



RULES OF
Department of Mental Health
Division 30—Certification Standards
Chapter 7—Crisis Services

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TITLE 9 – DEPARTMENT OF MENTAL HEALTH
Division 30 – Certification Standards
Chapter 7 – Crisis Services

9 CSR 30-7.010 Behavioral Health Crisis Centers

PURPOSE: This rule sets forth regulations for behavioral health crisis centers.

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

(1) Definitions. Unless the context clearly requires otherwise, the following terms as used in this rule mean –

(A) Behavioral Health Crisis Center (BHCC), unit which operates twenty-four (24) hours per day, seven (7) days per week and provides crisis services for individuals in severe distress with up to twenty-three (23) consecutive hours of supervised care to assist with deescalating the severity of their crisis;

(B) Crisis intervention, designed to interrupt and/or ameliorate a behavioral health crisis experience. The goal of crisis intervention is symptom reduction, observation, stabilization, and restoration to a previous level of functioning for the individual being served. Primary components include, but are not limited to –

1. Preliminary assessment of risk, mental status, substance use status, and medical stability;
2. Stabilization of immediate crisis;
3. Determination of the need for further evaluation and/or behavioral health services; and
4. Linkage to needed additional treatment services;

(C) Crisis stabilization, a direct service that assists with deescalating the severity of an individual's level of distress and/or need for urgent care associated with a behavioral health disorder; and

(D) Urgent Care Behavioral Health Crisis Center (U-BHCC), unit which operates less than twenty-four (24) hours per day, seven (7) days per week, and provides crisis services for individuals in severe distress with supervised care to assist with deescalating the severity of their crisis.

(2) Program Description. BHCCs and U-BHCCs are provided or arranged by an administrative agent or an affiliate. Services shall be provided in accordance with the 2020 edition of the *National Guidelines for Behavioral Health Crisis Care*, hereby incorporated by reference and made a part of this rule, and can be obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA), 5600 Fishers Lane, Rockville, MD 20857, (877) 726-4727. This rule does not incorporate any subsequent amendments or additions to this publication.

(A) Services shall be designed to serve as a community-based alternative to emergency department services, unnecessary hospitalization, and/or jail confinement by offering assessment, treatment, and short term stabilization for individuals with a mental health and/or substance use disorder.

(B) As specified in best practice one (1) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, centers shall function as a twenty-four (24) hour or less crisis receiving and stabilization facility.

(3) Certification/National Accreditation. At a minimum, organizations shall comply with 9 CSR 10-7.130 Procedures to Obtain Certification, to apply for certification/deemed status as a BHCC or U-BHCC and –

(A) Be certified by the department as a Certified Community Behavioral Health Organization (CCBHO);

(B) Obtain appropriate accreditation for crisis services within three (3) years of obtaining certification/deemed status (if not accredited for such at the time of initial application to the department) from the Commission on Accreditation of Rehabilitation Facilities (CARF) International, The Joint Commission (TJC), or Council on Accreditation (COA); and

(C) The CCBHO may arrange for BHCC or U-BHCC services to be provided through a designated collaborating organization (DCO).

(4) Program Requirements. BHCCs and U-BHCCs shall provide prompt assessment, stabilization (with or without medication), and determination of an appropriate level of care for the individual's continued behavioral health treatment in order to prevent unnecessary hospitalization, emergency department services, and/or jail confinement.

(A) In accordance with minimum expectation three (3) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, services shall be designed to address –

1. Behavioral/mental health crisis situations, including substance use; and
2. Varying clinical conditions to include individuals with co-occurring behavioral health and intellectual/developmental disabilities.

(5) Target Populations. The target population includes individuals with a confirmed or suspected mental health and/or substance use disorder diagnosis who are experiencing a behavioral crisis or are presenting for urgent behavioral health needs who are –

- (A) Children and youth, individuals age five (5) to seventeen (17) years; and/or
- (B) Individuals age eighteen (18) years and older.

(6) Physical Environment and Safety. All BHCCs and U-BHCCs shall be in compliance with 9 CSR 10-7.120 Physical Environment and Safety, and applicable state and local building codes, fire codes, and ordinances to ensure the health, safety, and security of all individuals.

