shall receive orientation to their new job responsibilities within thirty (30) days of actual transfer.

(C) The CPR provider shall provide orientation for volunteers and trainees within thirty (30) calendar days of initial attendance or



employment that includes, but is not limited to, the following:

- 1. Client rights and confidentiality policies and procedures, including verbal/physical/sexual abuse;
- 2. CPR program emergency policies and procedures;
- 3. Philosophy, values, mission and goals of the CPR provider; and
- 4. Other topics relevant to their assignments.

(D) Staff working within the CPR program also shall receive additional training within six (6) months of employment. This training shall include, but is not limited to:

- 1. Signs and symptoms of disability-related illnesses;
- 2. Working with families and caretakers of clients receiving services;
- 3. Rights, roles and responsibilities of clients and families;
- 4. Methods of teaching clients self-help, communication and homemaking skills in a community context;
- 5. Writing and implementing an individual treatment plan specific to community psychiatric rehabilitation services, including goal setting, writing measurable objectives and development of specific strategies or methodologies;
- 6. Basic principles of assessment;
- 7. Special needs and characteristics of individuals with serious mental illnesses;
- 8. Philosophy, values and objectives of community psychiatric rehabilitation services for individuals with serious mental illnesses; and
- 9. Staff working with children and youth shall receive additional training in the above areas as it pertains to children and youth.

(8) The CPR provider shall develop and implement a written plan for comprehensive training and continuing education programs for community support workers, community support assistants and supervisors in addition to those set out in section (7).

(A) Orientation for community support workers, community support assistants and supervisors shall include, but is not limited to, the following items:

- 1. Philosophy, values and objectives of community psychiatric rehabilitation services for individuals with serious and persistent mental illnesses;
- 2. Behavioral management, crisis intervention techniques and identification of critical situations;
- 3. Communication techniques;
- 4. Health assessment and medication training;

5. Legal issues, including commitment procedures;

6. Identification and recognition of critical situations; and

7. Staff working with children and youth shall receive additional training in the above areas as it pertains to children and youth.

(B) The curricula for training shall include a minimum set of topics as required by the department and through consultation by a psychiatrist.

(9) Each community support worker, community support assistant and supervisor shall complete ten (10) hours of initial training before receiving an assigned client caseload or supervisory caseload.

(10) 9 CSR 10-7.110 requires that all staff shall participate in at least thirty-six (36) clock hours of relevant training during a two (2)-year period. All staff working within the CPR program and services shall receive a minimum of twelve (12) clock hours per year of continuing education and relevant training.

(11) All training activities shall be documented in employee personnel files, to include the training topic, name of instructor, date of activity, duration, skills targeted/objective of skill, certification/continuing education units (if any) and location.

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. 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.*

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

9 CSR 30-4.035 Client Records of a Community Psychiatric Rehabilitation Program

PURPOSE: This rule prescribes the content requirements of a clinical record maintained by a community psychiatric rehabilitation program.

(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 10-7.030 Service Delivery Process and Documentation.

(2) The CPR provider shall implement policies and procedures to assure routine monitoring of client records for compliance with applicable standards.

(3) At intake, each CPR provider shall compile in a format acceptable to the department, and file in the client record an evaluation which shall include:

- (A) Presenting problem, request for assistance, symptoms, and functional deficits;
- (B) Personal, family, educational, treatment, and community history;
- (C) Reported physical and medical complaints and the need for screening for medical, psychiatric, or neurological assessment or other specialized evaluation;
- (D) Findings of a brief mental status examination;
- (E) Current functional strengths and weaknesses obtained through interview and behavioral observation;
- (F) Specific problem indicators for individualized treatment;
- (G) Existing personal support systems and current use of community resources;
- (H) Diagnostic formulation;
- (I) Specific recommendations for further evaluation and treatment;
- (J) Consultation between a physician and the psychologist or other mental health professional(s) conducting the psychosocial/clinical evaluation addressing the client's need and the appropriateness of outpatient rehabilitation. Consultation may be performed by an advanced practice nurse if that individual is providing medication management services to the client; and
- (K) The clinical record must support the level of care.

(4) The CPR provider shall develop and maintain for each client an individual treatment plan using a standardized format furnished by the department, at its discretion, which is filed in the master client record. The

treatment plans shall record, at a minimum, the following as indicated:

(A) Service Data.

1. The reason(s) for admission into rehabilitation services.

2. Criteria or plans, or both for movement.

3. Criteria for discharge.

4. A list of agencies currently providing program/services; the type(s) of service; date(s) of initiation of program/services.

5. A summary statement of prioritized problems and assets; and

(B) Treatment Goals and Objectives for the Treatment Plan and Any Components.

1. Specific individualized medication, psychosocial rehabilitation, behavior management, critical intervention, community support goals and other services and interventions as prescribed by the team.

2. The treatment regimen, including specific medical and remedial services, therapies and activities that will be used to meet the treatment goals and objectives.

3. A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter.

4. The type of personnel who will furnish the services.

5. A projected schedule for completing reevaluations of the client's condition and for updating the treatment plan.

6. Resources required to implement recommended services.

7. A schedule for the periodic monitoring of the client that reflects factors which may adversely affect client functioning.

8. Level of care.

(5) A physician shall approve the treatment plan. A licensed psychologist may approve the treatment plan only in instances when the client is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications. An advanced practice nurse may approve the treatment plan if that individual is providing medication management services to the client.

(6) The CPR provider shall ensure that the client participates in the development of the treatment plan and signs the plan. Client signature is not required if signing would be detrimental to client's well-being. If the client does not sign the treatment plan, the CPR provider shall insert a progress note in the case record explaining the reason the client did not sign the treatment plan.

(7) The treatment plan, goals, and objectives shall be completed within thirty (30) days of the client's admission to services.

(8) Each client's record shall document services, activities, or sessions that involve the client.

(A) Client records shall be legible and made contemporaneously with the delivery of the service or within three (3) business days of the time the service was provided.

(B) Services shall be documented in the client record prior to submitting for payment.

(C) For psychosocial rehabilitation, the clinical record shall include:

1. A weekly note that summarizes specific services rendered, client response to the services, and pertinent information reported by family members or significant others regarding a change in the client's condition, or an unusual/unexpected occurrence in the client's life, or both; and

2. Daily attendance records or logs that include actual attendance times, as well as activity or session attended. These program attendance records/logs must be available for audit and monitoring purposes, however integration into each clinical record is not required.

(D) For all other community psychiatric rehabilitation program services, the client record shall include documentation of each session or episode that involves the client.

1. The specific services rendered.

2. The date and actual time the service was rendered.

3. 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.

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

(9) In addition to documentation required under section (8), the CPR provider shall provide additional documentation for each service episode, unit or as clinically indicated for each service provided to the client as follows:

(A) Medication Services.

1. Description of the client's presenting condition.

2. Pertinent medical and psychiatric findings.

3. Observations and conclusions.

4. Client'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 client's ongoing medication regimen.

6. Pertinent/significant information reported by family members or significant others regarding a change in the client's condition, an unusual or unexpected occurrence in the client's life, or both;

(B) Crisis Intervention and Resolution Services.

1. Description of the precipitating event(s)/situation, when known.

2. Description of the client's mental status.

3. Interventions initiated to resolve the client's crisis state.

4. Client response to intervention.

5. Disposition.

6. Planned follow-up by staff; and

(C) Community Support Services.

1. Phone contact reports.

2. Pertinent information reported by family members or significant others regarding a change in the client's condition, an unusual or unexpected occurrence in the client's life, or both.

(10) An evaluation team, consisting of at least, a qualified mental health professional and the client's community support worker, if appropriate, shall review the treatment plan, goals and objectives on a regular basis, as determined by department policy.

(A) The review will determine the client's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the client's continued participation in specific community psychiatric rehabilitation services.

(B) The team shall document the review in detail in the client record.

(C) The CPR provider shall make the review available as requested for state or federal review purposes.

(D) The CPR provider shall ensure the client participates in the treatment plan review.

(E) For clients in the rehabilitation level of care, treatment plans shall be reviewed at a minimum every ninety (90) calendar days and the review documented in the case record.

(11) The treatment plan shall be rewritten annually and shall comply with the guidelines set forth in 9 CSR 30-4.035(4), (5), and (6).

(12) The CPR program also shall include other information in the client record, if not otherwise addressed in the intake/annual evaluation or treatment plan, including:

(A) The client's medical history, including:



1. Medical screening or relevant results of physical examinations; and

2. Diagnosis, physical disorders, and therapeutic orders;

(B) Evidence of informed consent;

(C) Results of prior treatment; and

(D) Condition at discharge from prior treatment.

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

(14) CPR program staff shall conduct or arrange for periodic evaluations for each client. Clients in the rehabilitation and intensive levels of care shall have annual evaluations completed. The evaluation shall be in a format approved by the department and shall include:

(A) Presenting problem and request for assistance;

(B) Changes in personal, family, educational, treatment, and community history;

(C) Reported physical/medical complaints;

(D) Current functional weaknesses and strengths;

(E) Changes in existing personal support systems and use of community resources;

(F) Description of the client's apparent change in condition from one (1) year ago;

(G) Specific problem indicators required by the department;

(H) Update of the diagnostic formulation;

(I) Specific recommendations for further evaluation and/or treatment;

(J) Information obtained through interview and behavioral observations that will contribute to the formulation of a new treatment plan; and

(K) Consultation between a physician and/or psychologist and the mental health professional(s) conducting the psychosocial/clinical evaluation addressing the client's need and appropriateness for continued outpatient rehabilitation.

(15) CPR program staff shall prepare and enter a discharge summary in the client's record when the client has been discharged from the CPR program. This discharge summary shall meet all requirements in 9 CSR 10-7.030(9).

(16) The CPR provider shall establish and implement a procedure that assures the inter-center transfer of referral and treatment information within five (5) working days.

(17) The CPR provider shall provide information, as requested, regarding client char-

acteristics, services, and costs to the department in a format established by the department.

(18) Each agency that is certified shall be subject to recoupment of all or part of Department of Mental Health payments when:

(A) The client record fails to document the service paid for was actually provided;

(B) The client record fails to document the service paid for was provided by a qualified staff person, as defined in the Department of Mental Health Purchase of Service Catalog;

(C) The client record fails to document the service that was paid meets the service definition, as defined in the Department of Mental Health Purchase of Service Catalog;

(D) The client record fails to document the amount, duration, and length of service paid for by the department; and

(E) The client record fails to document the service paid for was delivered under the direction of a current treatment plan that meets all the requirements for treatment plans set forth in 9 CSR 10-7.030 and 9 CSR 30-4.035.

