Integrated treatment is the best thing since sliced bread! Historically individuals with co-occurring mental health and substance use disorders could only expect sequential or parallel treatment. Sequential treatment is getting treatment for one disorder before being allowed to get treatment for the other disorder. The most important problem with the sequential treatment approach is that it ignores the interactive and cyclical nature of co-occurring disorders. Parallel treatment means going to one service provider or team to receive help for a mental health disorder, but having to go to another service provider or team to receive treatment for the substance use disorder. This sounds ok in theory; however, in practice there are many time issues with coordination of care. Consequently, the burden of integration is placed on the individual receiving services, who is usually ill equipped to handle this responsibility. Research over the years has shown that integrated treatment can overcome many of the disadvantages of traditional sequential or parallel approaches to co-occurring disorders. Integrated means the same practitioners or treatment team, working in one setting, provide both mental health and substance use interventions in a coordinated fashion in order to ensure that individuals being served receive one consistent message about treatment and recovery.

The Division of Behavioral Health supports integrated treatment and believes it is the right thing to do. In July 2007 Community Psychiatric Rehabilitation (CPR) providers were encouraged to provide treatment according to the Substance Abuse Mental Health Services Administration (SAMHSA) evidence based practice (EBP) toolkit for integrated treatment. Several agencies eagerly embraced this practice. This model focuses on treatment for those individuals with a serious mental illness and a co-occurring substance use disorder. Today all but three CPR providers are providing services based on the EBP. The division is piloting the EBP for transition age youth (age 16-25) and will soon be making available an integrated treatment model for Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers. The model for CSTAR providers is based on TIP 42 and the SAMHSA integrated treatment EBP and will focus on treatment for those with substance use disorders and a co-occurring mental health disorder.

We are very proud of Missouri’s service system and our network of service providers. Missouri is well respected on a national level for our innovation and the good work we do. So a big, big thank you to each and every one of you whose life work is to make a difference in the lives of those with mental illness and substance use disorders. The work you do is VERY important. The individuals we serve are counting on us to support them as they set meaningful goals and strive to live full, satisfying and hopeful lives in their community.
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

Hazelden Integrated Dual Disorders Treatment Curriculum
https://www.hazelden.org/OA_HTML/item/385159

Certified Peer Specialist Website:
https://dmh.mo.gov/mentalillness/PeerSupportServices.htm

Missouri Credentialing Board
www.missouricb.com/

Missouri Recovery Network
The Statewide Voice for Recovery
www.morecovery.org 573.634.1029

University of Minnesota MNCAMH
https://mncamh.umn.edu/co-occurring-disorders

MO COALITION
FOR COMMUNITY BEHAVIORAL HEALTHCARE
https://www.mocoalition.org

State of Missouri ITCD webpage:
https://dmh.mo.gov/mentalillness/provider/iddtproviders.html

New free publications!
http://store.samhsa.gov/home
This fall I was in Branson to provide workshops on engagement when I had the good fortune of an interesting experience with engagement. Unfortunately during the first day of training I was sick and running a fever, so after fighting through a training I sought refuge at my hotel. My greeting there was impressive, with a doorman letting me in and treating me warmly. After checking in I was instructed to head across the street to the member services building for my deluxe welcome package. Hoping for a granola bar and bottle of water in this guest package, I trudged that direction. Upon arrival I met with my "VIP" guest services representative. He provided me with his phone number that I could call upon 24 hours a day if I had a need (not sure that is good boundary setting). He asked what had brought me to town, and I told him that I was in town for a conference and would have no time to enjoy the sites of Branson, and that I was also "sick as a dog". My "VIP" representative then used some reflecting listening: "I hear that you are in town for a conference and won't have time to do much, but...let me tell you about a great opportunity tomorrow evening where you can hear about other exciting properties and even earn two free nights..." My deluxe welcome package was nothing more than a time share sales pitch and a folder full of lousy coupons. I responded pretty quickly with "resistance" to this pitch, bluntly told him that I was not interested, and walked out with a new training story. This guy had one shot to engage me and he blew it.

Calling me a "VIP" did not help when I felt I wasn’t heard. What started as pleasant talk ended with me walking away cynical and frustrated. What would have happened if he had responded with: "You are going to be really busy this week and clearly aren’t feeling well. Let’s get you out of here so you can get some rest. And if your schedule changes and you want some help finding some deals, give me a call"? There is a good chance I would have felt very positive about the interaction, recommended this hotel, and possibly even used those services as the week wore on. Instead, engagement was lost, the relationship was done, and now I am unlikely to return.

