



Co-occurring Disorders

IDDT - a note from DBH

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Over 50% of individuals with serious mental illness have a co-occurring substance use disorder within their lifetime. These individuals are at risk for many other problems including legal, medical and social complications. For years our community mental health centers have been serving these individuals through a continuum of services, including case management, crisis response, psychiatric rehabilitation, medication management, therapy and supported housing. Historically, clients involved in substance use were often referred to other substance treatment providers in the community or another substance program within their own agency. This could result in disjointed care and high drop-out rates. As complications from co-occurring issues have increased and become more serious, providers have responded by adding new and improved treatment strategies that help consumers develop hope, knowledge, skills and the support they

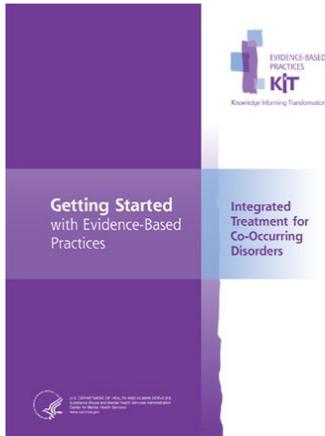
need to manage their multiple problems and pursue meaningful life goals. At the core of these services are evidence based practices including Assertive Community Treatment, Supported Housing, Illness Management and Recovery, Family Psychoeducation and Integrated Dual Disorder Treatment (IDDT).

Integrated treatment that addresses mental and substance use conditions simultaneously is associated with lower costs and better outcomes.

This multidisciplinary approach offers individuals comprehensive services for both mental health and substance use interventions within one team of practitioners and clinicians working closely together. The Division of Behavioral Health expects that Integrated Treatment for Dual Disorders is available for individuals with co-occurring mental illness and substance use disorders. This is crucial for agencies that want to participate in The

Excellence in Mental Health ACT. This federal legislative action will help increase access to community mental health and substance use treatment services, while improving Medicaid reimbursement for these services. It creates criteria for certified behavioral health clinics as entities designed to serve individuals with serious mental illness and substance use disorders that provide intense person centered, multidisciplinary, evidence based screening, assessment, diagnostics, treatment, prevention and wellness services. Therefore, it will be necessary for community behavioral health organizations to provide true integrated treatment for co-occurring disorders based on the SAMHSA identified evidence based practice. This moves beyond co-occurring capable case management and into a more defined role of treatment that is integrated and falls under an overarching principle from which the agency operates.

IDDT Resources



SAMHSA Toolkit for integrated treatment for co-occurring disorders

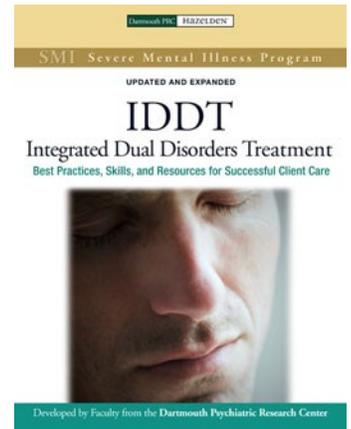
<http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>

DMH Web link for information on the original rollout of IDDT in Missouri

<http://dmh.mo.gov/mentalillness/provider/integratedtrmt.htm>

Hazelden Integrated Dual Disorders Treatment Curriculum

http://www.hazelden.org/OA_HTML/ibeCCtpItmDspRte.jsp?