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. 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.*

**Original authority: 630.655, RSMo 1980.*

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

PURPOSE: This rule describes client rights and confidentiality requirements for community psychiatric rehabilitation programs.

(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 10-7.020 Rights, Responsibilities and Grievances.

(2) The client shall have the right to have the treatment plan explained orally and to be given a copy of the treatment plan.

(3) The community psychiatric rehabilitation (CPR) provider shall protect a client's entitlement to access to information contained in the respective clinical record, except to the extent that the director of the CPR program determines the access would be detrimental to the client. The CPR provider shall document restrictions imposed by the CPR program director in the clinical record, with a specific rationale for the decision noted.

(4) The following forms are included herein:

(A) MO 650-1533; and

(B) MO 650-5839.



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL CLIENT INFORMATION

PATIENT NAME, HOSPITAL NO., DOB

I, (PATIENT, PARENT, GUARDIAN) AUTHORIZE AND REQUEST (NAME OF FACILITY)
TO RELEASE THE BELOW SPECIFIED INFORMATION OF (PATIENT'S NAME)
TO (PERSON, AGENCY, ORGANIZATION) (ADDRESS - STREET, CITY, STATE, ZIP)
WHO RECEIVED SERVICES FROM THE ABOVE MENTIONED FACILITY FROM (DATE) TO (DATE)

THE PURPOSE OF THIS INFORMATION RELEASE IS:
[] PLACEMENT [] AFTERCARE
[] TRANSFER OF TREATMENT [] TREATMENT PLANNING
[] OTHER (SPECIFY)

THE SPECIFIC INFORMATION TO BE DISCLOSED IS:
[] COMPREHENSIVE TREATMENT PLAN [] DISCHARGE SUMMARY
[] PSYCHIATRIC EVALUATION [] MEDICAL TESTS AND X-RAYS
[] SOCIAL SERVICE ASSESSMENT
[] OTHER (SPECIFY)

THIS AUTHORIZATION TO RELEASE INFORMATION IS SUBJECT TO THE FOLLOWING RESTRICTIONS:

MY SIGNATURE BELOW ACKNOWLEDGES MY UNDERSTANDING, AUTHORIZATION AND CONSENT FOR THE
FOLLOWING:
1. RELEASE OF TRANSFER OF THE INFORMATION DISCLOSED ABOVE TO PERSONS, AGENCIES, AND
ORGANIZATIONS NOT SPECIFIED IS PROHIBITED BY LAW.
2. THIS AUTHORIZATION INCLUDES BOTH INFORMATION PRESENTLY COMPILED AND INFORMATION TO BE
COMPILED IN THE ABOVE DURING THE COURSE OF THE PATIENT'S TREATMENT AT THE ABOVE FACILITY.
3. THIS CONSENT BECOMES EFFECTIVE (DATE) AND IS SUBJECT TO REVOCATION
BY THE UNDERSIGNED AT ANY TIME BY COMPLETING THE NOTICE OF REVOCATION AT THE BOTTOM OF
THE PAGE. ANY ACTIONS TAKEN BEFORE REVOCATION WILL NOT BE EFFECTED.
4. THIS CONSENT TO RELEASE INFORMATION (UNLESS REVOKED EARLIER) WILL TERMINATE 90 DAYS FROM
THE EFFECTIVE DATE.
5. SPECIFY ANY SPECIAL CONDITIONS, DATE, EVENTS THAT WOULD RESULT IN REVOCATION:
6. I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION.

WITNESS PATIENT SIGNATURE DATE
DATE PARENT OR LEGAL GUARDIAN DATE

NOTICE OF REVOCATION
I HEREBY REVOKE MY AUTHORIZATION TO RELEASE THE ABOVE SPECIFIED INFORMATION OF
(PATIENT) TO (PERSON, AGENCY, ORGANIZATION)

THIS REVOCATION CANCELS MY AUTHORIZATION
GIVEN ABOVE.
NOTE: A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION IS
AS VALID AS THE ORIGINAL
SIGNATURE OF PATIENT DATE
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
WITNESS DATE



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.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 30-4.039 Service Provision

PURPOSE: This rule sets out requirements for the provision of community psychiatric rehabilitation services.

(1) The community psychiatric rehabilitation (CPR) provider shall have written policies and procedures defining client eligibility requirements, intake procedures, client assignment and discharge, as set forth under 9 CSR 30-4.042.

(A) The CPR provider shall implement policies and procedures that assure admission to treatment within ten (10) working days of the date of eligibility determination for eligible clients with serious mental illness. CPR services shall be prioritized to 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 residential care facilities;

3. Have been determined to meet the admission criteria as set forth in 9 CSR 30-4.042;

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

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

6. 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;

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 private dwelling units and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing; or

E. Persons who are being discharged within the week from institutions in which they have been residents for more than thirty

(30) consecutive days and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing;

7. Persons at risk of out-of-home placement due to psychiatric disorder;

8. Persons having co-occurring disorders;

9. Persons moving from congregate to independent living;

10. Persons having a current episode of acute crisis, or use of the crisis system;

11. Persons who have used a hospital emergency room two (2) or more times during the prior year;

12. Persons attempting suicide one (1) or more times requiring hospitalizations; or

13. Persons unable to function for at least a six (6)-month period without mental health intervention.

(B) The CPR provider shall discharge from the community psychiatric rehabilitation program clients who have not received services for a twelve (12)-month period.

(C) The CPR provider and its affiliates shall reserve the right to refuse admission to clients under the following conditions:

1. If the client poses an imminent threat of harm to self or others;

2. When, at any specific time, the client is under the influence of alcohol or illegal drugs; and

3. When the program is operating at full capacity (a level previously determined). The CPR provider shall implement policies and procedures to monitor program capacity and advise designated department staff as necessary.

(D) The CPR provider and affiliates shall not have the right to refuse admission to clients on the basis of ineligibility for Medicaid or other sources of reimbursement.

(2) The CPR provider shall provide a community psychiatric rehabilitation program, either directly or through contractual agreement, to include, at a minimum, the following core services: intake/annual evaluation, as designated, crisis intervention and resolution, medication services, medication administration, community support and psychosocial rehabilitation.

(A) The CPR provider shall provide a timely access to and reasonable level of services for those clients found to be eligible for treatment, according to the admission criteria set forth in 9 CSR 30-4.042.

1. Intake/annual evaluation—CPR provider staff shall complete, or arrange to have completed, all annual evaluations within thirty (30) days following the anniversary date of

the client's intake evaluation or last annual evaluation.

2. Crisis intervention and resolution—shall be available upon demand on a twenty-four (24)-hour basis.

3. Medication services—a physician, psychiatrist or an advanced practice nurse shall see all clients requiring medication within ten (10) working days or sooner if clinically indicated of request for service.

4. Community support—the CPR provider shall assign all clients requiring community support services to a community support worker's caseload no later than ten (10) working days, or sooner if clinically indicated, of eligibility determination. The worker shall conduct an initial face-to-face contact as clinically appropriate but no later than five (5) working days of receiving the assignment.

5. Psychosocial rehabilitation—the CPR provider shall admit all clients requiring psychosocial rehabilitation services to a psychosocial rehabilitation program if adequate program capacity allows, within twenty (20) working days or sooner if clinically indicated of eligibility determination.

6. Transportation—the CPR provider shall provide or arrange for transportation for clients as deemed clinically and programmatically necessary to attend the psychosocial rehabilitation program and to receive medication services.

(3) The CPR program shall provide treatment which will assist in the support and rehabilitation of persons with serious mental illnesses.

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

(B) The CPR program shall assure accessibility to its provided services. Access shall require no more than one and one-half (1 1/2) hours of travel by automobile.

(C) The department shall designate the minimum geographic boundaries of service areas throughout the state. Exceptions shall only be granted by the director upon appeal from prospective providers.

1. The CPR provider shall designate an identified service area(s) it will serve.

2. The CPR program shall provide community psychiatric rehabilitation program services to the eligible residents of its designated service area to the extent that adequate program/facility capacity is available.

(4) The CPR provider shall have procedures approved by the department for emergency physician intervention linked to its crisis intervention and resolution service.



(5) The CPR provider shall have written policies and procedures which assure that an eligible client has access to needed services of the CPR provider beyond those services of a community psychiatric rehabilitation program.

(6) The CPR provider shall provide non-emergency community psychiatric rehabilitation services including, at a minimum, but not limited to, community support during evenings or weekends, or both to accommodate individual client needs.

(7) The CPR provider shall agree to provide community support and crisis intervention services to clients in their own home and in other locations off-site from its offices and facilities. The CPR provider shall have written policies and procedures to assure that a client shall not be required to visit a pre-selected site in order to receive needed treatments other than medication services, physician consultation and psychosocial rehabilitation. The CPR provider shall allow clients a choice in the service site to the extent that facility and program capacity and the treatment plan allow.

(8) The CPR program provides the following services and liaison activities to the criminal or juvenile justice system(s):

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

(B) Information for law enforcement, court, juvenile officers and probation/parole personnel about services offered by the CPR provider; and

(C) Provision of community psychiatric rehabilitation services to persons with serious mental illness who are on parole, probation or in forensic aftercare, as appropriate, and working closely with the parole or probation officer, or juvenile officer and department forensic aftercare workers within the limits of confidentiality.

(9) The CPR provider shall provide the following services and liaison activities to state and local public assistance/housing agencies and employment/training agencies:

(A) Promotion of effective relationships with state and local public assistance/housing agencies and employment/training agencies through training, education and consultation;

(B) Information for personnel of state and local public assistance/housing agencies that provide public benefits about services offered by the CPR provider; and

(C) Provision of assistance to persons with serious mental illness in seeking public benefits, and in working closely with the staff of state and local public assistance/housing and employment/training agencies within the limits of confidentiality to expedite the application process and continuation of the client's eligibility.

(10) The CPR provider shall assure that clients receive the most appropriate care that is available. Transfer of a client from one (1) service to another, from community to hospital, hospital to community or to another CPR provider, as consistent with the client's needs, may be considered to obtain that care and treatment.

(A) The CPR provider shall have written procedures for referral from one (1) service element to another within the CPR program and to other CPR providers.

1. Procedures shall assure that pertinent records, or portions of records, and other relevant information are readily transferable and are handled to comply with confidentiality regulations.

