



Integrated Treatment for Co-occurring Disorders

ITCD - a note from the Division of Behavioral Health

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Another new year is quickly upon us and with it comes exciting developments. The ITCD community is growing quickly both for the adult population but also for Transitional Age Youth (TAY). Cape Girardeau is debuting a new TAY team and Kansas City, Columbia, Sedalia, and Kansas City are all homes to new adult teams. Serving the TAY population through the ITCD program is a new venture and will require a different approach to providing services effectively. Not only are outreach and engagement a special focus of importance with the TAY population but also the level of contact the team will have with families or identified natural supports of the client. We look forward to learning more about providing services to the TAY who are in need from our new specialized teams.

A quickly expanding need within ITCD treatment includes a focus on wellness management services. Teams are already equipping themselves to provide wellness services through the use of Illness Management and Recovery (IMR) and Wellness Recovery and Action Planning (WRAP). We have recommended the IMR toolkit from SAMSHA, the Lindy Fox IMR for co-occurring disorders materials and the Hazelden IMR Publication. All are excellent materials to educate staff, provide 1:1 as well as group materials on well-

ness concepts. Many teams now include a Certified Missouri Peer Specialist who can enhance wellness and recovery services. Peer Specialists are trained in the 5 Stage Recovery Process which supports any wellness program provided within the team. DBH has offered trainings this year in WRAP, especially for the Peer Specialists. Teams are utilizing the Stages of Change model to assist individuals with each of their identified disorders in providing education and support to help them move forward in their own recovery.

DMH has begun providing brief training videos for new members of ITCD teams, including the ITCD Specialist and Team Leadership. The videos include a PowerPoint presentation based directly from the Co-Occurring toolkit fidelity protocol which introduces the new member to ITCD, the co-occurring treatment philosophy and their particular role on the team. Additional training videos are being developed both for specific members on the team and for the full team to view.

DBH has a vision this year of bringing hope, opportunity and community inclusion to individuals, giving them the opportunity to pursue their dreams and live their lives as valued members of their communities. As we approach this goal, we continue to uphold ITCD as one of the most exciting services offered in the state.



Fidelity Facet

Group treatment is one of the key components of ITCD treatment. Groups attract clients who may be interested in having a sense of comradery and purpose as well as to be able to relate with others experiencing similar problems and successes. For that reason, offering co-occurring group treatment is essential to ITCD teams. Programs offer groups that are specifically designed to address both mental health

and substance use problems and the curriculum is stage-matched to the attendees' level of change readiness. If your program offers groups like this and 65% of ITCD clients regularly attend group treatment, you may score a "5" on Group Treatment for Co-Occurring disorders on the Integrated Treatment fidelity scale.

M R N

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Payoff Matrix Helps Clients Make Changes

A few tried-and-true practices can help clients struggling with addictions or chronic illnesses resolve to take the steps needed to change their behaviors and improve their health.

Participants often wax and wane in their motivation to make changes in their life. They may often feel ambivalent about changes, even ones they want to make. This is understandable. Practitioners can help participants weigh the pros and cons of change through exploratory discussions. For example, they might ask, "What do you think would be the advantages of applying for Social Security benefits?" and "What do you think would be the disadvantages of applying for benefits?" Or practitioners might help participants use a payoff matrix.

The payoff matrix involves prompting the participant to identify the advantages and disadvantages of an action or a behavior as well as the advantages and disadvantages of not performing the action or behavior. For example, the payoff matrix could be used to help a person decide whether to stop smoking marijuana. The practitioner asks the client to explore both the positive and negative effects of smoking marijuana and then to weigh the importance of those effects. The positive effects of smoking marijuana might include having friends to hang out with, feeling temporarily "high" rather than depressed, and being less bored. The negative effects might include financial problems, precipitation of health risks, and interference with achieving employment goals. The practitioner then also asks about the positive and negative effects of stopping smoking marijuana. Examples of positive effects of not smoking might include better control over one's money, less severe symptoms, less conflict with family members, and a better ability to pursue one's vocational goals. Examples of negative effects of not smoking might include having to say "no" to friends who smoke, finding new friends who don't smoke, not having an escape from depressed feelings, and not having anything fun to do when feeling bored. When considering the advantages of changing the behavior in question, it is im-

portant for the practitioner to encourage the participant to think of whether such a change could help the person achieve his or her recovery goals.