(A) The physical environment shall –

1. Promote a sense of safety, calm, and deescalation for individuals and staff;
2. Have adequate space to ensure the comfort of individuals served;
3. Have adequate space to ensure privacy and confidentiality for individuals served;
4. Have furnishing and fixtures that are constructed of durable materials not capable of breakage into pieces that could be used as a weapon, ligature risk, or for self-harm; and
5. Have interior finishes, lighting, and furnishings that suggest a non-institutional setting that conforms to applicable fire and safety codes.

(B) In accordance with best practice two (2) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, policies and procedures shall ensure there are designated areas for individuals being transported to the center by law enforcement/first responders and those seeking services on a walk-in basis.

1. Hours of operation shall be clearly communicated to law enforcement and other referral sources.



(C) If the BHCC/U-BHCC has an open floor model, space for screening, evaluation, and treatment services must be separate for children/youth and adults, if both are served.

(7) Care Criteria. Each BHCC and U-BHCC shall implement written screening and intake criteria for individuals who present for an evaluation.

(A) A “no wrong door” access model shall be utilized. In accordance with minimum expectations one (1), six (6), and seven (7) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, all individuals who present for an evaluation and/or stabilization shall be screened as specified in subsection (7)(C) of this rule, including walk-ins and those who are referred/transported by law enforcement.

(B) If screening results in an individual not being offered services, documentation of the rationale for the denial of services and facilitated referral of the individual to other appropriate services must be maintained.

(C) Service criteria shall include but is not limited to –

1. Presence of a suspected and/or known mental illness diagnosis and/or substance-related disorder and the individual is expressing a need for behavioral health services; and

2. Presence of a severe situational crisis; and/or

3. Presence of risk of harm to self, others, and/or property (risk may range from mild to imminent).

(D) In accordance with minimum expectation two (2) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, medical clearance is not required prior to provision of services, however, each individual served must be assessed for medical stability and receive necessary medical support while in the program.

1. In accordance with minimum expectation four (4) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, physical health issues that can be appropriately managed by crisis center staff shall be addressed by qualified staff in accordance with policies and procedures.

2. If a physical health issue occurs requiring medical care that cannot be addressed while an individual is receiving services in the BHCC/U-BHCC, the treating center shall arrange for the individual to be appropriately transported to a medical facility to address the physical health issue.

(E) As appropriate, medications (including medication assisted treatment for a substance use disorder) shall be prescribed while connecting the individual with ongoing services.

(8) Staff Qualifications. In accordance with minimum expectation five (5) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, the BHCC/U-BHCC shall be adequately staffed to meet the treatment needs of individuals served and to ensure their safety and the safety of staff.

(A) Each center shall have the staffing capacity to assess individuals’ physical health needs and deliver care for most minor physical health challenges, with established written protocols to transfer an individual to more medically staffed services, if needed.

(B) The center shall be staffed by a multidisciplinary team who is able to respond to the needs of individuals experiencing all levels of crisis. Staff shall include but is not limited to –

1. Medical director – a licensed psychiatrist (available via telemedicine or audio-only). The medical director for the BHCC/U-BHCC shall be the same individual who serves in this capacity for the CCBHO.

A. Direct services shall be provided by a licensed

physician (includes psychiatrist) or licensed psychiatric mental health nurse practitioner (PMHNP), advanced practice registered nurse (APRN), physician assistant, resident physician (includes psychiatrist), and/or assistant physician in a written collaborative practice arrangement with a physician and with experience treating the target population. Services may be provided via telemedicine.

B. BHCCs and U-BHCCs shall have access to a practitioner to prescribe medications approved by the Food and Drug Administration to treat opioid use disorders (methadone must be provided by a certified opioid treatment program);

2. Clinical program director – must be a qualified mental health professional (QMHP) to oversee program operations and clinical practice, with experience treating the target population;

3. Nurse – registered nurse (RN) or licensed practical nurse (LPN); and

4. Certified peer specialist.

(9) Staff Coverage. Staff coverage shall ensure the continuous supervision and safety of individuals served. Staff coverage shall be determined by the agency.

(A) Coverage at a minimum, shall include –

1. Two (2) behavioral health staff must be on-site during receiving hours;

2. One (1) QMHP must be available during receiving hours (may be via telemedicine);

3. One (1) RN or one (1) LPN must be available during receiving hours (may be via telemedicine); and

4. A physician (includes psychiatrist), PMHNP, APRN, assistant physician, resident physician (includes psychiatrist), and/or physician assistant must be available during receiving hours and must immediately respond to calls from staff, delay not to exceed one (1) hour.