Much of the resistance we get when working with clients actually comes from us, the helpers. We cause the discord by trying to fix, by not listening, assuming what is or should be important to clients, and plowing ahead with a change plan when the ambivalence is still unresolved. Listen for the smoke alarms of discord: Clients defending themselves (It's not so bad, everyone does it), squaring off (YOU don't get it, YOU don't know what its like to be a single mom), Interrupting, and shutting down (disengagement). A key to engagement is recognizing when there is discord and responding to it. Reflect when you hear discord, apologize when you move too fast or try to fix, listen to understand when a client feels they are not being heard. Using the right language (VIP) means nothing if the client does not feel engaged. Remember, you often get one shot at engagement--Don't blow it!

**ITCD Networking call schedule 2019:**

Phone in at 866-630-9348 from 10-11am
January 4th, April 5th, July 5th and October 4th

*To schedule training for individual role or team orientation to ITCD, contact Lori Norval at lori.norval@dmh.mo.gov*
THE BJC ITCD TEAM FEATURE

By: Barbara Hargiss

The BJC Behavioral Health’s (BJC-BH) southeast location in Farmington, continues to expand its Integrated Treatment for Co-Occurring Disorders (ITCD) team as we now have 13 team members that serve three different counties. The ITCD team consists of our team lead who is a licensed professional counselor and has the credentials of ICCDP-D and is MARS certified. We also have a psychiatrist, two psychiatric mental health nurse practitioners, seven case managers (including our housing specialist) a community support specialist and a certified peer specialist. We currently offer 11 ITCD groups that include a Family Group, two Seeking Safety groups, Trauma/Addiction group and a group held at our Cluster Apartment location. The ITCD team continues to work with the employment specialist team offering supportive employment to clients regardless what Stage of Treatment they are in. The ITCD team also works extensively with all of our BJC-BH nurses, especially with our expanded Suboxone program as we currently have 11 clients receiving treatment at this time. Our goal at BJC-BH is to offer ITCD services to all clients giving them the opportunity to become empowered in their own treatment goals including reaching and maintaining their recovery.

“My Group” by Lee Ann (a BJC-BH client engaged in ITCD services)

Look around this room and see, people just like you and me. Some have more problems than others, gather up now, you sisters and brothers.

People in here take care of each other, lending a hand to one person or another. Whoever is hurting the most that day, we try to just listen to what they say. Then somebody may offer advice, so if you are tempted to use, maybe you’ll think twice.

But even if you mess up, please come back, all of here have been through that. Keep coming in and you might begin, to want to stay sober and start your life over.

RECOVERY
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 QAP or 2) a QMHP with one year of training or supervised experience in substance use treatment, and 3) if the QMHP 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 or a person who is certified or registered as a substance use 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: https://missourich.com/wp-content/uploads/2018/05/careerdiagramladder.pdf
The Missouri Opioid-Heroin Overdose Prevention and Education (MO-HOPE Project) is conducting an overdose education and naloxone distribution training of trainers in Kansas City on Nov. 11th.

This training prepares individuals to train those who will discuss overdose education and naloxone use with individuals at risk of experiencing or witnessing an opioid overdose. After completion of this course, participants will be given resources to present materials to others. This course is most appropriate for individuals who will offer trainings to county and municipal health departments, treatment providers, social service agencies (including homeless shelters, domestic violence shelters, food banks, etc), medical providers, and other community organizations and agencies that may work with at-risk individuals.

- Opioid Overdose Background: Learn about opioid overdose causes and trends
- Opioid Epidemic: Learn about existing efforts to combat the opioid crisis and legislative protections for naloxone use and dispensing
- Opioid Overdose Prevention, Recognition, and Response: Learn how to correctly identify and respond to an overdose event, including how to administer naloxone, and how to prevent future overdoses
- Delivering Overdose Education and Naloxone Distribution (OEND): Learn how to provide clients with overdose education, and either distribute or recommend how and where a client can acquire naloxone.

MO-HOPE Evaluation: Learn how to participate in MO-HOPE evaluation protocols, including teaching clients/patients how to complete “Overdose Field Reports” when naloxone is used to reverse an overdose.

Participants may utilize this training for expanding the capacity of their own organizations, or offer education to other individuals or organizations. We request that each organization interested in training limit themselves to 5 participants due to limited space.


Brandon Costerison MO-HOPE Project Manager  P: 314.962.3456 x315  www.ncada-stl.org
DBH ITCD fidelity
team/technical support contacts

**Website:** [www.dmh.mo.gov/mentalillness/provider/idtproviders.htm](http://www.dmh.mo.gov/mentalillness/provider/idtproviders.htm)

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