Missouri Credentialing Board

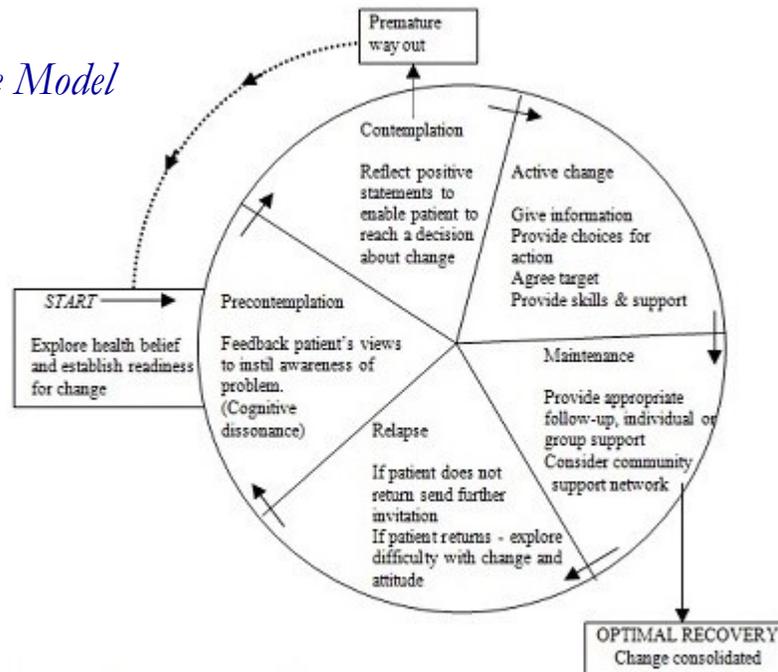
www.missouricb.com

Peer Support Services Website:

www.peerspecialist.org

How do communities move forward in implementing MAT as a routine part of care? Read more in this week's post from Aaron Williams, Director of Training and Technical Assistance for Substance Abuse, National Council, on the [ATTC/NIATx Service Improvement Blog!](#)

Stages of Change Model



Intervention process using the Stages of Change model

Source; Adapted from the work of Prochaska and DiClemente

IDDT Specialist Qualifications

9 CSR 30-4.0431(5)(A)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.



A **QSAP** is one of the following:

A licensed (or provisionally licensed) QMHP with one year of full time experience in substance use treatment. If an individual has less than one year of experience in Integrated Treatment (IT), they must be actively acquiring 24 hours of training in IT specific content and receive supervision (could be via phone under contract) from experienced IT staff. The 24 hours of training in IDDT specific content can include, but not limited to:

- Co-occurring mental health and substance use disorders
- Motivational interviewing
- Stage-wise treatment interventions
- Addictions treatment
- Relapse prevention
- Cognitive behavioral treatment

OR

A person who is certified or registered (not recognized) as a substance abuse professional by the Missouri Substance Abuse Counselor's Certification Board. Further clarification of credentials includes:

Qualified Substance Abuse Professional Credentials:

CCDP - Co-Occurring Disorders Professional

CCDP-D - Co-Occurring Disorders Professional - Diplomate

CCJP - Certified Criminal Justice Addictions Professional

CADC - Certified Alcohol Drug Counselor

CRADC - Certified Reciprocal Alcohol Drug Counselor

CRAADC - Certified Reciprocal Advanced Alcohol Drug Counselor

RSAP-P - Registered Substance Abuse Professional – Provisional

The below credentials are NOT Qualified to provide the Co-Occurring Counseling or Supplemental Assessment (Not a QSAP):

RASAC I - Recognized Associate Substance Abuse Counselor I

RASAC II - Recognized Associate Substance Abuse Counselor II

There is no application to be a QSAP, just as there is no application to be a QMHP. The person in the position just needs to meet the above criteria as evidenced by documentation in their personnel file. The original language - "co-occurring counselor competency requirements established by the Department of Mental Health"- was used as a placeholder for the co-occurring credential that did not yet exist.

IDDT: AN EVOLVING MODEL

Pilot studies during the 1990s showed consumers demonstrated better outcomes when services incorporated motivational approaches, assertive outreach, comprehensiveness, and a long-term perspective, within the structure of a multidisciplinary team.

Drake et al. 2001



Monica Reagan, LPC, Dr. Cathy Brock, LPC, Heather Capriola, RASAC II, MARS, Chelsea Houseman, RASAC II, MARS