(B) Qualified staff must be available to administer, screen, inventory, and store prescribed medications within their scope of duties, practice, training, and as authorized by statute.

(C) Qualified staff, within their scope of duties, practice, and/or training, shall be available to conduct an initial health assessment and utilize evidence-based tools to determine the individual’s medical stability, intoxication, substance use, and/or level withdrawal/impairment.

(10) Policies and Procedures. The BHCC/U-BHCC shall maintain and implement written policies and procedures including, but not limited to –

(A) Intake screening, service, and clinical assessment protocols;

(B) Community outreach and education strategies for crisis stabilization services, including access to and location of service site(s), hours, and days of operation for each site through written material and other means of communication, and how these components will be accomplished on an ongoing basis;

(C) Detoxification/withdrawal management services as defined in 9 CSR 30-3.120. If the BHCC/U-BHCC does not provide this service, facilitated referrals to a local hospital or another qualified service provider shall be made for withdrawal management or other medical services, if determined necessary during an individual’s evaluation process;

(D) Safety and emergency protocols as specified in 9 CSR 10-7.120 Physical Environment and Safety, as well as specific protocols for the population served;

(E) Prescription medication protocols, including storage of medications in accordance with 9 CSR 10-7.070;

(F) Screening for and accessing services for emergency medical conditions, including transport by emergency medical



service;

(G) Monitoring the physical and psychological well-being of individuals including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified in the organization's policies and procedures associated with evaluations;

(H) Linking individuals to housing services upon discharge, as needed;

(I) Linking individuals to transportation services upon discharge, as needed;

(J) Linking individuals to social services or community resources, as needed;

(K) Assessment and referral process for individuals with a suspected substance use disorder and/or mental health disorder;

(L) Care coordination and continuity of care for individuals served including but not limited to referral process, follow-up, and transfer of records within five (5) days, in accordance with best practice five (5) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule;

(M) Infection prevention and control; and

(N) Use of physical and chemical restraints as specified in 9 CSR 10-7.060 Emergency Safety Interventions.

(11) Community Partnerships. BHCCs and U-BHCCs shall have a referral relationship, collaborative agreement, and/or memorandum of understanding (MOU) with the following community providers:

(A) Crisis response with law enforcement, dispatch, emergency medical services, and first responders;

(B) Local hospitals, primary care clinics, and Federally Qualified Health Centers (FQHC);

(C) Qualified providers of detoxification/withdrawal management services;

(D) Schools;

(E) Housing supports;

(F) Local Continuum(s) of Care; and

(G) Recovery support and recovery housing providers.

(12) Coordination and Continuity of Care. Service coordination and continuity of care efforts shall include but are not limited to –

(A) Identifying and linking individuals with available community resources necessary to stabilize the crisis and ensure transition to routine care;

(B) Referring individuals to behavioral health services if not currently receiving such services;

(C) Connecting and/or referring individuals to appropriate local resources including emergency room enhancement (ERE) staff, community behavioral health liaisons (CBHLs), and/or certified peer specialists, who shall conduct and document timely follow-up to determine the individual's current status and need for any additional assistance or services;

(D) Contacting and coordinating care with current service providers, when feasible and in accordance with state and federal confidentiality regulations;

(E) Connecting individuals to housing, food, or other resources;

(F) Connecting individuals with recovery support and/or recovery housing providers;

(G) Connecting individuals with community-based behavioral health providers in other geographic regions; and

(H) Incorporating some form of intensive support beds into a partner program (within the organization or with another local agency), if available, for individuals who need additional support beyond that of the BHCC/U-BHCC in accordance with

best practice three (3) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule.

(13) Documentation Requirements. Based on the individual's ability to cooperate and communicate with staff due to their crisis situation, the following intake documentation shall be obtained:

(A) Presenting problem and referral source, if applicable;

(B) Rationale for denial of services and referral of the individual to other appropriate services, if necessary;

(C) Personal and identifying information;

(D) Status as a current or former member of the U.S. Armed Forces;

(E) Current mental health and substance use symptoms;

(F) Current medications and any medications administered;

(G) Screening for suicide risk and completion of a comprehensive, standardized suicide risk assessment and planning, when clinically indicated, in accordance with minimum expectation eight (8) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule;

(H) Screening for risk of violence and completion of a comprehensive, standardized violence risk assessment and planning, when clinically indicated, in accordance with minimum expectation nine (9) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule;

(I) Current trauma-related symptoms and/or concerns for personal safety;

(J) Crisis intervention and prevention plan, when clinically indicated (a copy shall be provided to the individual served); and

(K) Discharge information including outcome of the crisis, services provided, treatment/recovery plan, care coordination efforts, follow-up, and referrals.

