



IDDT - a note from the Division of Behavioral Health

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Greetings from DMH: So your agency has an integrated treatment for co-occurring disorders program. Your brochure explains what people should expect from the program, your assessments capture information about both mental illness and substance use disorders and you send people down the hall to the integrated treatment program when they have co-occurring disorders. Now, how do you as an agency or a team know you are providing services according to the evidence based model (besides receiving a DMH fidelity review once a year)? The answer lies in ensuring that key elements are there when, at the end of the day, you look at yourself in the mirror. Do people know what they are supposed to be doing to help people reach recovery? Do they have guidance to do so? And are you taking an objective look at what is actually happening to know things are going as planned. So... according to research and literature that equates to training, supervision and quality assurance.

Training should address the basic needs of all staff as well as the needs of those who are specialists. Because of the high prevalence of

substance use disorders in people with severe mental illness, all clinicians need basic training in working with individuals with co-occurring disorders. This includes information about the interactions between substance use and mental illness, tools and instruments for recognizing and assessing mental health and substance use problems, an understanding of the concepts of stages of change and stages of treatment, treatment planning skills, strategies for engaging individuals in treatment and enhancing their motivation to change, and the principles of collaborating with family members and other significant persons in treatment. The integrated treatment specialists need to develop additional expertise in specific therapeutic modalities, including individual cognitive-behavioral therapy, group based motivational and skills training approaches, family therapy, as well as skills for addressing common problem areas such as housing instability, legal problems, health problems, risky behaviors and trauma/victimization.

(Continued on page 3)

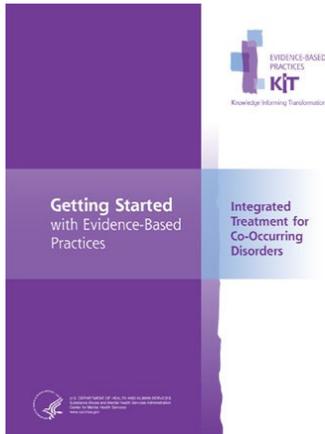
Fidelity Facet



Most IDDT programs exist within an agency serving a larger group of individuals diagnosed with mental illness, which is considered the “target population”. Literature estimates that 40% of individuals within the target population tend to be eligible to receive IDDT services. Some agencies are equipped to know exactly what percentage of the target population are eligible through a variety of means such as tracking diagnoses. The goal of the IDDT program is to serve at least 80% of

those who are deemed as eligible from the target population. Therefore, if your community support program serves 300 individuals and 200 of them have co-occurring disorders, which would make them eligible for IDDT services, then the goal is to serve at least 80% of the 200 individuals. ($200 \times .80 = 160$) If the IDDT program is serving 160, then the “penetration rate” of the program is as high as expected and the fidelity score for that program would rate a 5 out of 5.

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>



Center for Evidence-Based Practices—Substance Abuse & Mental Illness
<http://www.centerforebp.case.edu/practices/sami/iddt>

Missouri Credentialing Board

www.missouricb.com/



ireta
 Institute for Research, Education
 & Training in Addictions

Toolkit for treating individuals with co-occurring disorders

[Click here to view](#)

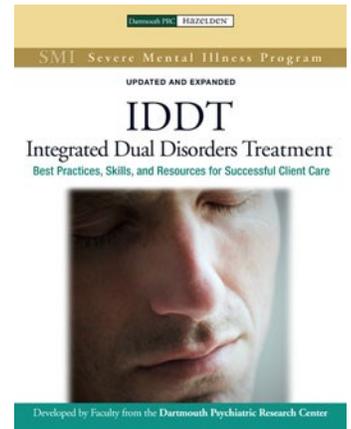
Hazelden Integrated Dual Disorders Treatment Curriculum

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

Peer Support Services

Website:

www.peerspecialist.org



MRN

MISSOURI RECOVERY NETWORK

The Statewide Voice for Recovery

www.morecovery.org 573.634.1029

Introducing: Missouri Recovery Network

The Missouri Recovery Network (MRN) was established in August, 1999. The initial funds for MRN were provided by a three year DHSS SAMHSA grant. When the grant was written, those in recovery from a substance use disorder had limited involvement in helping shape practices, policies and opportunities for those in recovery and seeking recovery. It became known that the recovery community had much knowledge and insight to share based on their life experiences and that their

contribution could and would positively affect and shape the mental health service delivery system. It was proposed in the original grant that funds would be used to establish a statewide recovery advocacy organization which would become involved in training and educating people in recovery about the mental health/behavioral health care system, the process of policy and systems change, and advocacy. Read more at www.morecovery.org

(taken from www.morecovery.org)



The National Alliance for the Mentally Ill (NAMI) can be a great source of supportive groups in your area. The NAMI Family Support Group can help people cope within the family in a variety of ways. Check to see if there is a local NAMI chapter in your area and read more about the Family Support Groups at <http://www.nami.org/Find-Support/Family-Members-and-Caregivers>



Wellness Recovery Action Plan

By Mary Ellen Copeland, PhD

Discover more here:

<http://www.mentalhealthrecovery.com/>

IDDT - a note from the Division of Behavioral Health...continued

As far as supervision goes, integrated treatment specialists need to receive structured weekly supervision from a supervisor experienced in co-occurring disorders. The supervision can be either group or individual, but CANNOT be peers-only supervision without a supervisor. The supervision should be consumer centered and explicitly address the co-occurring treatment model and how it applies to specific consumer situations. Administrative meetings and meetings that are not specifically devoted to co-occurring disorders treatment do not count. Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of services according to the co-occurring treatment model. Another critical element is quality improvement. This can take many forms, but usually involves data-based

supervision, electronic decision support systems, client outcome monitoring, fidelity reviews, and intensive review of individual clients who are not making progress. Good quality assurance committees help the agency with important decisions, such as penetration goals, hiring and training needs. QA committees also help guide and sustain the implementation of an evidence based practice by reviewing fidelity to the model, making recommendations for improvement, advocating and promoting the practice within the agency and in the community and deciding on, measuring and keeping track of key program and client outcomes relevant to an evidence based practice. A commitment to quality improvement is essential for successful program implementation.

MRN Presents...

"We Are the MISSING LINK to Long-Term Recovery"
1st Annual Peer Leadership Summit

March 18, 2016

Join peer specialists from across the state as we unify, collaborate, network, and learn.

Location: Lodge of Four Seasons, Lake Ozark, Missouri.

MRSS/MRSS-Ps, CMPS, VA peer specialists, and peer supervisors are encouraged to attend. 7.5 CEUs will be available. Save the date!

Save the date....and for more info contact:

Missouri Recovery Network
www.morecovery.org
573-634-1029

MISSOURI COALITION FOR COMMUNITY BEHAVIORAL HEALTHCARE

Representing Missouri's not-for-profit community mental health centers, as well as alcohol and addiction treatment agencies, affiliated community psychiatric rehabilitation service providers, and a clinical call center. www.mocoalition.org



"The most important thing about recovery is to pass the message on"

Maurice Gibb

DID YOU KNOW....

That a new law in New York requires drug courts to allow medication for opioid addiction? Read more [here](#)

Motivational Interviewing Corner

By Scott Kerby, Truman Behavioral Health IDDT Specialist

I remember a job that I started and was immediately expected to perform at a high level despite receiving minimal training. Unfortunately, this is not an uncommon occurrence. Just like a fielder having a bad game in baseball where the ball always finds you, a poorly trained employee has a way of attracting (or creating) difficult situations. This certainly was the case with me...I'm just lucky we did not end up with any law suits as I learned on the job and eventually became less dangerous.

This reminds me of how many organizations train their staff in Motivational Interviewing. They provide a 4 hour training, or possibly even a 2 day training, and then tell their staff "Now go do it." Unfortunately, there is little follow-up, less ongoing investment, and nothing set up to measure if staff are actually doing motivational interviewing (what staff write in their notes is unlikely to be an accurate measure of MI skill). I am thankful that pilots are not trained in this way.

The Spirit of Motivational Interviewing, or approach, is by far the most important piece of MI, and is the part that can be most easily adopted (by

many). However, research has found that MI is actually quite difficult to master, and takes a great deal of work for most people. Consider taking inventory as an agency to see if you are expecting your staff to "do" MI without working to create a culture of MI in your agency that is more than throw-away trainings with little real impact on clinical behavior. Several agencies are successfully implementing strategies that are setting their employees up for success using MI. Have questions? Email me at Skerbyconsulting@gmail.com and I would be glad to freely share strategies that seem to hold some promise for lasting MI skill development.

If you have any questions about further developing Motivational Interviewing in your practice feel free to contact Scott Kerby. He has information on free and cost effective resources and can help you find a trainer to fit your agency's needs. Scott.Kerby@tmcmcd.org

Staff Qualification for Co-occurring treatment in the CPR Program

For provision of individual co-occurring counseling, group co-occurring counseling, and co-occurring assessment supplement, eligible providers must be either a qualified mental health professional (QMHP) or a qualified substance abuse professional (QSAP) and meet co-occurring counselor competency requirements established by the Department of Mental Health. For group education the eligible provider shall have documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QSAP who meets the co-occurring counselor competency requirements. Co-occurring counselor competency requirements are defined as: 1) a QMHP or a QSAP with one year of training or supervised experience in substance abuse treatment, and 2) if an individual has less than one year of experience in IT, must be actively acquiring 24 hours of training in IT specific content* and receive supervision from experienced IT staff.

A QMHP is defined within 9 CSR 30-4.030 and can be found by following this link:

<http://www.sos.mo.gov/adrules/csr/current/9csr/9c30-4.pdf>

A QSAP is defined within IDDT as: A physician or qualified mental health professional who is licensed or provisionally licensed in Missouri with at least one (1) year of full-time experience in the treatment of persons with substance use disorders; or a person who is certified or registered as a substance abuse professional by the Missouri Credentialing Board**.

*The 24 hours of training in IDDT specific content can include, but is not limited to:

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

**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

More information can be found by following this link: <http://www.missouricb.com/careerladder.pdf>

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.