IDDT TEAM FEATURE

SUBMITTED BY RICK STRAIT, LPC, CRADC, IDDT PROGRAM MANAGER

Community Counseling Center

Community Counseling Center started our IDDT program on October 15, 2013. This was new program for Community Counseling Center and we started with our Cape Girardeau office. We started off with two IDDT case managers. They helped forge the way and helped explain the program to prospective clients. On October 15, 2014 we celebrated our IDDT one year anniversary. During this first year we have experienced a lot of growth. Our fidelity score increased in Cape from our initial fidelity visit. We have expanded our program to include three additional sites (Perryville, Fredericktown and Ste. Genevieve). We have two full time substance abuse specialists and we increased from one client to fifty-seven clients and growing. We have put a lot of focus in the training and development of all IDDT staff in the areas of Cognitive Behavior Therapy, Motivational Interviewing, and Stage-wise Treatment. In this last year we added the following credentials to our IDDT team. 1- Certified Co-occurring Disorder Professional-diplomat (CCDP-D), 1- Registered Substance Abuse Professional (RSAP), 5 – Medication Assisted Recovery Specialist (MARS), and 3 – Recognized Associate Substance Abuse Counselors II (RASAC II). We currently have two staff that are preparing to take their certification test. As the program manager I couldn't be happier with our IDDT team. I enjoy watching the team grow and our clients receiving better evidence based treatment. I have been asked numerous times when starting the IDDT program, what is it I like most about IDDT and why do I think this program will work. I have three favorite things about IDDT program: 1. The weekly multi-disciplinary team meetings where we really can staff clients and look at solutions and recommendations as a team, looking from many different perspectives with the ability to think out of the box. 2. Stage-wise treatment – I have been working in treatment for almost fifteen years and too often treatment is forced when clients are not ready and when they are ready, they have to wait, and 3. Time unlimited, here again in the past sometimes the focus was on the length of treatment and clients would run out of services while they may still need the help. As we celebrate our one year anniversary, we set goals for continued growth this next year which are: 1. expanding to Marble Hill, 2. increasing to 110 clients throughout all five locations, and 3. continuing to improve our fidelity score.

Did you know approximately 8.9 million adults have co-occurring disorders; that is they have both a mental and substance use disorder? Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.

Taken from SAMHSA.gov



IDDT GROUP FEATURE

SUBMITTED BY MELISSA GASPER, LMSW, CRAADC , IDDT TEAM LEADER

Family Guidance

The Family Guidance Center, St. Joseph IDDT department offers our consumers an opportunity to participate in several different education groups each week. One specific curriculum being offered is “Transition Skills for Recovery” taken from Straight Ahead: Transition Skills for Recovery. Several consumers have expressed frustration due to a perceived lack of coping skills to aid in their recovery. The group works with the curriculum to identify skills and tools they may have utilized in their addiction, which can now be transitioned for their recovery. Some examples are resourcefulness, determination and problem solving skills. The group works together to reinforce key recovery concepts and provide each participant with information, skills and encouragement to strengthen and maintain recovery on their own.

Our R.N. recently began facilitating groups both in one of our local Residential Care Facilities and in the Family Guidance offices which are focused on educating consumers about Health and Wellness. Currently the R.N. is covering topics such as management of high blood pressure and diabetic care. We are planning to include smoking cessation information in the near future.

Thanks Rick & Melissa!

Motivational Interviewing Corner

By Scott Kerby, Truman IDDT Specialist

As a member of the Motivational Interviewing Network of Trainers (MINT), I frequently get the opportunity to train multidisciplinary staff members in both the art and science of Motivational Interviewing (MI). The science behind MI is strong and growing, with numerous research projects testing what it is that makes MI effective in helping our clients change. This often involves things like the number of reflections versus questions asked, certain beneficial clinician behaviors that promote change (affirmations), and certain clinician behaviors that make change less likely (offering unsolicited advice). Many times those first learning MI are rightly mechanical in their approach—it takes very intentional effort to learn the deceptively tricky intricacies of Motivational Interviewing. That certainly is an important piece in learning this style, yet is insufficient as an approach to reaching true proficiency. I would encourage everyone who wants to learn MI to not just boil it down to a numbers game, but to remember that even more than the science, it is the art of MI that really helps clients in their efforts to change. The interpersonal style of relating to clients, our presence, is what truly defines MI. It is our approach to the individual, thinking of them as an honored guest in our living room, as a fellow expert on this journey, of treating our involvement in their lives as something sacred. In the spirit of MI we fight the urge to fix, to flood with knowledge, to jump to a plan of action prematurely. Instead we approach from a place of genuine curiosity, allowing the client to drive while we strategically help navigate. This interpersonal style is a necessary part of motivational interviewing, and without it all of the technical skills matter very little. Research shows us that the clinician's behavior, how we approach the client, largely determines negative client responses such as “denial”, “resistance”, and “discord.” So as we continue to add MI to the clinical toolbox, please resist the temptation to see it simply as a set of techniques, and instead view it primarily as a “way of being” with the clients we serve. To miss that is to miss Motivational Interviewing.

Thanks Scott!

Peer Support with Lisa

Lisa Martin is the DMH Staff Training & Development Coordinator. She oversees operations regarding Peer Support services. Here is more about what she does and how important Peer Support staff are in mental health:

Lori: Tell us a bit about your role at DMH and interest in working with Peers.