2. Procedures shall assure that follow-up is carried out on referrals to outside CPR programs or providers, as applicable.

(B) The policies and procedures shall stipulate the conditions under which referrals are made. These conditions may include:

1. Special services not provided by the CPR provider; or

2. Other ancillary services that will contribute to the well-being of the client.

(C) The CPR provider shall implement policies and procedures that assure the continuity of care between or among referring providers including prior treatment programs, both inpatient and outpatient psychiatric and substance abuse programs.

(D) The CPR provider shall maintain a current resource directory of area community service agencies that may be used in the referral process. The CPR provider shall make its resource directory available to consumers upon request.

(11) Each program shall coordinate with inpatient psychiatric programs to assure continuity of care for eligible individuals returning to the community. This includes active participation of the community support team in the discharge planning.

(A) CPR providers shall provide ongoing community support service to active community psychiatric rehabilitation CPR program clients who are admitted to inpatient psychiatric care.

(B) The CPR provider shall have a procedure to assure that, within five (5) calendar

days of the discharge, active community psychiatric rehabilitation program clients who are discharged from an inpatient psychiatric program are seen face-to-face by the community support worker. The CPR provider shall document the contact in the client record.

(C) The procedure includes active follow-up within five (5) days of clients who failed to keep their appointment or a missed appointment.

(12) The program shall establish and implement procedures to contact community support clients who miss a scheduled appointment or whose absence is unanticipated. The procedures shall establish time frames for contacting the client which are consistent with clinical needs and the seriousness of the client's disability.

(13) The CPR provider shall utilize community support assistants as adjuncts to and assistants to the treatment team. Community support assistants may not be assigned an independent client caseload, and may receive assignments and direction from a community support worker.

(14) The CPR provider shall take appropriate precautions to assure the provision of confidentiality and safety of children and youth in all aspects of programming including but not limited to:

(A) Outings;

(B) Transportation; and

(C) Day program activities.

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. 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.*

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



9 CSR 30-4.040 Quality Assurance

PURPOSE: This rule sets out requirements for quality assurance activities and functions for community psychiatric rehabilitation programs.

(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 10-7.040 Quality Improvement.

(2) The community psychiatric rehabilitation (CPR) provider shall establish a quality assurance process that includes, but is not limited to, the following functions:

(A) Evaluating the competencies of clinical staff as set out in 9 CSR 40-4.034(6);

(B) Supervising of all staff as set out in 9 CSR 30-4.034(2);

(C) Monitoring of clinical records as set out in 9 CSR 30-4.035(2);

(D) Monitoring of identified process and outcomes of the CPR provider's community psychiatric rehabilitation program as set out in sections (3)–(6); and

(E) Monitoring compliance of affiliate programs and subcontractors with applicable program standards.

(3) The CPR provider shall establish, support and maintain the quality assurance process through the CPR provider's professional and administrative staff by—

(A) Delegating the administration and coordination of the quality assurance process to a quality assurance committee, group or individual; and

(B) Actively involving the CPR program's medical staff in the activities of the quality assurance process including, but not limited to, clinical care issues and practices related to the use of medications.

(4) The CPR provider shall develop and implement a quality assurance plan that integrates the functions of the quality assurance process into the CPR program's psychiatric services.

(A) The CPR provider shall describe the quality assurance process in a written quality assurance plan, approved by the governing body.

(B) The quality assurance plan shall identify the persons or positions responsible for the implementation of the quality assurance program.

(C) The CPR provider and its governing body shall review the plan annually and revise it as appropriate.

(5) The CPR provider shall monitor key programmatic indicators jointly identified by the CPR provider and the Division of Comprehensive Psychiatric Services.

(A) The CPR provider shall collect data for each indicator on an ongoing basis, using a standardized format, which the department, at its discretion, may require.

(B) When a significant problem or quality of care issue is identified, the CPR provider shall act to correct the problem or improve the effectiveness of care, or both. The CPR provider shall assess corrective or supportive actions through continued monitoring.

(6) The CPR provider shall maintain a quality assurance record system.

(A) The record system shall contain documentation, including monitoring reviews, reports, recommendations, corrective actions and the status of previously identified problems or outcomes related to certification standards, or both.

(B) The CPR provider shall centrally maintain the record system and make it available for review.

(C) The record system shall include minutes of all quality assurance meetings with attendance, time, place, date, actions or recommendations for action noted.

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.

*Original authority: 630.655, RSMo 1980.

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 rehabilitation 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/>
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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., show, 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:



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 Admission Criteria

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

(1) Prior to admitting any individual, community psychiatric rehabilitation (CPR) providers that have been awarded provisional certification may be required to submit documentation for clinical review.

(A) The clinical review unit, within seven (7) working days, either shall—

1. Determine that the individual is eligible for admission and authorize the appropriate services;

2. Suspend eligibility determination and prior authorization of services pending the receipt of requested additional information; or

3. Determine that the individual is not eligible for admission.

(B) No provisionally certified CPR provider shall admit any individual before approval is given by the clinical review unit.

(2) Prior to admitting or reauthorizing any individual for CPR services, all certified CPR providers and affiliates shall submit to the appropriate administrative agent or designee, the name of the person seeking services with basic demographic information, background, and historical information, if available and shall provide support to the person by arranging an appointment for an evaluation. The administrative agent or designee shall conduct an evaluation to determine that the individual is eligible for admission to the CPR provider and to determine whether the individual is among the priority populations of the division as specified in 9 CSR 30-4.039(1)(A) and further defined in the Administrative Agent's Service Area Agreements and Plans available from the Division of Comprehensive Psychiatric Services.

(A) The administrative agent or designee within thirty (30) working days, shall—

1. Conduct a complete intake or annual evaluation as set out in 9 CSR 30-4.035(7) and (18);

2. For persons seeking admission to the CPR services, provide or authorize emergency services and crisis intervention during the period prior to completion of the intake evaluation; and

3. Forward to the referring agency and the client—

A. Confirmation that the individual is eligible to be admitted to the CPR program, and determine that the individual is among the priority populations of the division;

B. A determination that the individual is not eligible for admission to the CPR program and a statement of the client's rights of appeal; or

C. Confirmation that the individual is eligible to be admitted to the CPR program, but has been determined not to be among the priority populations of the division and, therefore, is eligible for admission only after eligible priority clients have been admitted to the CPR program. A statement of the client's right of appeal with regard to any finding that the individual is not in the priority population shall also be provided.

(B) If the administrative agent or designee confirms that the individual is eligible to be admitted to the CPR program and determines that the individual is among the priority populations of the division, then the individual shall be given an opportunity to select a CPR provider from among the CPR programs available in the service area. All eligible priority clients shall be provided the list of providers as set out in Appendix A.

1. The CPR provider selected by the individual shall work with the individual to develop the individual treatment/rehabilitation plan.

2. If an individual does not express a CPR provider preference, then the individual will be admitted to the administrative agent's, or the designee's program.

(C) If the administrative agent or designee determines that the individual is not eligible to be admitted to the CPR program, then the individual shall be referred to other programs and services for which s/he may be eligible. The referral to other programs and services shall accompany the notice of appeal rights furnished the client as set out in 9 CSR 30-4.042(2)(A)3.C.

(D) If the administrative agent or designee confirms that the individual is eligible to be admitted to the CPR program, but determines that the individual is not among the priority populations of the division, the administrative agent or designee may provide services as appropriate.

(E) An individual denied services because of the intake process shall have the right to appeal the decision to deny services to the

division director or his/her designee. This appeal shall be sent in written form to the division director within sixty (60) days following notice of denial by the administrative agent.

(3) The CPR provider shall not admit any person who would not benefit from the services of a CPR provider.

(4) The criteria for admission to community psychiatric rehabilitation program services shall include:

(A) Disability. There shall be clear evidence of serious and/or substantial impairment in the 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 intake evaluation and assessment:

1. Social role functioning/family life—the ability to sustain functionally the role of 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 physician or licensed psychologist shall certify a primary *Diagnostic and Statistical Manual* (DSM) diagnosis as defined in 9 CSR 10-7.140(2)(OO) or *International Classification of Diseases, Ninth Revision with Clinical Modification* (ICD-9-CM), using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses in Axis I or other areas.

1. Schizophrenia.

A. Disorganized.

(I) DSM IV code: 295.1X

(II) ICD-9-CM code: 295.1X

B. Catatonic.

(I) DSM IV code: 295.2X

(II) ICD-9-CM code: 295.2X

C. Paranoid.

(I) DSM IV code: 295.3X

(II) ICD-9-CM code: 295.3X

D. Schizophreniform.

(I) DSM IV code: 295.4X

(II) ICD-9-CM code: 295.4X

E. Residual.

(I) DSM IV code: 295.6X

(II) ICD-9-CM code: 295.6X

F. Schizoaffective.

(I) DSM IV code: 295.7X

(II) ICD-9-CM code: 295.7X



- G. Undifferentiated.
 - (I) DSM IV code: 295.9X
 - (II) ICD-9-CM code: 295.9X
- 2. Delusional disorder.
 - A. DSM IV code: 297.1X
 - B. ICD-9-CM code: 297.1X
- 3. Bipolar I disorders.
 - A. Single manic episode.
 - (I) DSM IV code: 296.0X
 - (II) ICD-9-CM code: 296.0X
 - B. Most recent episode manic.
 - (I) DSM IV code: 296.4X
 - (II) ICD-9-CM code: 296.4X
 - C. Most recent episode depressed.
 - (I) DSM IV code: 296.5X
 - (II) ICD-9-CM code: 296.5X
 - D. Most recent episode mixed.
 - (I) DSM IV code: 296.6X
 - (II) ICD-9-CM code: 296.6X
- 4. Bipolar II disorders.
 - A. DSM IV code: 296.89
 - B. ICD-9-CM code: 296.89
- 5. Psychotic disorders NOS.
 - A. DSM IV code: 298.9
 - B. ICD-9-CM code: 298.9
- 6. Major depressive disorder-recurr.
 - A. DSM IV code: 296.3X
 - B. ICD-9-CM code: 296.3X
- 7. Obsessive-Compulsive Disorder.
 - A. DSM IV code: 300.30
 - B. ICD-9-CM code: 300.3
- 8. Post Traumatic Stress Disorder.
 - A. DSM IV code: 309.81
 - B. ICD-9-CM code: 309.81
- 9. Borderline Personality Disorder.
 - A. DSM IV code: 301.83
 - B. ICD-9-CM code: 301.83
- 10. Anxiety Disorders.
 - A. Generalized Anxiety Disorder.
 - (I) DSM IV code: 300.02
 - (II) ICD-9-CM code: 300.02
 - B. Panic Disorder with Agoraphobia.
 - (I) DSM IV code: 300.21
 - (II) ICD-9-CM code: 300.21
 - C. Panic Disorder without Agoraphobia.
 - (I) DSM IV code: 300.01
 - (II) ICD-9-CM code: 300.01
 - D. Agoraphobia without Panic Disorder.
 - (I) DSM IV code: 300.22
 - (II) ICD-9-CM code: 300.22
 - E. Social Phobia.
 - (I) DSM IV code: 300.23
 - (II) ICD-9-CM code: 300.23
- 11. For children and youth only.
 - A. Major depressive disorder, single episode.
 - (I) DSM IV code: 296.2X
 - (II) ICD-9-DM code: 296.2
 - B. Bipolar disorder, not otherwise specified.