Core Components of IDDT

*Integrated Care *Assertive Outreach *Access to a full array of services *Stage-wise Interventions *Motivational Counseling *Self-help Liaison *Multidisciplinary Team Approach *Time Unlimited approach

SURROUNDED BY SUPPORT

BY HEATHER JENKINS, BS, CCJP, MARS

COMMUNITY COUNSELING CENTER

For as long as I have worked as a Substance Abuse Specialist in our IDDT program, I have loved it. I love how a consumer is able to not only receive services from a Substance Use Specialist for their co-occurring symptoms, but also how the consumer benefits from a whole team supporting them. Recently, I was able to see this whole team approach in action.

A consumer of mine had been isolating after a recent relapse and I was concerned about him. I called and received no answer so then I went to his apartment to check on him. He answered the door, stated that he was doing ok, and then after a brief conversation, he asked me to leave and stated that he would be in group the following day. Shortly after I returned to the office, I received a call from the same consumer. He stated that he was experiencing suicidal thoughts and was embarrassed for not telling me when I stopped by his home. I asked if he would be agreeable to coming to my office if I provided transportation to and from the visit and he agreed. Once in my office, he began to speak at length about his feelings of frustration, hurt, and pain after he lost a job that he interviewed for. After he was passed over for this job, he relapsed. He explained that some of his suicidal thoughts were because he felt he had no other options. As I spoke to him, we were able to collectively identify a plan for this consumer to feel in more control of his life. I contacted his Employment Specialist to schedule an appointment and to briefly discuss the consumer's last job interview. I

contacted our IDDT Peer Specialist to schedule an appointment to discuss self-advocacy. I contacted the pharmacy to aid the consumer in getting the medications that his psychiatrist prescribed, but that he was previously unable to pick up. At the conclusion of the session, we were able to plan a schedule for the rest of the week and he was able to identify a glimmer of hope that his life could change.

We, as a team, were able to wrap this consumer in services at a very vulnerable time in his life. He left my office with a plan, a schedule, and support instead of a list of things to do and people to call. Will our support and efforts result in a life of abstinence and no more suicidal thoughts? Maybe. Maybe not. However, our efforts and team approach did provide that consumer with renewed support and confidence that he may not have received otherwise.

Thanks Heather!



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

iddtproviders.htm

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Follow us on Twitter: @MentalHealthMO

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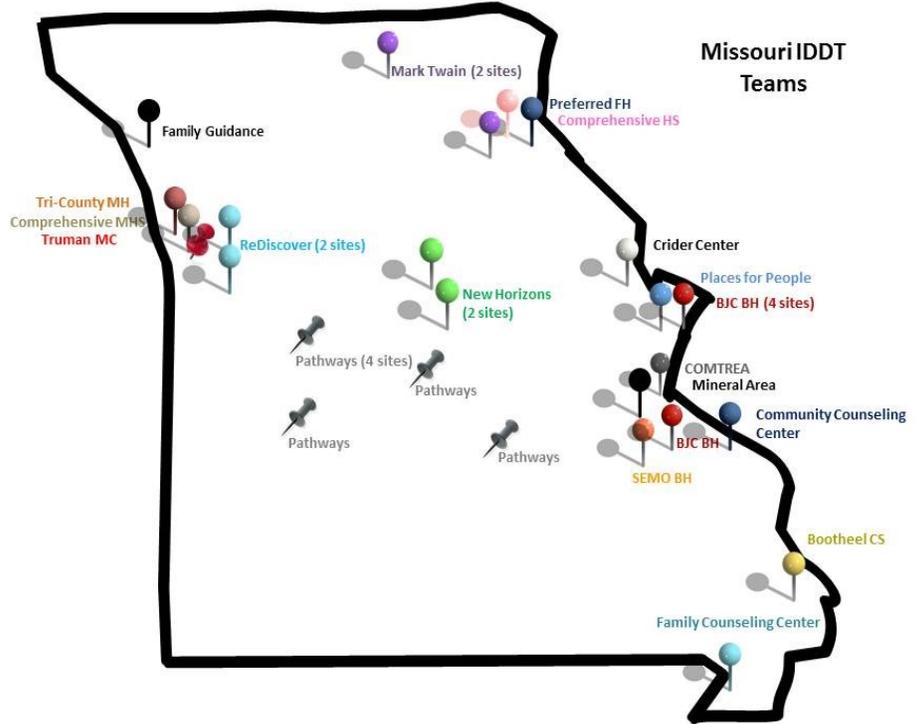
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Mineral Area Community Psychiatric Rehabilitation Center (MACPRC)

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

Southeast Missouri Behavioral Health

Crider HEALTH CENTER
Full, Productive, Healthy Lives for Everyone

ReDiscover
Help, Hope, and Healing

COMPASS HEALTH
guiding solutions

COMTREA
Founded 1973

FAMILY GUIDANCE CENTER
for behavioral healthcare

TMC
TRUMAN MEDICAL CENTER
Behavioral Health

Preferred Family Healthcare

COMMUNITY COUNSELING CENTER

TRI-COUNTY MENTAL HEALTH SERVICES, INC.