Lisa: I began working at DMH with the task of managing the Consumer Operated Service Program (COSP) contracts with Certified MO Peer Specialist (CMPS) Mickie McDowell. It was working with Mickie that opened my eyes to the world of Peer Support. Through Mickie and the COSPs I had the opportunity to see peer support in action. I was blown away. Individuals' willing to share their recovery stories to help others is such an intimate, moving, and hopeful experience to witness. It was this experience that made me want to do whatever I could in any position to see Peer Support grow and flourish in Missouri.

Lori: Who can be a Peer Specialist?

Lisa: An individual must:

Self-identify as a present or former primary consumer of mental health or substance use services.

Be at least 21 years of age.

Have a high school diploma or equivalent.

Pass a background check or request an exception to the findings.

Complete a State approved training program and pass a standardized examination

Have a job commitment from a mental health agency, consumer operated service program or psychiatric hospital.

Complete the application located on the following website: www.peerspecialist.org

Complete a 5-Day Basic Training Program

Following completion of the 5-Day Basic Training Program, the individual must pass a State of Missouri approved certification examination. Annual continuing education will be offered.

Continued on next page:

Peer Support with Lisa continued

Lori: Many agencies are taking advantage of hiring Peer Specialists in treatment for mental illness and addictions. Can you tell us the advantages of having peers on staff?

Lisa: Some of the benefits of provider services to the service delivery system are

- ▶ Empowerment, meaningful relationships, and opportunities to improve their lives are benefits to people engaged in these services.
- ▶ Peer providers serve as role models, modeling recovery to non-peer staff, families and peers receiving behavioral health services.
- ▶ Substance use peer recovery support and other recovery support activities demonstrate improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment
- ▶ Reduced substance use
- ▶ Reduced hospitalization and crisis services
- ▶ Improved quality of life and health
- ▶ Improved self-esteem
- ▶ The (re)discovery of hope
- ▶ The development of relationships of trust

(Retrieved from: *Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention*, NASMHPD, September 15, 2014)

Lori: What kind of feedback have you received from Certified Peers working in the field now?

Lisa: Peer providers in the field report how much peer support is needed in the settings in which they work; this can include psychiatric hospitals, community mental health centers, ADA providers, and Consumer Operated Service Programs. There is a strong desire for more education among organizations as to the value and purpose of peer support in conjunction with all other roles. Peer providers in Missouri also report how meaningful the work is to them as a professional and all I have spoken with have asked for additional training opportunities. There is also a desire for more networking opportunities with other peer providers in the state. As the state authority we are working hard with organizations and other stakeholders to help meet the requests made by Certified Peers in the field.

Lori: What do you feel the future holds for trained peers in behavioral health treatment?

Lisa: The future is bright for peer providers in Missouri! The evidence supporting peer providers continues to grow as does the use of peer support in integrated care; and as we know evidenced based practices and integrated care are the wave of the future when it comes to the services we provide. The Department of Mental Health continues to include the voice of peers in the DMH Strategic Directions for 2013-2018 stating that there will be an increasing emphasis on “A Stronger Consumer Voice in DMH planning and program operation and greater opportunities for peer employment in DMH service systems.” Utilizing and strengthening peer support and the use of peer providers serving adults, transitional age youth, and families receiving our services is the way to get us all the way there! Peer support has the backing of DMH as well as the Division of Behavioral Health. We continue to work toward strengthening, improving, advocating for, and valuing peer support in Missouri.

Thanks Lisa!

Fidelity Facet



In staging clients with co-occurring disorders, those in action or relapse prevention stages are more motivated to manage their own illnesses. At this point they begin to develop skills and supports to control symptoms and pursue a healthier lifestyle.

Effective IDDT programs provide some form of counseling that promotes cognitive-behavioral skills matched to these stages of change. Counseling can be individual or in a group setting. Do IDDT clinicians understand co-occurring counseling concepts consistently? Is there evidence that 80%

or more of clients in action and relapse prevention stages are receiving substance use counseling? If you answered yes to all of these questions you may rate a perfect fidelity score in this area!



