So here we are, a few short weeks into CCBHC implementation…dipping our toes (or treading water it sometimes seems) as we embark on a journey that is designed to demonstrate the cost effectiveness of converting Medicaid reimbursement for community behavioral health services from a fee-for-service reimbursement system to a prospective payment system while improving the availability, accessibility, and quality of community behavioral healthcare.

State community behavioral health systems are increasingly viewed as a key piece of the health reform puzzle. Whether we are talking about integrating with physical health care, addressing the needs of Medicaid’s most expensive and complex populations, or being the go-to system for high-visibility public health issues (suicide prevention, opioid addiction) more is expected of community behavioral health systems than ever before.

For the first time in more than a generation, our country has a common definition for a certified comprehensive behavioral health center and reimbursement based on the true anticipated costs of care. This will fundamentally transform the way organizations deliver care. The focus will move away from a productivity focused system to a system focused on client outcomes, quality services and recovery for the people we serve.

Integrated Treatment for Co-occurring Disorders is a required evidence based practice for all CCBHCs across the State of Missouri – which is really good news for individuals needing this service! And this demonstration project fully supports integration and quality care – something that Missouri’s ITCD teams have focused on all along. Keep up the good work and thanks for all that you do.

When you walk through the door of any CCBHC you will have access to a full array of services to address your mental health and substance use treatment needs, basic primary care assessments, and important support services. All will emphasize recovery, wellness, trauma sensitivity, and cultural and linguistic competence. All will be available in one familiar place. CCBHCs can now begin to think about how best to deliver services guided by allowable costs rather than externally imposed rates. In other words, our system has an awesome opportunity to reimagine a true recovery, wellness, trauma-sensitive, multi-culturally prepared, individualized system of services.

To be added to the distribution list for this newsletter, please contact lori.norval@dmh.mo.gov to provide your email address.
**ITCD 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 Practice—Substance Abuse & Mental Illness**

http://www.centerforebp.case.edu/practices/sami/iddt

**Missouri Credentialing Board**

www.missourieb.com/

**Hazelden Integrated Dual Disorders Treatment Curriculum**

https://www.hazelden.org/OA_HTML/item/385159

**DMH Peer Support Services Website:**

www.peerspecialist.org

**University of Minnesota MNCAMH**

https://mncamh.umn.edu/co-occurring-disorders

**Missouri Recovery Network**

The Statewide Voice for Recovery

www.morecovery.org  573.634.1029

**SAMHSA**

New free publications!

http://store.samhsa.gov/home
In the article “Is Low Therapist Empathy Toxic”, Bill Miller and Terry Moyers present compelling research and commentary on the impact of empathy on client outcomes, as well as the nature of measuring empathy. Often lumped in the “nonspecific” skill of clinicians, Miller and Moyers argue that empathy, particularly empathy defined along the lines of Rogerian “accurate empathy”, is not only measurable but impacts sessions to such a high degree that it could be considered an evidence based practice itself.

The paper cites several studies that investigated the impact of empathy on outcomes, with some incredible findings. One study looked at client drinking outcomes where clinician’s empathy was measured by a tool created by Truax and Carkhuff. Clinicians were then ranked based on their empathy scores. The empathy scores accounted for 2/3rds of the variance in the outcomes. So the clinicians that ranked high on empathy had much better outcomes, and bulk of the outcomes were related to their empathy score. Not only that, but the clinicians that scored low in empathy had worse outcomes than a control group that was given a self-help book to read on their own. Look at that again—low empathy clinicians are likely not only less effective than high empathy clinicians, but they actually make change less likely to occur in our clients! It can be argued that they are doing harm, that our clients would be better off if they completely avoided low empathy treatment. There is still a lot of research to be done in this area, but the correlation appears to be strong.

The good news is that empathy, defined as a “commitment to understanding the client’s personal frame of reference and the ability to convey this hear meaning back to the client via reflective listening (Moyers and Miller)”, can be taught and learned by most clinicians. This is particularly true when the skill is focused on over time with feedback. As an agency, what kind of value, screening, teaching, and training are you putting into empathy and reflective listening? There may not be a more important clinician skill when it comes to substance use disorder treatment. Please check out Miller and Moyer’s paper, “Is Low Therapist Empathy Toxic” for more information and suggestions.

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 products and can help with your Motivational Interviewing needs.

skerbyconsulting@gmail.com

Show Me You Care About Suicide Prevention

August 3-4, 2017  Hampton Inn and Suites
1225 Fellows Place
Columbia, MO 65201

Register Today!
Registration Price $179

Come hear our Keynote, Johnathon Singer, PhD as he presents: Overview of School-Based Suicide Prevention & Five Things Everyone Should Know About Suicide Prevention and Social Media
Get more info at SuicidePreventionConference.com
In an effort to significantly improve access, availability, and quality of community-based support services, Ozark Center implemented the ITCD program in June 2017 within our CPRP program offering treatment for individuals with co-occurring substance use and serious mental health disorders who are often vulnerable, underserved, and without adequate financial resources and social supports. We serve individuals in our four county service area: Barton, Jasper, Newton, and McDonald. Ozark Center’s ITCD team is happy to report that things are going great during our start-up period! At present, our focus is on the most severe COD individuals.

The ITCD team currently serves 20 individuals. At the moment, our ITCD team consists of the ITCD Supervisor/ITCD Specialist, 2 ITCD Community Support Specialists (CSS), part-time ITCD Specialist, collaborating APN, Health Care Home (HCH) Director, HCH RN, and collaborating HCH physician. Adjunct team members include Activity Therapists, Employment Specialist, and Housing Specialist. We are in the process of hiring a full-time ITCD Specialist and have future plans to hire an ITCD Peer Support Specialist (PSS). We are excited to offer services under one umbrella of care. Stay tuned!

ITCD Networking call every 2 months, second Friday of the month from 10-11am. Next call August 11th at bridge, 526-5622/outside of DMH 866-630-9348.
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: CADC, CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, and RADC-P are considered 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 - Registered Substance Abuse Professional
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
DBH contacts

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

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

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

Kelly Orr, CMHC/DD Specialist
Telephone: (314)787-5972
Kelly.Orr@dmh.mo.gov

Lori Norval, MS, LPC Mental Health Manager
Telephone: (417) 448-3476
Work cell (417) 448-9955
Lori.Norval@dmh.mo.gov

Carolyn Conus, MS, Program Specialist II
Telephone: (573) 526-0264
Carolyn.Conus@dmh.mo.gov

Ruth Ann Fink, LCSW
Telephone: (816) 482-5742
Ruth.Fink@dmh.mo.gov

Chrystal Frey, Quality Assurance Specialist
Telephone: (417)448-3462
Chrystal.Frey@dmh.mo.gov

Rebecca Seitz, MSW, LCSW Program Specialist II
Telephone: (573)592-3072
Rebecca.Seitz@dmh.mo.gov

Karen Will, MS, CCDP-D, SQP-R, SAP, MARS Program Specialist II
Telephone: (573) 751-8175
Karen.Will@dmh.mo.gov

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