- (I) DSM IV code: 296.80
- (II) ICD-9-CM code: 296.7
- C. Reactive attachment disorder of infancy or early childhood.
 - (I) DSM IV code: 313.89
 - (II) ICD-9-CM code: 313.89
- 12. For adults aged sixty (60) years and over.
 - A. Major depressive disorder, single episode.
 - (I) DSM IV code: 296.2X
 - (II) ICD-9-DM code: 296.2
 - (C) Duration. Rehabilitation services shall be provided to those individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following occurrences:
 1. Persons who have undergone psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);
 2. Persons who have experienced an episode of continuous residential care other than hospitalization, for a period long enough to disrupt the normal living situation;
 3. Persons who have exhibited the psychiatric disability for one (1) year or more; or
 4. Persons whose treatment of psychiatric disorders has been or will be required for longer than six (6) months;
 - (D) Additional criteria may be used to establish the need for and amount of services including results from a standardized assessment prescribed by the department; and
 - (E) Whenever discrepancies occur regarding the appropriateness of an ICD-9-CM versus a DSM diagnosis, the DSM diagnosis shall prevail.

(5) Under the following circumstances, children and adolescents under the age of eighteen (18) years of age may be provisionally admitted to community psychiatric rehabilitation program services:

- (A) Disability: There shall be clear evidence of serious and/or substantial impairment in the 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 intake evaluation and assessment:
 1. Social role functioning/family life—the individual is at risk of out-of-home or out-of-school placement; and
 2. Daily living skills/self-care skills—the individual is unable to engage in personal care (such as grooming, personal hygiene) and community living (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 person is exhibiting behaviors or symptoms that are consistent with an unestablished CPRP eligible diagnosis, they may be provisionally admitted to CPRP for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR eligible diagnosis is appropriate without an opportunity to observe and evaluate the person's behavior, mood, and functional status. In such cases, there must be documentation that clearly supports the individual's level of functioning as defined in subsection (5)(A);
- (C) Duration: There must be documented evidence of an individual's functional disability as defined in subsection (5)(A) for a period of ninety (90) days prior to provisional admission;
- (D) Provisional admissions 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 listed in 9 CSR 30-4.042(4)(B) of the rule, the diagnosis must be documented and the individual may continue in the CPR program;
- (E) If an individual who has been provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging appropriate follow-up services. Follow-up services shall be documented in the discharge summary of the clinical record;
- (F) All admission documentation is required for those provisionally admitted, with the exception of the comprehensive evaluation, which may be deferred for ninety (90) days.

vidual's age, developmental level, and social role functioning;

(B) Diagnosis: If a person is exhibiting behaviors or symptoms that are consistent with an unestablished CPRP eligible diagnosis, they may be provisionally admitted to CPRP for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR eligible diagnosis is appropriate without an opportunity to observe and evaluate the person's behavior, mood, and functional status. In such cases, there must be documentation that clearly supports the individual's level of functioning as defined in subsection (5)(A);

(C) Duration: There must be documented evidence of an individual's functional disability as defined in subsection (5)(A) for a period of ninety (90) days prior to provisional admission;

(D) Provisional admissions 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 listed in 9 CSR 30-4.042(4)(B) of the rule, the diagnosis must be documented and the individual may continue in the CPR program;

(E) If an individual who has been provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging appropriate follow-up services. Follow-up services shall be documented in the discharge summary of the clinical record;

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

AUTHORITY: section 630.050, RSMo Supp. 2009 and sections 630.655 and 632.050, RSMo 2000. 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*



II, 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.

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

9 CSR 30-4.043 Treatment Provided by Community Psychiatric Rehabilitation Programs

PURPOSE: This rule sets policies and procedure requirements relating to psychiatric treatment services provided by community psychiatric rehabilitation programs.

(1) The community psychiatric rehabilitation (CPR) provider shall establish and implement written policies and procedures regarding the evaluation of the medical need of clients in consultation with a physician.

(A) The evaluation team shall determine a person's need for a physical examination.

1. The procedure shall include health questions, date of last physical examination, awareness of any medical problems and current medications prescribed and taken.

2. The CPR provider shall file results of the physical examination in the person's clinical record.

(2) The CPR provider shall provide the following community psychiatric rehabilitation services to eligible clients, as prescribed by individualized treatment plans:

(A) Crisis intervention and resolution, face-to-face emergency or telephone intervention services, available twenty-four (24) hours a day on an unscheduled basis to the client, designed to resolve crisis, provide support and assistance, and to promote a return to routine adaptive functioning. Key service functions shall include, at a minimum, but are not limited to:

1. Interacting with an identified client, family members, legal guardian, significant others, or a combination of these;

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

3. Identifying the maladaptive reactions exhibited by the client;

4. Evaluating the potential for rapid regression;

5. Attempting to resolve the crisis; and

6. When indicated, referring the client for treatment in an alternative setting. Non-

medical staff providing crisis intervention and resolution shall have immediate twenty-four (24)-hour telephone access to physician consultation;

(B) Medication services, goal-oriented interaction regarding the need for psychoactive medications and the management of a medication regimen. Advanced practice nurses and psychiatric pharmacists may provide this service, subject to the guidelines and limitations promulgated for each specialty in statutes and administrative rules. Psychiatric pharmacists are allowed to provide all key service functions with the exception of prescribing medications under (2)(B)7. Key service functions shall include, but are not limited to:

1. An assessment of the client's presenting condition;

2. A mental status exam;

3. A review of symptoms and medication side effects;

4. A review of client functioning;

5. An assessment of the client's ability to self-administer medication;

6. Client education regarding the effects of medication and its relationship to the client's mental illness; and

7. When indicated, the prescription of medications;

(C) Consultation services, a service provided by a physician, an advanced practice nurse, or a psychiatric pharmacist and consisting of a review of a client's current medical situation either through consultation with one (1) staff person or in team discussions related to the specific client. The intent is to provide direction to treatment. This is an optional service which may not substitute for supervision nor for face-to-face intervention with clients;

(D) Medication Administration. Key service functions include: any therapeutic injection of medication (subcutaneous or intramuscular); monitoring lab levels including consultation with physicians, consumers, and caseworkers; coordination of medication needs with pharmacies, clients, and families, including the use of indigent drug programs (excluding the routine placing of prescription orders and refills with pharmacies); setting up medication boxes; medication drops to consumer residences; patient education regarding medications; recording initial patient histories and vital signs; monitoring medication compliance; monitoring medication side-effects including the use of standardized evaluations; and monitoring physician orders for treatment modifications requiring patient education;

(E) Medication Administration Support. The coordination of medication needs with

pharmacies, clients and families including the use of indigent drug programs (excluding the routine placing of prescription orders and refills with pharmacies); setting up medication boxes; medication drops to consumer residences; monitoring medication compliance; and monitoring vital signs;

(F) Community support, activities designed to ease an individual's immediate and continued adjustment to community living by coordinating delivery of mental health services with services provided by other practitioners and agencies, monitoring client progress in organized treatment programs, among other strategies. Key service functions include, but are not limited to:

1. Assessing and monitoring a client's adjustment to community living;

2. Monitoring client participation and progress in organized treatment programs to assure the planned provision of service according to the client's individual treatment plan;

3. Participating in the development or revision of a specific individualized treatment plan;

4. Providing individual assistance to clients in accessing needed mental health services including accompanying clients to appointments to address medical or other health needs;

5. Providing individual assistance to clients in accessing a variety of public services including financial and medical assistance and housing, including assistance on an emergency basis, and directly helping to meet needs for food, shelter, and clothing;

6. Assisting the client to access and utilize a variety of community agencies and resources to provide ongoing social, educational, vocational and recreational supports and activities;

7. Interceding on behalf of individual clients within the community-at-large to assist the client in achieving and maintaining their community adjustment;

8. Maintaining contact with clients who are hospitalized and participating in and facilitating discharge planning;

9. Training, coaching and supporting in daily living skills, including housekeeping, cooking, personal grooming, accessing transportation, keeping a budget, paying bills and maintaining an independent residence;

10. Assisting in creating personal support systems that include work with family members, legal guardians or significant others regarding the needs and abilities of an identified client;

11. Encouraging and promoting recovery efforts, consumer independence/self-care and responsibility; and



12. Providing support to families in areas such as treatment planning, dissemination of information, linking to services, and parent guidance;

(G) Community support assistants, as defined in 9 CSR 30-4.030 and 9 CSR 30-4.034, may provide the following community support services:

1. Providing individual assistance to clients in accessing needed mental health services including accompanying clients to appointment to address medical or other health needs;

2. Providing individual assistance to clients in accessing a variety of public services including financial and housing, including assistance on an emergency basis, and directly helping to meet needs for food, shelter, and clothing;

3. Assisting clients to access and utilize a variety of community agencies and resources to provide ongoing social, educational, vocational and recreational supports and activities;

4. Training, coaching and supporting in daily living skills, including housekeeping, cooking, personal grooming, accessing transportation, keeping a budget, paying bills and maintaining an independent residence;

5. Accompanying clients to activities in the community if appropriate;

6. Following up with clients regarding appointments, completion of forms, returning forms or receipts and other similar activities;

(H) Intensive Community Psychiatric Rehabilitation (CPR) as defined in 9 CSR 30-4.045;

(I) Psychosocial Rehabilitation. Key service functions include, but are not limited to, the following services which must be available within the community psychiatric rehabilitation program as indicated by individual client need:

1. Initial screening to evaluate the appropriateness of the client's participation in the program;

2. Development of individualized program goals and objectives;

3. The provision of rehabilitative services which may occur during the day, evenings, weekends or a combination of these. Services should be structured, but are not limited to a program site;

4. Services that enhance independent living skills;

5. Services that address basic self-care needs;

6. Services that enhance the use of personal support systems;

7. Transportation to and from community facilities and resources as a part of program strategies;

8. Services shall be provided according to individual need toward goals of community inclusion, integration, and independence; and

9. Services should be available to adults as well as children and youth who need age-appropriate developmental focused rehabilitation; and

(J) Psychosocial Rehabilitation-Recovery Support. A program certified by the department. Key service functions include, but are not limited to, the following services as indicated by individual client need:

1. A supervised, low demand environment that permits clients to practice skills and behaviors that will generalize to assist with personal relationships and supports, community integration and other life activities;

2. Support of informal, low demand group activities to engage the client to promote receptiveness to service delivery, cooperation with clinical interventions and medication as well as building trust to promote self-disclosure about symptoms, medication effects and other pertinent information;

3. Participation in support and self-help activities and groups that promote recovery;

4. Participation in informal and organized group activities to help reduce stress and improve coping that are normative to the community such as exercise, self-education, sports, hobbies, supportive social networks, etc.;

5. Provision of a safe environment for adaptive skills development and practice for individuals vulnerable to victimization due to the severity of their symptomatology and for those experiencing acute distress due to their psychiatric illness;

6. Ongoing informal assessment regarding participant mental status and communication of relevant information and behavioral descriptions to the team for follow-up as necessary; and

7. Participation may be scheduled or unscheduled.

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. 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.

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

9 CSR 30-4.0431 Integrated Dual Disorders Treatment Programs

PURPOSE: This rule sets forth standards and regulations for the provision of integrated dual disorders treatment 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) Integrated Dual Disorders Treatment (IDDT) is integrating substance abuse treatment with community psychiatric rehabilitation treatment for individuals with co-occurring psychiatric and substance use disorders. IDDT is a practice based on evidence and research for individuals with serious mental illness and substance use disorders.

(2) Agencies certified as Community Psychiatric Rehabilitation (CPR) providers may offer further specialized treatment for co-occurring psychiatric and substance use disorders and shall use the *Co-occurring Disorders: Integrated Dual Disorders Treatment (IDDT) Implementation Resource Kit* published by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services at PO Box 42557, Washington, DC 20015 Evaluation Edition 2003, to implement integrated treatment for individuals with co-occurring psychiatric and substance use disorders. A copy of the IDDT Implementation Resource Kit is available at the Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health and a copy may be obtained by contacting the Division of Comprehensive Psychiatric Services. The IDDT Implementation Resource Kit that is



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 IDDT model of treatment.

(4) Admission Criteria. Persons meeting criteria for this level of service must meet admission criteria as defined in 9 CSR 30-4.042 and must have a co-occurring substance use disorder.

(A) Individuals shall receive screening for mental health and substance use/abuse disorders using the department-approved screening tools.

(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. IDDT shall be delivered by a multidisciplinary team responsible for coordinating a comprehensive array of services available to the individual through CPR with the amount of frequency of service commensurate with the individual's assessed need.

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

1. A physician or an advanced practice nurse;
2. A registered professional nurse;
3. A qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH);
4. Additional staff sufficient to provide community support, and retain the responsibility for acquisition of appropriate housing and employment services;
5. A qualified substance abuse professional defined as a person who demonstrates substantial knowledge and skill regarding substance abuse by being one (1) of the following:

A. A physician or qualified mental health professional who is licensed in Missouri with at least one (1) year of full-time experience in the treatment of persons with substance use disorders; or

B. A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselor's Certification Board, Incorporated.

(B) The multidisciplinary treatment team shall meet regularly to discuss each individ-

ual's progress and goals and provide insights and advice to one another.

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

(D) The number of IDDT teams shall be determined by the needs and number of individuals being supported.

(E) Only qualified staff shall provide IDDT treatment services. Qualified staff for each service shall include:

1. For individual counseling, group counseling, and assessment, a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) or a qualified substance abuse professional defined as a person who demonstrates substantial knowledge and skill regarding substance abuse by being one (1) of the following:

A. A physician or qualified mental health professional who is licensed in Missouri with at least one (1) year of full-time experience in the treatment of persons with substance use disorders; or

B. A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselor's Certification Board, Incorporated.

2. For group education, eligible providers shall have documented education and experience related to the topic presented and either be, or be supervised by, a qualified mental health professional or a qualified substance abuse professional who meets co-occurring counselor competency requirements established by the department; and

3. Qualified mental health professionals and qualified substance abuse professionals shall meet the co-occurring counselor competency requirements as approved by the department.

(6) Treatment.

(A) IDDT shall be delivered according to the IDDT criteria and will be time unlimited with the intensity modified according to level of need and degree of recovery; shall include interventions to promote physical health; and shall target specific services to individuals who do not respond to treatment.

(B) In addition to eligible CPR services, IDDT services include the following:

1. Co-occurring individual counseling. A structured goal-oriented therapeutic process in which an individual interacts on a face-to-face basis with a counselor in accordance with the individual's rehabilitation plan in order to resolve problems related to the

individual's documented mental disorders 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 face-to-face interaction with one (1) or more members of the individual's family for the purpose of assessment or supporting the individual's recovery;

2. Co-occurring group counseling. Face-to-face goal oriented therapeutic interaction among a counselor and two (2) or more individuals as specified in individual rehabilitation 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 education. 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 participants, consumers as well as family members, 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 and interaction. Group size shall not exceed twenty (20) individuals;

4. Co-occurring assessment supplement. Individuals suspected of having co-occurring substance use disorders and mental health disorders must receive additional assessments to document the co-occurring disorders and assess the interaction of the co-occurring disorders over time. The completion of the co-occurring assessment shall be documented by the submission to the department of data required by the department and the development of a comprehensive integrated treatment plan to address problems related to the co-occurring disorders;

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



6. The agency shall provide housing and vocational services consistent with the IDDT 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 are assisted to connect with self-help programs in the community.

(D) Families and significant others shall receive education and, as appropriate, be involved in therapy.

(7) Records.

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

(B) The treatment plan shall address mental health and substance abuse 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) Quality improvement. The agency's quality improvement plan shall include monitoring compliance with the provider's IDDT program; identifying and measuring the individual's satisfaction and outcomes; and self-assessing fidelity to the IDDT model.

AUTHORITY: section 630.050, RSMo Supp. 2008 and sections 630.655 and 632.050, RSMo 2000. Original rule filed Sept. 2, 2008, effective April 30, 2009.*

**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 Programs

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

PUBLISHER'S NOTE: The Department of Mental Health 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 team-based approach to delivering comprehensive and flexible treatment, support, and services to individuals who have the most serious symptoms of severe mental illness and who have the greatest difficulty with basic daily activities.

(2) Agencies certified as Community Psychiatric Rehabilitation (CPR) providers may offer ACT services and shall use the *Assertive Community Treatment (ACT) Implementation Resource Kit* published in 2003 by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services at PO Box 42557, Washington, DC 20015, Evaluation Edition 2003, to implement the ACT program. Agencies shall also use *A Manual for ACT Start-Up* by Deborah J. Allness, M.S.S.W. and William H. Knodler, M.D., published in 2003 by National Alliance for the Mentally Ill (NAMI), Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042. A copy of the *ACT Implementation Resource Kit* and *A Manual for ACT Start-Up* is available at the Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health and a copy may be obtained by contacting the Division of Comprehensive Psychiatric Services. The *ACT Implementation Resource Kit* and *A Manual for ACT Start-Up* that are incorporated by reference with this rulemaking 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 Abuse 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 multidisciplinary 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:

lowing:

1. A psychiatrist 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 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 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 psychiatrist or advanced practice nurse shall attend at least two (2) team meetings per week either face-to-face or by teleconference;

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

1. A registered professional nurse with six (6) months of psychiatric nursing experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation; or

2. During the first year of program operation, a registered professional nurse shall work with no more than fifty (50) individuals as a seventy-five percent (75%) Full-Time Equivalent (FTE) for up to twelve (12) months;

(D) A team leader who is a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) that is full time with one (1) year of supervisory experience and a minimum of two (2) years experience working with adults with serious mental illness in community settings;

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

1. A substance abuse specialist who is a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR)1. or 2. with one (1) year of training or supervised experience in substance abuse treatment shall be assigned to no more than fifty (50) individuals; or

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

3. A QSAP who has less than one (1) year experience in Integrated Dual Disorders Treatment (IDDT) shall be actively acquiring twenty-four (24) hours of training in IDDT-specific content and receive supervision from experienced IDDT staff;



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

1. A vocational specialist who qualifies as a community support worker as defined in 9 CSR 30-4.034(2)(H)1. with one (1) year of experience and training in vocational rehabilitation and supported employment shall be available to no more than fifty (50) individuals; or

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

3. A vocational specialist with six (6) months of vocational experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation;

(G) The team shall include a peer specialist which shall be self-identified as a present or former primary consumer of mental health services; be assigned full time to a team and shall participate in the clinical responsibilities and functions of the team in providing direct services; and serve as a model, a support, and a resource for the team members and individuals being served by the first year of program operation. Peer specialists, at a minimum, shall meet the qualifications of a community support assistant as defined in 9 CSR 30-4.030(2)(P) and 9 CSR 30-4.034(2)(H)2.;

(H) The team shall include a program assistant. A team of one hundred (100) individuals requires one (1) Full Time Equivalent (FTE) prorated based on team size. 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. Triaging 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 worker or a qualified mental health professional as defined in 9 CSR 30-4.034 (2)(H)1. or 9 CSR 30-4.030(2)(HH); 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 prima-

ry provider of services for the purpose of recovery from serious mental illness and shall have responsibility to help individuals meet their needs in all aspects of living in the community.

(B) The team shall meet face-to-face at least four (4) 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.

(7) Admission Criteria. Individuals who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive mental health services. Individuals shall have at least one (1) of the following diagnoses, one (1) or more of the following conditions, and meet all other admission criteria as defined in 9 CSR 30-4.042:

(A) Schizophrenia.