Sometimes after completing the payoff matrix, especially when the participant clearly sees how the behavior change may help him or her achieve his or her goal, the person becomes motivated to work on changing the behavior. However, at other times, despite the evident advantages of changing the behavior, the participant may continue to feel ambivalent about changing the behavior. In this situation, the key to shifting the decisional balance toward change often lies in further exploring and addressing concerns the participant has about the anticipated change--specifically, addressing the participant's perceptions of the negative effects or disadvantages of change.

Using the previous example of a participant deciding whether to quit smoking marijuana, the practitioner could explore with the participant strategies for reducing the disadvantages of not smoking, such as dealing with friends who smoke, feeling depressed much of the time, and having nothing fun to do. Examples of strategies for addressing such problems could include learning to say "no" to friends when they invite the person to smoke marijuana, identifying new places or activities where the person could meet people who do not smoke, learning new ways of coping more effectively with depressed feelings, and developing new and rewarding things to do with one's spare time.

Considering these strategies and making a plan to learn and implement them can motivate participants to make important lifestyle changes that will help them better manage their psychiatric disorder and achieve their recovery goals.

Excerpted and adapted from the Implementation Guide to Illness Management and Recovery IMR: Personalized Skills and Strategies for those with Mental Illness. by Susan Gingerich and Kim T. Mueser. Hazelden, 2011 Hazelden Publishing. *Behavioral Health Evolution*. Retrieved from

<http://www.bhevolution.org/public/payoffmatrix.page>

CLARIFYING THE STAGES OF CHANGE & TREATMENT

The “stages of change” refer to an internal process—related to our clients. As an integrated treatment specialist, this process is difficult to observe or measure accurately. However, as consumers go through the process of changing, they tend to interact with the treatment system in characteristic ways and should be offered different interventions at different stages. For example, what they find helpful before they consider their behavior a problem is different from what they find helpful when they are actually ready to stop using or after they have stopped.

The “stages of treatment” refers to the treatments that have been found to help consumers during the different stages of their recovery. The focus is more on the provider. The chart below shows how the stages of treatment correspond to the stages of change.

The fidelity protocol asks the ITCD program to stage each disorder, meaning aspects effecting the whole person. This includes but is not limited to mental health, physical health and substance use.

The Stages of Change	The Stages of Treatment
Pre-contemplation	>Engagement
Contemplation/Preparation	>Persuasion
Action	>Active Treatment
Maintenance	>Relapse Prevention

Team feature

Compass Health Clinton

Team feature

Submitted by Dana Wyatt, ITCD Specialist

We are lucky in Clinton to have a truly integrated team to include two ITCD Specialists providing individual counseling sessions and groups. We have a prescriber who participates in weekly staffing, another prescriber who provides medication assisted treatment, a housing specialist, a peer specialist, employment services, and access to residential services if needed. The team collaborates 3 days per week in huddle and more if needed. The groups currently being offered are

Illness Management and Recovery, Enhanced Illness Management and Recovery, and Co-occurring Process Group. Our team understands the importance of access to recovery resources in the community, which our peer assists with. This team is awesome with coordinating with and advocating for our customers with outside agencies, which is essential in addressing potential peripheral issues while in recovery.

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 addiction professional (QAP) 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 QAP who meets the co-occurring counselor competency requirements. Co-occurring counselor competency requirements are defined as: 1) a QMHP or a QAP 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 integrated treatment, must be actively acquiring 24 hours of training in integrated treatment specific content* and receive supervision from experienced integrated treatment 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 QAP is defined within ITCD 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 ITCD 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 Addiction 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

RADC-P - Registered Substance Abuse Professional – Provisional

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

MAADC I or II

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

There is no application to be a QAP, 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.