(14) Measuring Program Effectiveness. In accordance with best practice four (4) of the *National Guidelines for Behavioral Health Crisis Care*, as referenced in section (2) of this rule, BHCCs and U-BHCCs shall collect, enter, and submit data utilizing all reporting tools as directed by the department.

(15) Staff Training and Education. Staff are expected to comply with the training requirements specified in 9 CSR 10-7.110(2)(F), Personnel. All staff of the BHCC/U-BHCC shall complete minimum training requirements as follows:

(A) Screening, assessment, and planning for risk of suicide;

(B) Screening, assessment, and planning for risk of violence;

(C) Evidence-based and best practice interventions to prevent and address disruptive behaviors and behavioral crises;

(D) Basic First Aid;

(E) Cardiopulmonary Resuscitation (CPR); and

(F) Administration of naloxone, as appropriate with staff qualifications.

(16) Trauma-Informed Care. Services shall be provided in accordance with 9 CSR 10-7.010(11), Essential Principle, Trauma-Informed Care.

AUTHORITY: section 630.050, RSMo 2016. Original rule filed Nov. 2, 2022, effective June 30, 2023.*

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

**9 CSR 30-7.020 Sobering Centers**

PURPOSE: This rule sets forth requirements for operation of a sobering center.

(1) Definitions. Unless the context clearly requires otherwise, the following terms as used in this rule shall mean –

(A) Sobering center, short-term care facility designed to allow an individual who is intoxicated and nonviolent to safely recover from the immediately debilitating effects of alcohol and drugs. Sobering centers typically operate twenty-four (24) hours per day, seven (7) days per week and provide supervised care for individuals experiencing acute intoxication for up to twenty-three (23) consecutive hours; and

(B) Acute intoxication, a transient condition that follows the ingestion or consumption of alcohol or a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgment, affect or behavior, or other psychophysiological functions and responses.

(2) Program Description. Sobering centers are operated by a Certified Community Behavioral Health Organization (CCBHO).

(A) Services shall be designed to serve as a community-based alternative to emergency department services, unnecessary hospitalization, and/or jail confinement, offering short-term stabilization for individuals experiencing acute intoxication.

(3) Certification. At a minimum, the organization shall comply with 9 CSR 10-7.130 Procedures to Obtain Certification, to apply for certification/deemed status as a sobering center by the department.

(4) Program Requirements. Sobering centers shall provide prompt assessment, stabilization (with or without medication), and determination of appropriate monitoring needed for the individual to return to a state of clinical sobriety.

(A) Services shall be designed to address acute intoxication with the goal of symptom reduction as evidenced by –

1. Eating, drinking, and/or swallowing without difficulty;
2. Walking without ataxia or unsteady gait;
3. Baseline mental status representing unimpaired cognition; and
4. Cognitive status supporting reasonable decisions.

(B) Referrals to community resources and/or treatment and recovery services shall be made, as appropriate.

(5) Target Population. The target population includes individuals age eighteen (18) years and older who are experiencing acute intoxication and have a high or imminent risk of law enforcement contact and/or emergency department intervention.

(6) Physical Environment and Safety. All sobering centers shall be in compliance with 9 CSR 10-7.120 Physical Environment and Safety, and applicable state and local building codes, fire codes, and ordinances to ensure the health, safety, and security of all individuals.

(A) The physical environment shall –

1. Promote a sense of safety and calm for individuals and staff;
2. Have adequate space to ensure the comfort of individuals served;
3. Have adequate space to ensure privacy and confidentiality for individuals served;
4. Have furnishing and fixtures that are constructed of durable materials not capable of breakage into pieces that

could be used as a weapon, ligature risk, or for self-harm; and

5. Have interior finishes, lighting, and furnishings that suggest a non-institutional setting that conforms to applicable fire and safety codes.