1. Disorganized.
 - A. DSM IV code: 295.1X
 - B. ICD-9-CM code: 295.1X
2. Catatonic.

- A. DSM IV code: 295.2X
- B. ICD-9-CM code: 295.2X

3. Paranoid.
 - A. DSM IV code: 295.3X
 - B. ICD-9-CM code: 295.3X

4. Schizophreniform.
 - A. DSM IV code: 295.4X
 - B. ICD-9-CM code: 295.4X

5. Residual.
 - A. DSM IV code: 295.6X
 - B. ICD-9-CM code: 295.6X

6. Schizoaffective.
 - A. DSM IV code: 295.7X
 - B. ICD-9-CM code: 295.7X

7. Undifferentiated.
 - A. DSM IV code: 295.9X
 - B. ICD-9-CM code: 295.9X;

(B) Delusional Disorder.

1. DSM IV code: 297.1X
2. ICD-9-CM code: 297.1X;

(C) Bipolar I Disorders.

1. Single manic episode.
 - A. DSM IV code: 296.0X
 - B. ICD-9-CM code: 296.0X
2. Most recent episode manic.
 - A. DSM IV code: 296.4X
 - B. ICD-9-CM code: 296.4X
3. Most recent episode depressed.
 - A. DSM IV code: 296.5X
 - B. ICD-9-CM code: 296.5X
4. Most recent episode mixed.
 - A. DSM IV code: 296.6X
 - B. ICD-9-CM code: 296.6X;

(D) Bipolar II Disorders.

1. DSM IV code: 296.89
2. ICD-9-CM code: 296.89;

(E) Psychotic Disorders NOS.

1. DSM IV code: 298.9
2. ICD-9-CM code: 298.9;

(F) Major Depressive Disorder-Recur.

1. DSM IV code: 296.3X
2. ICD-9-CM code: 296.3X;

(G) The diagnosis may coexist with other psychiatric diagnoses in Axis II or other areas;

(H) For individuals exhibiting extraordinary clinical needs, the team may apply to the clinical director of the division to approve admission to ACT services; and

(I) The conditions shall include the following:

1. Recent discharge from an extended stay of three (3) months or more in a state hospital;

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 criminal justice involvement including arrest and incarceration;

5. Reside in substandard housing, is homeless, or at imminent risk of becoming homeless;

6. Have been identified through department data indicating high use of services or who are functioning poorly and do not attend office-based mental health programs consistently; or

7. Other indications demonstrating that the individual has difficulty thriving in the community.

(8) Admission Process.

(A) The team shall develop a process for identifying individuals who are appropriate for ACT services.

(B) When the team receives a referral for ACT services, the team leader confirms that the individual meets the ACT admission 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, 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 that 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) No more than six (6) new individuals shall be admitted to an ACT team per month unless approved by the department.

(G) 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 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.

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

(I) The team shall ensure that the individual receiving services participates in the development of the treatment plan 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.

(J) A psychiatrist 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. An advanced practice nurse may approve the treatment plan if he/she is providing medication management services to the individual.

(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*.

(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, 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 seven (7) parts as follows:

1. Psychiatric history, mental status, and diagnosis;
2. Physical health;
3. Use of drugs or alcohol;
4. Education and employment;
5. Social development and functioning;
6. Activities of daily living; and
7. Family structure and relationships.

(D) The primary case manager and other members of the team, with supervision from the team leader, shall complete 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, friends, and others in the community.

(F) The comprehensive assessment is a daily and continuous process that is updated every six (6) months.

(G) A psychiatric and social functioning history timeline shall be developed using the protocol included in the publication, *A Manual for ACT Start-Up*.

(H) Treatment plans shall be developed utilizing information obtained from the psychiatric and social functioning history timeline and the comprehensive assessment.

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

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

(K) The comprehensive treatment plan shall be developed within thirty (30) days after admission.

(L) The treatment plan shall be reviewed and 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) ACT services shall be available at least two (2) hours of direct services each weekend day or holiday.

(C) A team member shall be on call at all hours.

(D) Crisis assessment is provided by the team or arranged for by an after-hours crisis intervention system, twenty-four (24) hours per day. When the team is contacted, the team shall determine the need for team intervention either by phone or face-to-face with backup by the team leader and psychiatrist.

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

(F) The team shall provide goal driven case management functions for all individuals enrolled in ACT including, but not limited to, the following:

1. Locating and maintaining safe, affordable housing with an emphasis on individual choice and independent community housing;

2. Assistance with financial management support, including the use of legal mechanisms when appropriate;

3. Support and skills training and illness management strategies to support activities of daily living;

4. Facilitating peer support and self-help programs as desired by the individual; and

5. Providing psycho-education to individuals and their family members, with the individual's permission, as appropriate.

(G) The team shall have a process to manage emergency funds for individual's served.

(H) Clinical staff to client ratio, excluding the psychiatrist, shall be 1:10.

(I) Clinical staff to client ratio shall be no more than 1:13 if the team continues to demonstrate outcomes in areas such as vocational, housing, and hospitalizations comparable to teams with lower caseloads.

(J) The clinical team shall be no smaller than five (5) FTE and no larger than ten (10) FTE.

(K) At a minimum, individuals shall be contacted face-to-face by the team an average of two (2) hours per week.

(L) 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.

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

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

(O) Individuals shall have direct contact with more than two (2) team members per



month.

(P) Individuals with co-occurring substance abuse disorders shall be provided integrated mental health and substance abuse treatment.

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

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

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

(T) The team shall have an average of four (4) or more contacts per month with family and support systems in the community, including landlords and employers, after obtaining the individual's permission.

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

1. Establishing ongoing communication and collaboration between the team, family members, and others;

2. Educating the family about mental illness and the family's role in treatment;

3. Educating the family about symptoms management and early identification of symptoms indicating onset of disease; and

4. Providing interventions to promote positive interpersonal relationships.

(V) 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.

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

(X) The team shall participate in discharge planning.

(11) Discharge Criteria.

(A) Individuals shall have achieved community living goals for the previous six (6) months.

(B) Social supports shall have been in place for the previous six (6) months.

(C) Individuals shall have stable housing for the previous six (6) months.

(D) 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.

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

(F) Documentation of discharge 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.

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

1. Dates of admission and discharge;
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 discharge; and
6. Medical status and needs that may require ongoing monitoring and support.

(H) An aftercare plan shall be completed prior to discharge. 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 are logged 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. 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 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 team shall review the treatment plan, goals, and objectives on a regular basis, as determined by department policy.

1. The review shall determine the individual's progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for the individual's continued participation in specific community psychiatric rehabilitation services.

2. The team shall document the review in detail in the individual's record.

3. The ACT provider shall make the review available as requested for state or federal review purposes.

4. The ACT provider shall ensure the individual participates in the treatment plan review.

(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 provider shall establish and implement a procedure that assures the inter-center transfer of referral and treatment information within five (5) working days.

(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.

(J) Each agency that is certified shall be subject to recoupment of all or part of department payments when—

1. The individual's record fails to document the service paid for was actually provided;



2. The individual's record fails to document the service paid for was provided by a qualified staff person, as defined in the Department of Mental Health Purchase of Service Catalog;

3. The individual's record fails to document the service that was paid meets the service definition, as defined in the Department of Mental Health Purchase of Service Catalog;

4. The individual's record fails to document the amount, duration, and length of service paid for by the department; or

5. The individual's record fails to document the service paid for was delivered under the direction of a current treatment plan that meets all the requirements for treatment plans set forth in 9 CSR 10-7.030.

(13) Quality Improvement—The agency's quality improvement plan shall include monitoring compliance with the ACT standards.

(A) Records shall show evidence that the team monitors hospitalization, housing, employment, and criminal justice contacts for all individual's using a tracking form approved by the department and submitted to the division on a quarterly basis.

(B) The agency shall conduct an annual fidelity self-assessment.

(C) The team shall participate in fidelity reviews conducted by the division.

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

AUTHORITY: section 630.050, RSMo Supp. 2009 and sections 630.655 and 632.050, RSMo 2000. Original rule filed Aug. 14, 2009, effective March 30, 2010.*

**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

PURPOSE: This rule sets forth standards and regulations for the provision of intensive community psychiatric rehabilitation service.

(1) Intensive Community Psychiatric Rehabilitation (CPR). A level of support designed to help consumers who are experiencing an acute psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient or residential setting. It is a comprehensive, time-limited, community-based service delivered to consumers who are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.

(A) The intensive community psychiatric rehabilitation is intended for the following consumers:

1. Persons who would be hospitalized without the provision of intensive community-based intervention; or

2. Persons who have extended or repeated hospitalizations; or

3. Persons who have crisis episodes; or

4. Persons who are at risk of being removed from their home or school to a more restrictive environment; or

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 require assertive outreach and engagement.

(B) Intensive community psychiatric rehabilitation is provided by treatment teams delivering services that will maintain the consumer within the family and significant support systems and assist consumers in meeting basic living needs and age appropriate developmental needs.

(C) A treatment team comprised of individuals required to provide the specific services identified on the Individualized Treatment Plan (ITP), delivers this level of service to consumers who meet the Community Psychiatric Rehabilitation (CPR) eligibility criteria.

(2) Admission Criteria. Persons meeting criteria for this level of service must meet admission criteria as defined in 9 CSR 30-4.042, will be in need of intensive clinical intervention or support to alleviate or eliminate the need for admission into a psychiatric inpatient or a restrictive living setting and must meet at least one (1) of the following descriptions:

(A) A person who is being discharged from a Department of Mental Health facility or Department of Mental Health purchased bed;

(B) A person who has had extended or repeated psychiatric inpatient hospitalizations or crisis episodes within the past six (6) months;

(C) A person who has had multiple out-of-home placements due to their mental disorder; or

der; or

(D) A person who is at imminent risk of being removed from his/her home, school or current living situation.

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

(A) The treatment team shall be supervised by a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) and shall include the following:

1. Individuals required to provide specific services identified on the Individualized Treatment Plan; and

2. The consumer, and family if developmentally appropriate.

(B) Treatment team models shall follow one (1) of two (2) options:

1. The treatment team may serve exclusively individuals enrolled in the intensive CPR level; or

2. The treatment team may serve individuals enrolled in intensive CPR and individuals enrolled in the rehabilitation levels.

(4) Treatment.