Website: www.dmh.mo.gov/mentalillness/provider/iddtproviders.htm

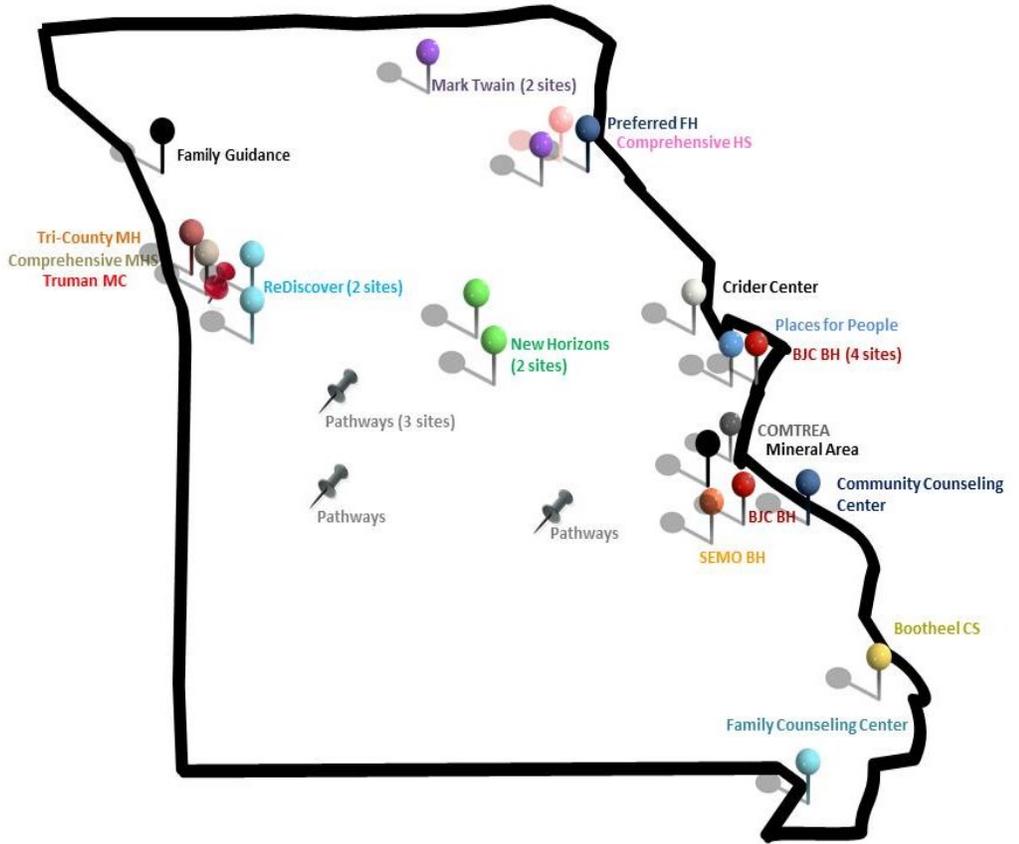
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Susan Blume, Manager of Service Implementation and Evaluation
Telephone: (573) 751-8078
Fax: (573) 751-7815
Susan.Blume@dmh.mo.gov

Bobbi Good, LCSW
Telephone: (816) 387-2894
Fax: (816) 387-2897
Bobbi.Good@dmh.mo.gov

Trish Grady BSW Program Specialist I
Telephone: (573) 840-9296
Fax (573) 840-9191
Trish.Grady@dmh.mo.gov

Lori Norval, M.S., LPC, QA Specialist
Telephone: (417) 448-3476
Fax: (417) 667-6526
Lori.Norval@dmh.mo.gov
Work cell (417) 448-9955



**Mineral Area Community
Psychiatric Rehabilitation
Center (MACPRC)**

Missouri IDDT teams

**COMPREHENSIVE
Health Systems, Inc.**
"for quality mental health care"

placesforpeople
Community Alternatives for Hope, Health and Recovery

BJC Behavioral Health

COMPREHENSIVE
MENTAL HEALTH
SERVICES, INC.

New Horizons
Community Support Services

Family Counseling Center, Inc.

BCS
Bootheel Counseling
Services

Mark Twain
Behavioral Health

BH

Crider
HEALTH CENTER
Full, Productive, Healthy Lives for Everyone

Pathways
COMMUNITY HEALTH

Help, Hope, and Healing
ReDiscover

**Southeast Missouri
Behavioral Health**

**FAMILY
GUIDANCE
CENTER** for behavioral healthcare

COMTREA
Founded 1973

**Preferred
Family Healthcare**



TMC
TRUMAN MEDICAL CENTER
Behavioral Health

**COMMUNITY
COUNSELING CENTER**

**TRI-COUNTY
MENTAL HEALTH
SERVICES, INC.**