(7) Care Criteria. Each sobering center shall implement written screening and intake criteria for individuals who present for services.

(A) All individuals who present for services from a referral source shall be screened as specified in subsection (7)(C) of this rule, including those who are referred/transported by law enforcement.

1. Hours of operation shall be clearly communicated to law enforcement and other referral sources.

(B) If in-person screening results in an individual not being offered services, documentation of the rationale for the denial of services and facilitated referral of the individual to other appropriate services must be maintained.

(C) Service criteria shall include, but is not limited to –

1. Presence of acute intoxication; and
2. Presence of high or imminent risk of law enforcement contact and/or emergency department intervention.

(D) Medical clearance is not required prior to provision of services; however, each individual served must be able to ambulate with minimal assistance, including the use of assistive devices required for existing medical conditions.

1. Individuals referred from a hospital must meet medical stability eligibility criteria.

2. If a physical health issue requiring medical care occurs that cannot be addressed while an individual is receiving services in the sobering center, the treating center shall arrange for the individual to be appropriately transported to a medical facility to address the physical health issue.

(E) As appropriate, medications (including medication-assisted treatment for a substance use disorder) shall be prescribed while coordinating ongoing services with the individual.

(8) Staff Qualifications. The sobering center shall be adequately staffed to meet the needs of individuals served to ensure their safety and the safety of staff.

(A) Each center shall have the staffing capacity to monitor vital signs with established written protocols to transfer an individual to a medical facility, if needed.

(B) The center shall be staffed by a multidisciplinary team that is able to respond to the needs of individuals experiencing acute intoxication. Staff shall include, but is not limited to –

1. Medical director, a licensed physician. The medical director for the sobering center can be the same individual who serves as the medical director for the Certified Community Behavioral Health Organization (CCBHO).

A. Direct services shall be provided by a licensed physician (includes psychiatrist), resident physician (includes psychiatrist), physician assistant, assistant physician, licensed psychiatric mental health nurse practitioner (PMHNP), and/or advanced practice registered nurse (APRN) who is in a written collaborative practice arrangement with a physician and with experience treating the target population. Services may be provided via telemedicine;

2. Qualified practitioner(s) to treat opioid use disorders with narcotic medications approved by the Food and Drug Administration (methadone must be provided by a certified opioid treatment program);

3. Clinical program director, a qualified mental health professional (QMHP) to oversee program operations and clinical



practice, with experience treating the target population;

4. Nurse, paramedic, or emergency medical technician (EMT); and
5. Certified peer specialist(s).

(9) Staff Coverage. Staff coverage shall ensure the continuous supervision and safety of individuals served. Staff coverage shall be determined by the sobering center.

(A) At a minimum, coverage shall include –

1. Two (2) behavioral health staff who are on-site during receiving hours;

2. One (1) QMHP who is available during receiving hours (may be via telemedicine);

3. One (1) nurse, paramedic, or EMT who is available during receiving hours (may be via telemedicine); and

4. A physician or resident physician (including psychiatrist), assistant physician, physician assistant, PMHNP, and/or APRN, who is available during receiving hours and must immediately respond to calls from staff, delay not to exceed one (1) hour.

(B) Qualified staff must be available to administer, screen, inventory, and store prescribed medications within their scope of duties, practice, and/or training.

(C) Qualified staff, within their scope of duties, practice, and/or training, shall be available to conduct an initial health assessment and utilize evidence-based tools to determine the individual's medical stability, intoxication, substance use, and/or level of withdrawal/impairment.

(10) Policies and Procedures. The sobering center shall maintain and implement written policies and procedures including but not limited to –

(A) Intake screening, service, and clinical assessment protocols;

(B) Community outreach and education strategies for acute intoxication stabilization services including access to and location of service site(s), hours, and days of operation for each site through written material and other means of communication, and how these components will be accomplished on an ongoing basis;

(C) Withdrawal management (detoxification) services as defined in 9 CSR 30-3.120. If the sobering center does not provide this service, facilitated referrals to a local hospital or another qualified service provider shall be made for withdrawal management or other medical services, if determined necessary during an individual's evaluation process;

(D) Safety and emergency protocols as specified in 9 CSR 10-7.120 Physical Environment and Safety, as well as specific protocols for the population served;

(E) Prescription medication protocols, including storage of medications in accordance with 9 CSR 10-7.070;