(A) Intensive CPR shall include—

1. Multiple face-to-face contacts on a weekly basis and may require contact on a daily basis;

2. Services that are available twenty-four (24) hours per day and seven (7) days per week;

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

(B) A full array of CPR services as defined in 9 CSR 30-4.043 shall be available to each individual based upon identified needs. In addition, the following services are also available, including but not limited to:

1. Outreach and engagement;

2. Behavioral aide/family assistance worker;

3. Targeted case management;

4. Clinical interventions for the purpose of stabilizing the individual offered twenty-four (24) hours per day and seven (7) days per week;

5. Increased services to assist the individual with medication stabilization;

6. Utilization of natural services and supports needed to maintain the individual in the community;

7. Day treatment.

(C) The frequency of service delivery shall be based upon the individual's assessed acuity and need.



(D) Individuals can be moved out of the intensive level when:

1. There is a reduction of acute symptoms; and
2. The individual is able to function in the rehabilitation level of CPR; or
3. The individual chooses to move from the intensive level.

(5) Client Records.

(A) For consumers currently enrolled in the CPR Program, documentation must be present in the client record indicating the individual's acuity level and supporting admission into the intensive level of care. Upon admission to the intensive level of care, the following is required—

1. A progress note must be written that documents the individual's acuity level and compliance with admission criteria;
2. The treatment plan must be updated to reflect the higher level of service the individual will receive while participating in the intensive level of care;
3. The appropriate outcomes packet shall be completed and forwarded to the department; and
4. Service system reporting shall be updated to reflect participation with the appropriate program code.

(B) For new consumers who have been admitted directly from the community into the intensive level of care, a brief evaluation to substantiate acuity and criteria for admission will initially be accepted which may be in the form of a separate report or progress note that includes the following elements: presenting problem, recent psychiatric history, current medications, current housing status, current legal status, family and/or guardian, and mental status examination.

1. Each individual shall have a psychiatric evaluation at admission. For individuals who have been discharged from an inpatient bed into the intensive level of care, a psychiatric evaluation completed at the facility will initially be accepted.

2. A comprehensive evaluation shall be completed within thirty (30) days of admission except for individuals admitted provisionally.

3. Treatment plans shall be developed upon admission to the intensive level of care.

4. The appropriate outcomes packet shall be completed and forwarded to the department.

5. Service system reporting shall be updated to reflect participation with the appropriate program code.

(C) Treatment plans shall be reviewed on a weekly basis and the review documented in the case record with a summary progress note

including updates to the treatment plan as appropriate.

(D) Each individual shall have a critical intervention plan.

(E) All services provided must have accompanying progress notes that include:

1. Specific type of service rendered as defined in the CPR menu of services or the Purchase of Service Catalogue;
2. Date and actual time the service was rendered;
3. Who rendered the service;
4. The setting in which the service was rendered;
5. The amount of time it took to deliver the service;
6. The relationship of services to the treatment regimen described in the treatment plan;
7. Updates describing the client's response to prescribed care and treatment; and
8. Signature and position of staff member delivering the service.

(F) Upon change from the intensive level of care, a transition plan for follow-up services must be documented in a level of care transition summary and reflected in an updated treatment plan.

(G) Upon change from the intensive level of care, the provider must complete the appropriate outcomes packet and forward to the department.

(6) Quality Assurance.

(A) The department will track the following indicators:

1. Hospitalizations that occur while the individual is participating in the intensive level of care; and
2. Consumer movement to a more restrictive level of care while the individual is participating in the intensive level of care.

(B) The department will monitor specific services provided to an individual while they are enrolled in intensive CPR. The providers shall maintain and have available for review, the detail regarding service delivery. This information must be in the same format as if the services had been billed separately. The review may consist of documents sent to the department for review or a face-to-face review on-site at an agency.

*AUTHORITY: sections 630.050, 630.655 and 632.050, RSMo 2000. * Emergency rule filed Dec. 28, 2001, effective Jan. 13, 2002, expired July 11, 2002. Original rule filed Dec. 28, 2001, effective July 12, 2002.*

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

9 CSR 30-4.046 Psychosocial Rehabilitation

PURPOSE: This rule provides standards for psychosocial rehabilitation programs operated as part of a community psychiatric rehabilitation program.

(1) The activities of the psychosocial rehabilitation program shall focus on—

(A) Development of behaviors and abilities that will allow the client to return to activities appropriate to his/her age and based on the client's assessed needs;

(B) Development of behaviors and abilities that will allow the client to fully participate in community living;

(C) Prevention of extended psychiatric hospitalization(s);

(D) Establishment and improvement of an individual's desire or motivation to maximize independence;

(E) Development of a personal support system; and

(F) Provision of meaningful activity which is appropriate to the age and level of functioning and interest of the client.

(2) The psychosocial rehabilitation program shall be accredited by the Council on Accreditation of Rehabilitation Facilities or licensed as a day program by the department under 9 CSR 40-1.015-9 CSR 40-10.155 inclusive.

(A) In those instances in which certification standards are more restrictive than licensure standards, the certification standards shall prevail.

(B) The director of the psychosocial rehabilitation program shall be a mental health professional and shall have two (2) years of relevant work experience.

(3) The psychosocial rehabilitation program shall implement policies and procedures for intake screening, referral and client assignment.

(A) Intake policies and procedures shall define procedures for referral of persons ineligible for psychosocial rehabilitation services.

(B) Maximum client waiting time from initial face-to-face contact to intake screening is ten (10) working days or sooner if clinically indicated.

(C) The intake screening shall determine the client's need of psychosocial rehabilitation, functional strengths and weaknesses and transportation needs.

(D) Full assessment and development of a psychosocial rehabilitation program plan shall occur within thirty (30) days of admission to the program.



(4) The psychosocial rehabilitation program shall establish policies and procedures to implement and maintain documentation of measurable progress in the following key services:

(A) Training/rehabilitation in community living skills;

(B) Prevocational training/rehabilitation either directly or through subcontracts, according to individual client need, including, at a minimum, but not limited to, the following:

1. Interview and job application skills;
2. Therapeutic work opportunities; and
3. Temporary employment opportunities; and

(C) Development of personal support systems through a group modality.

(5) The community psychiatric rehabilitation (CPR) provider shall provide or arrange transportation to and from the psychosocial rehabilitation program, as well as to various sites in the community, to provide off-site training/rehabilitation in realistic settings.

(6) The psychosocial rehabilitation program shall provide regular client access to facilities and equipment necessary to provide opportunities for training and rehabilitation in daily living skills, including at a minimum, those activities associated with meal preparation and laundry.

(7) The psychosocial rehabilitation program shall provide off-site services on a regular basis as part of the structured plan of activities for training/rehabilitation of community living skills.

(8) The psychosocial rehabilitation program shall provide or arrange for services on evenings and weekends, as required, to effectively address the rehabilitation needs of the program clients.

(9) The psychosocial rehabilitation program shall implement policies and procedures to provide for the participation of clients, client family members and client advocates (with client agreement) in the planning, development and evaluation of the psychosocial rehabilitation program's activities.

*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.*

**Original authority: 630.655, RSMo 1980.*

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

(1) The community psychiatric rehabilitation (CPR) provider shall establish an identifiable unit within the CPR program which coordinates and provides community support services for persons with serious mental illnesses. The unit is organized to perform those functions within the scope of community support services, including critical interventions.

(2) The program shall implement a mechanism for the development of a critical intervention plan for community support clients who are judged by the evaluation team to be in need of critical intervention strategies.

(3) The CPR provider shall implement policies and procedures to provide adequate, appropriate and effective community support services. Those policies and procedures shall include:

(A) A mechanism to assure the provision of all needed community psychiatric rehabilitation services, as indicated in the client's current individualized treatment plan;

(B) A mechanism to assure the provision of all needed services in addition to the community psychiatric rehabilitation program, as indicated in the client's current individualized treatment plan;

(C) The methodology for assignment of clients to community support worker/teams, including:

1. Procedures to assure that each client is afforded choices in the selection of community support workers;

2. A mechanism to assure that all admitted clients are assigned to an active caseload of community support worker; and

3. A mechanism to assure compliance with minimum/maximum caseload requirements;

(D) A process to assure an effective transfer and follow-up of a client between or among community support workers or community support teams. Staff shall document client acceptance, rationale and follow-up of the transfer in the clinical record;

(E) The determination of increase or deterioration of client functioning through ongoing needs assessment and quality assurance activities;

(F) The identification and documentation of unresolved service delivery constraints;

(G) Contribution and participation of staff providing community support services in the CPR program's quality assurance process;

(H) Development of suitable revisions to the client's treatment goal(s) as indicated by growth or deterioration of individual client functioning, condition;

(I) Program and aggregate evaluation activities to determine service effectiveness;

(J) The program shall assure that there are effective and appropriate interventions during critical situations which pose risk of serious harm to the client or the client's ability to live outside of an institution or a more restrictive setting.

1. CPR program staff shall report the situation and intervention immediately by phone to the staff's supervisor and the program's clinical director. The client's clinical record shall contain documentation of the situation, intervention and require staff contacts.

2. Qualified mental health professional staff shall monitor the client as frequently as clinically necessary as documented in the client record or in the client's critical intervention plan, until the situation no longer is judged as critical.

3. Staff shall report, monitor and document all subsequent interventions related to the original critical situation; and

(K) The programs shall conduct a monthly case review of all critical interventions occurring during the previous month.

(4) Critical intervention goals and objectives shall describe or include:

(A) An individualized listing of critical situations precipitating events or actual crises that are known from the client's recent and long-term history; and

(B) A listing of possible interventions in hierarchical order or restrictiveness, that may be used when identified critical situations are recognized. Interventions may include, for example, the immediate filling of a prescription; use of alternative sleeping arrangements on a temporary basis; daily monitoring; assessment of medications compliance and regimen; outpatient commitment; voluntary or civil involuntary admission to an inpatient psychiatric program.

(5) Observation and monitoring of the client shall occur in the client's place of residence at least quarterly or more frequently as stipulated by the client's individual treatment plan. Exceptions shall be documented.

(6) The CPR provider shall conduct a monthly case review of all critical interventions occurring during the previous month.

(A) The review shall include an evaluation of the etiology of the situation, the adequacy of the critical intervention plan and the



appropriateness and effectiveness of all resulting interventions.

(B) The review team shall document findings of the reviews and incorporate the results into the program's critical intervention planning and evaluation strategies.

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.*

**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

PURPOSE: This rule prescribes the contents to be found in client's records.

(1) Each agency that is certified shall comply with all requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Abuse Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

(2) Treatment plans shall be reviewed and updated as necessary to reflect client progress and changes in treatment goals and services.

(3) Treatment plans shall be revised and rewritten at least annually.

(4) Treatment plans shall be developed by and approved by an individual who meets the minimum requirements for a qualified mental health professional as defined in 9 CSR 30-4.010.