DBH contacts

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

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

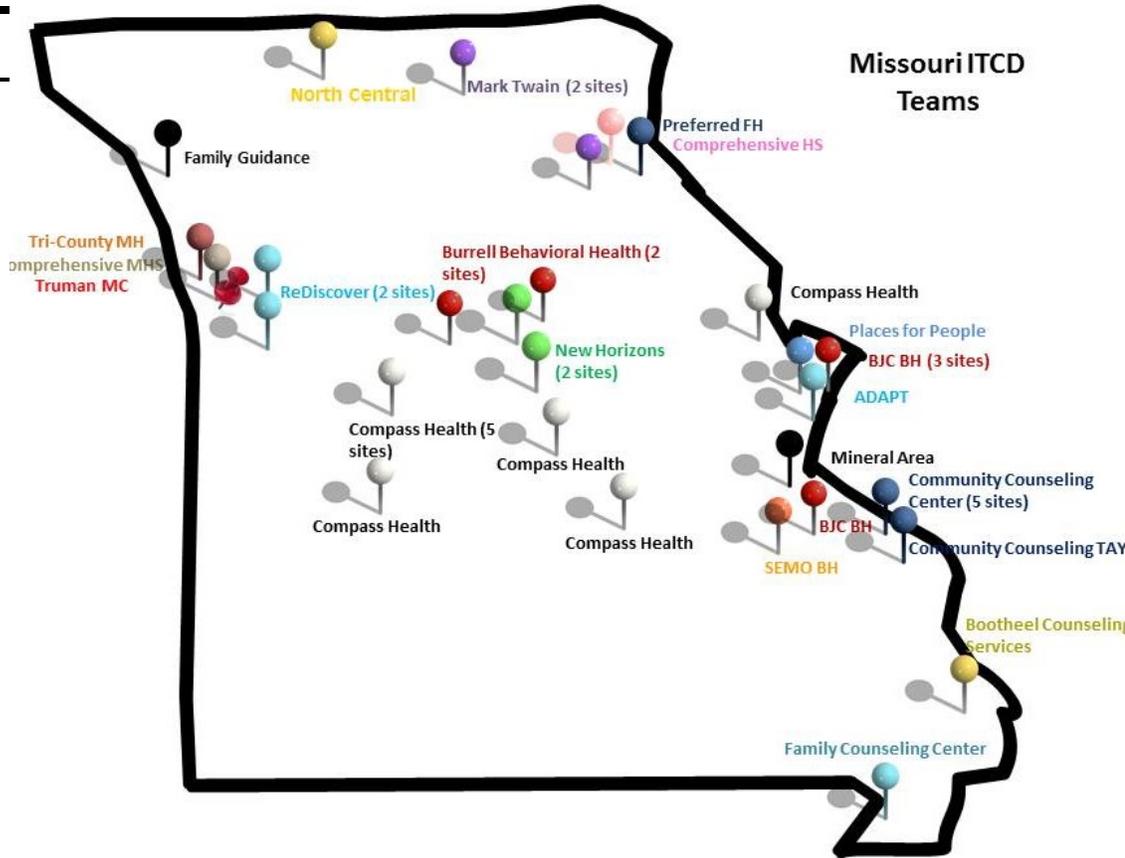
Trish Grady, BSW, Program Specialist II
Telephone: (573) 840-9296
Fax: (573) 840-9191
Trish.Grady@dmh.mo.gov

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

Mia Ferrell, M Ed., LPC, CCJP, Program Specialist II
Telephone: (573) 751-3876
Mia.Ferrell@dmh.mo.gov

Kelly Orr, CMHC/DD Specialist
Telephone: (314)877-5972
Fax: (314)877-6130
Kelly.Orr@dmh.mo.gov

Amy Bledsoc, LPC, Program Specialist II
Telephone: (573)751-8575
Fax: (573)-751-7814
Amy.Bledsoc@dmh.mo.gov



Mineral Area Community Psychiatric Rehabilitation Center (MACPRC)

Missouri ITCD teams

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NORTH CENTRAL MISSOURI MENTAL HEALTH CENTER

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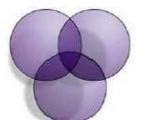
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