(F) Screening for and accessing services for emergency medical conditions, including transport by first responders/emergency medical service;

(G) Monitoring the physical and psychological well-being of individuals including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified in the organization's policies and procedures associated with evaluations;

(H) Linking individuals to housing services upon discharge, as needed;

(I) Linking individuals to transportation services upon discharge, as needed;

(J) Linking individuals to social services or community resources, as needed;

(K) Assessment and referral process for individuals with

a suspected substance use disorder and/or mental health disorder;

(L) Care coordination and continuity of care for individuals served including but not limited to referral process, follow-up, and transfer of records within five (5) days, as applicable;

(M) Infection prevention and control; and

(N) Exclusion criteria and protocol when the sobering center is not able to provide services to an individual.

(11) Referral Sources. At a minimum, the following are required referral sources for consideration for admission:

(A) Law enforcement;

(B) Emergency medical services;

(C) Other first responders;

(D) Engaging Patients in Care Coordination (EPICC) Coaches;

(E) Community-based organizations participating in department supported outreach services;

(F) Local hospitals, primary care clinics, urgent care clinics, and Federally Qualified Health Centers (FQHC);

(G) Community Behavioral Health Liaisons; and

(H) Mobile Crisis Response.

(12) Community Partnerships. At a minimum, sobering centers shall have a referral relationship, collaborative agreement, and/or memorandum of understanding (MOU) with the following community providers/agencies:

(A) Qualified providers of withdrawal management services;

(B) Housing supports;

(C) Local hospitals, primary care clinics, and FQHCs;

(D) Local Continuum(s) of Care; and

(E) Recovery support and recovery housing providers.

(13) Coordination and Continuity of Care. Service coordination and continuity of care efforts shall include, but are not limited to:

(A) Identifying and linking individuals with available community resources necessary to ensure transition to routine care;

(B) Referring individuals to behavioral health services, if they are not already receiving those services;

(C) Connecting and/or referring individuals to appropriate local resources including emergency room enhancement (ERE) staff, community behavioral health liaisons (CBHL), and/or certified peer specialists who shall conduct and document timely follow-up to determine the individual's current status and need for additional assistance or services;

(D) Contacting and coordinating care with current service providers when feasible and in accordance with state and federal confidentiality regulations;

(E) Connecting individuals to housing, food, or other resources;

(F) Connecting individuals with recovery support and/or recovery housing providers;

(G) Connecting individuals with community-based behavioral health providers in other geographic regions; and

(H) Incorporating intensive support beds into a partner program (within the organization or with another local agency), if available, for individuals who need additional support beyond that of the sobering center.

(14) Documentation Requirements. Based on the individual's ability to cooperate and communicate with staff due to their presenting condition, the following intake documentation shall be obtained:

(A) Presenting problem and referral source, if applicable;



- (B) Rationale for denial of services and referral of the individual to other appropriate services, if necessary;
- (C) Personal and identifying information;
- (D) Status as a current or former member of the U.S. Armed Forces;
- (E) Current mental health and substance use symptoms;
- (F) Current medications and any medications administered;
- (G) Screening for suicide risk and completion of a comprehensive, standardized suicide risk assessment and planning, when clinically indicated;
- (H) Screening for risk of violence and completion of a comprehensive, standardized violence risk assessment and planning, when clinically indicated;
- (I) Current concerns for personal safety; and
- (J) Discharge information including services provided, care coordination efforts, follow-up, and referrals.

(15) Measuring Program Effectiveness. Sobering centers shall collect, enter, and submit data utilizing all reporting tools as directed by the department.

(16) Staff Training and Education. Staff shall comply with the training requirements specified in 9 CSR 10-7.110 Personnel, subsection (2)(F). All staff of the sobering center shall complete minimum training requirements as follows:

- (A) Screening, assessment, and planning for risk of suicide;
- (B) Screening, assessment, and planning for risk of violence;
- (C) Evidence-based and best practice interventions to prevent and address disruptive behaviors and behavioral crises;
- (D) Basic First Aid;
- (E) Cardiopulmonary Resuscitation (CPR);
- (F) Administration of naloxone; and
- (G) Trauma-informed care.

AUTHORITY: section 630.050, RSMo 2016. Original rule filed March 21, 2023, effective Sept. 30, 2023.*

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