(5) The provider shall ensure that the client participates in the development of the treatment plan and signs the plan. Client signature is not required if signing would be detrimental to the client's well-being. If the client does not sign the treatment plan, the provider shall insert a progress note in the case record explaining the reason why the client did not sign the plan.

(A) For children and youth, the parent or guardian shall participate in the development of the treatment plan and sign the plan. If the parent or guardian does not sign the treatment plan, the provider shall insert a progress note in the case record explaining why they did not sign the plan.

(B) The child or youth is not required to sign the treatment plan. However, the child or youth shall participate in the development of the treatment plan as appropriate.

(6) Each agency shall have a written method and procedure to assure quality client records which includes routine review of client records.

(7) Each agency that is certified shall be subject to recoupment of all or part of Department of Mental Health payments when:

(A) The client record fails to document the service paid for was actually provided;

(B) The client record fails to document a qualified staff person as defined in the Department of Mental Health Purchase of Service Catalog, provided the service;

(C) The client record fails to document the service that was paid meets the service definition as defined in the Department of Mental Health Purchase of Service Catalog;

(D) The client record fails to document the amount, duration, and length of the service paid for by the department; and

(E) The client record fails to document the service paid for was delivered under the direction of a current treatment plan that meets all the requirements for treatment plans set forth in 9 CSR 10-7.030 and 9 CSR 30-4.160.

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.*

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

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 Treatment

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

(1) Each agency that is certified shall comply with all requirements set forth in Department of Mental Health Core Rules for Psychiatric and Substance Abuse Programs, 9 CSR 10-7.030 Service Delivery Process and Documentation.

(2) The program shall have written policies and procedures defining client eligibility



requirements, intake procedures and client assessment.

(3) Services shall be provided under the direction of a treatment plan.

(A) An initial treatment plan shall be developed at intake during admission to the outpatient program.

(B) A master treatment plan shall be developed after ten (10) visits.

(4) The program shall provide treatment which will assist in the support and rehabilitation of client.

(A) Clients who have not received services for a six (6)-month period shall be placed on an inactive list.

(B) Clients who have not received services for a twelve (12)-month period shall be discharged from the program.

(5) All services shall be delivered by qualified professionals as defined in the Department of Mental Health Purchase of Service Catalog.

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

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.*

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

9 CSR 30-4.195 Access Crisis Intervention Programs

PURPOSE: This rule sets forth standards and regulations for Access Crisis Intervention Programs.

(1) The Access Crisis Intervention (ACI) program is designed to be provided by administrative agents with certified outpatient programs.

(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 by telephone or face-to-face 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 Comprehensive Psychiatric Ser-

vices (CPS) as an entry and exit point into state mental health service delivery system for a geographic service area defined by the division;

(C) Alcohol and drug detoxification services—services providing detoxification which is the process of withdrawing a person from alcohol, other drugs or both in a safe, humane, and effective manner;

(D) Community outreach/education plan—a plan outlining how families, consumers, consumer 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: intake and annual evaluations, crisis intervention and resolution, medication services, physician consultation services, medication administration, community support and psychosocial rehabilitation in a nonresidential setting for individuals with serious mental illness in conjunction with standards set forth in 9 CSR 30-4.031–9 CSR 30-4.047;

(F) Community support—as defined in 9 CSR 30-4.043(2)(F)–(G);

(G) Consumer—a person who receives mental health services or ACI services, regardless of source of payment. Parents and/or legal custodians/guardians of children and youth are primary consumers if they are actively engaged in the treatment planning and/or delivering services and supports for the child or youth. A secondary consumer is an individual who is concerned and involved in supporting and treating primary consumers. This category includes family members and significant others involved in the treatment and support processes; sponsors for persons who engage in substance abuse; children of parents who have mental illness or substance abuse issues; and persons who advocate for vulnerable populations;

(H) Consumer advocate—individuals who will assist consumers with treatment planning, care issues and the complaint/grievance and resolution process;

(I) Consumer satisfaction—a measure of the degree to which an individual, who is receiving or has received ACI services from the department, perceives the services to be successfully addressing, or to have successfully addressed their individual needs for professional services;

(J) Division—the Division of Comprehensive Psychiatric Services;

(K) Internal agency protocol—a specific method indicating how the agency plans to respond to guidelines set forth by the depart-

ment;

(L) Mental health coordinator—as defined in 632.005(10), RSMo;

(M) Mental health professionals—as defined in 9 CSR 30-4.030(2)(HH);

(N) Mobile crisis response—specialized staff available to assess and intervene face-to-face with consumers where the crisis is occurring or another secure location in the community;

(O) Risk assessment—the process of assessing dangerousness to self or others;

(P) 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;

(Q) Specialized program—programs operated by an agency that provide specific services to designated eligible consumers enrolled in that program;

(R) Telephone hotline services twenty-four (24)-hour—a published, centralized, twenty-four (24)-hour staffed toll-free telephone number to provide direct means of crisis assessment and triage for consumers in crisis, their families, and agencies needing assistance.

(4) Consumer Records.

(A) Consumers receiving only telephone hotline or mobile outreach through the ACI program do not require a treatment plan, however, for current clients of the department or those who are in the process of being admitted to a mental health program, there shall be evidence of coordination between the ACI staff and the treating staff.

(B) At a minimum, those 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, client, law enforcement, judge, hospital, emergency room, mental health professional;
3. Name, address, telephone number, and date of birth;
4. Presenting problem;
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 regarding another person, the identified consumer for the purpose of intervention must be the person calling, as well as, the person being called about. For data collection, the identified consumer is the person being called about.



(E) At a minimum, those 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;
7. Disposition and follow-up.

(F) The agency must document when the consumer does not provide identifying information.

(G) Agencies providing ACI services must submit to the department, reports and documentation as prescribed by the department according to the department's standardized form.

(H) Agencies providing ACI services must meet the 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) Consumers receiving only telephone hotline or mobile outreach through the ACI program do not require a treatment plan, however, for current clients of the department or those who are in the process of being admitted to a mental health program, there should be evidence of coordination between the ACI staff and the treating staff.

(C) ACI programs must operate or arrange for a twenty-four (24)-hour 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 hard-of-hearing, deaf and persons who have a limited understanding of the English language;

7. Written description of ongoing hotline outreach activities;

8. Written description of a process for identifying and utilizing community resources in the delivery of telephone hotline services.

(D) Each administrative agent must have designated agency staff person on call to the ACI system twenty-four (24) hours per day and seven (7) days per week.

(E) If the consumer, consumer advocate, or family member requests to speak with an individual from a specialized program, including but not limited to, the Community Psychiatric Rehabilitation Program (CPRC) community support worker and, the ACI clinical staff have determined that this action is clinically necessary, the ACI hotline staff shall contact the appropriate designated agency staff person.

(F) 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.

(G) Once this contact has occurred, the designated agency staff person shall respond to the caller and/or secure the appropriate requested specialized program personnel involved.

(H) 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.

(I) 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.

(J) If ACI staff does not follow the procedure listed in (I) and (J) of this section, 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 quality assurance process within forty-eight (48) hours.

(K) ACI programs must have a written description for resource and referral to the following services:

1. Acute hospitalization;
2. Medical services;
3. Alcohol and drug detoxification services;
4. Priority outpatient scheduling within twenty-four (24) hours or the next working day;
5. Children and youth services;
6. Psychiatric availability;

7. Civil involuntary detentions when initiated by the mental health coordinators.

(L) ACI programs must operate a twenty-four (24)-hour 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 hotline;
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;
6. Written documentation of how mobile response services respond to hard-of-hearing, deaf and persons who have a limited understanding of the English language.

(M) ACI programs shall provide mobile response to known and unknown consumers twenty-four (24) hours per day and seven (7) days per week at the location of the crisis or to another secure community location.

(N) Mobile response shall not be provided exclusively in emergency rooms, jails or mental health facilities.

(O) 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.

(P) 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 both for phone and continually during contact;
3. Availability of multiple staff to respond for face-to-face contact;
4. Backup available by pager;
5. Written protocols for mobile response to be delivered in safe locations when necessary.

(Q) 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, either by phone or with the mobile response team.

(R) If the caller is not satisfied, the grievance procedure must be followed as defined in 9 CSR 10-7.020(7)(A)-(C).

(6) Quality Assurance.



(A) Each agency providing ACI services must develop a community outreach/education plan that includes details of how the following groups will become familiar with the ACI system:

1. Families;
2. Consumers;
3. Consumer advocates;
4. State agencies including the Division of Family Services, Division of Senior Services and Division of Youth Services;
5. Law enforcement agencies;
6. 911 personnel;
7. Schools;
8. Juvenile courts;
9. Emergency medical services personnel;
10. Residential care facilities;
11. Homeless shelters and/or providers;
12. Public housing;
13. 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, at least annually, demonstrate community awareness.

(E) The telephone number for ACI must be published in a local telephone book.

(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 Quality Assurance Plan.

(G) Programs providing ACI services must conduct the Consumer Satisfaction ACI Interview Survey as prescribed by the department.

(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 qualified mental health professional as defined in 9 CSR 30-4.030.

2. Staff providing telephone hotline services must have immediate access to a qualified mental health professional.

(B) For mobile response, the mobile crisis team shall have at least one (1) qualified mental health professional 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 qualified mental health professional as defined in 9 CSR 30-4.030.

(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 shall have received training and have experience in responding to crisis situations with individuals and families.

(F) Each region and/or provider must have an ACI Training Plan. The training plan shall include consumers, families and consumer 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 consumers;
5. Other competencies as required by the department.

(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;
3. Question, answer and observation by supervisory staff and peers;
4. Consumer satisfaction and clinical outcomes.

(L) New ACI staff must receive clinical supervision and must shadow the supervisor or experienced crisis workers for a minimum of two (2) weeks prior to providing crisis services.

(M) 9 CSR 10-7.110 requires that all staff participate in at least thirty-six (36) clock hours of relevant training during a two (2)-year period. All staff working within the ACI program and services shall receive a minimum of twelve (12) clock hours per year of continuing education and relevant training.

(N) All training activities shall be documented in employee personnel files, to include the training topic, name of instructor, date of activity, duration, skills targeted/objective of skill, certification/continuing education units (if any) and location.

(8) Fiscal Management. The agency will provide financial information to the department or any of its divisions upon request, relating but not limited to, program administration and services provided through any programs, services or activity using funds provided by the department.

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