

Summary view

CCISC – Comprehensive Continuous Integrated System of Care

CCISC was developed by Kenneth Minkoff and Christie Kline for individuals with co-occurring mental and substance use disorders and requires system-wide change using existing resources.

Areas covered	Description
<p>Key Principles of Treatment</p>	<ul style="list-style-type: none"> • Because so many individuals have co-occurring disorders each program in the system must be designed to assist individuals with co-occurring disorders. • The foundation of substance abuse and mental health treatment in an integrated system is strength-based in every aspect of treatment • All individuals with CODs are not the same. For example, a high substance use client may have lower mental health needs and is matched with individualized appropriate services. Or, a high substance use client may have high mental health needs and will be matched with other appropriate services. • When co-occurring issues co-exist, both are treated as primary issues that are addressed simultaneously • Phases of recovery and stages of change match the client’s progression • Treatment must be completely individualized to match the specific aspects of every client • Every aspect of the system is focused toward being welcoming, supportive, and nurturing success for each client
<p>Access & referral</p>	<p>There is “No Wrong Door” for individuals to access services: Individuals with co-occurring disorders, Mental Health only or Substance Use only disorders all enter through the same doors and receive the appropriate level and kinds of treatment.</p> <p>A single Integrated Assessment Tool is used by all staff so that all clients are thoroughly assessed using one tool. Clients are no longer assessed multiple times.</p>
<p>Treatment approach</p>	<p>All staff is trained to be Co-Occurring Capable.</p> <p>Cross training of counselors occurs so that any staff can function in their specific role at any site.</p> <p>Training requirements for staff will vary based upon job description, and all staff will receive basic training to work with both disorders.</p>
<p>Integration approach</p>	<p>Some sites may offer specialty Substance Use only or Mental Health only services and other sites may offer both specialty services at the same site. However, <u>all sites will be capable of treating Co-Occurring Disorders.</u></p> <p>Each program works with a specific cohort of co-occurring disorder needs. All</p>

	<p>sites can provide basic COD services, but clients may need to be transferred to another site that has more specialized services to meet their needs. Each site also has a quality improvement process in place.</p>
Financial implications	<p>Cost of staff training Cost of program redesign Reimbursement for services (MediCal, private insurance, etc) Contract changes Consultant fees to implement the system Initial trainings may interfere with productivity</p>
Management issues	<p>Clinical supervision ability to supervise CODs Data integration Policies and procedures need to be revised to accommodate the new procedures</p>
Cultural competency	<p>Cultural competency trainings are currently provided through the Learning Institute and can be expanded as needed.</p>
Outcomes	<p>SAMHSA recognizes the CCISC model for integration of treatment for individuals with CODs.</p> <p>Improved functioning for homeless clients (ACTS, Tampa, FL)</p> <p>Decreased Depression</p> <p>Severity Index, SA, MH symptoms, wait times, misdiagnosis, and increased client satisfaction</p>
Implementation requirements	<p>Change in culture from DADS and MH are separated and cannot “share the client” to culture of working together and “sharing the client.” Expand client services in each program beyond their current limit of SU only or MH only.</p> <p>Creation of communication system so client needs are relayed to his/her whole team and the treatment plan is followed.</p> <p>Each staff must be trained in core COD competencies</p> <p>Highly recommended to utilize consultants in the beginning of implementation (first 3 years)</p>

**CCISC – Comprehensive Continuous Integrated System of Care
Examples of CCISC Implementation**

	<i>San Mateo</i>	<i>San Diego</i>
Access & referral	Client assessed upon first contact and referred to appropriate “clinical team” Co-location and separate locations	No wrong door policy Developed screening tool “Co-occurring screening tool” (COST)
Treatment approach	Individualized to meet client’s needs. 3 way integration- Primary Care, MH and SA	Provides individualized treatment. Most services are provided by contractors. Encourages use of evidence based practices
Integration approach	Can be completely integrated for clients with co-occurring disorders	Strives for co-occurring capability and capacity. Developed a committee to identify required attitudes, values, skills and knowledge regarding co-occurring disorders
Financial implications	Decreased spending ROI (return of investment ration 6:1 Used grants and one- time funds to cover the cost Decreased inpatient costs. Increased outpatient costs. \$100,000 consultation fees per year over a 3 year period	Provided specific training on co-occurring disorders and the CCISC model to all staff. Utilized internal administrators and clinical staff to participate as trainers and provided training for trainers
Management issues	Streamlined management and expanded frontline staff	Created and adopted a Co-Occurring Mental Health and Substance Abuse Disorders Consensus document. Utilized self-surveys to evaluate co-occurring capability initially and periodically. Created Strategic Plan.
Cultural competency	Found more cultural training was needed.	Integrated into county philosophy of cultural competence
Outcomes	Decrease in inpatient use and	Developed measurable changes in agency in

	increase in use of outpatient	order to track integration effectiveness. Increase of COD clients identified in MH system from 16% to 43%. Do not have current system for identifying outcomes for COD clients
Implementation Issues/barriers	Implementation was difficult initially due to shift in paradigm. Took 3 years to fully implement.	Need to develop fidelity tools to monitor integration effectiveness. Others implementation barriers or problems are not available in the literature.

Narrative: CCISC

Based on the Four Quadrant Model, the Comprehensive Continuous Integrated System of Care (CCISC) is designed to assist agencies and programs in becoming more welcoming, recovery-oriented and co-occurring capable. CCISC is a system that is designed to permeate every level of the organization- policy, program, practices and procedures, and it emphasizes quality improvement. CCISC starts with the premise that co-occurring illnesses are the expectation and not the exception and that each case is individualized. This model of integration matches Santa Clara County's dedication to strength-based and recovery models of mental health and drug and alcohol treatment for all clients. This model also strongly encourages cultural competence and the use of evidence-based practices.

In the CCISC model, there is no wrong door for entering into treatment services. An assessor who is skilled and trained in assessing both mental health and substance use issues meets with each client in order to direct the client to the "best fit" for service. When a client receives the services that best fits their needs, there are higher rates of client retention in service, and each client receive the lowest level of service that meets their needs.

All programs in the entire system become Dual Diagnosed Capable (DDC) or Dual Diagnosis Enhanced (DDE). DDC programs work with individuals with CODs that have stabilized psychiatric disorders so that clients are able to participate in addiction treatment. DDE programs address CODs simultaneously for individuals with more severe symptoms. Services use existing resources and operate within existing funding streams.

This model recognizes that individuals with CODs have a wide range of disorders so that there is no single best practice for all individuals with CODs. Consequently the system develops a wide range of best practices to provide the best treatment for each disorder a client presents with, based on quadrant, diagnoses, level of functioning and external support system. Interventions are not only diagnosis-specific, but are also matched to the stages of change that a client is in with each disorder. Case management may also be provided for clients with more severe disorders and case management intensity is based on the level of need for each individual client.

Training is necessary for the "development of basic dual diagnosis competencies for all clinicians." CCISC requires universal competency and has competency lists available to assist in designing competency programs. "Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency." CCISC has competency assessment tools available to assist in ensuring that staff are adequately trained.

They also have train-the-trainer curricula to assist with ongoing training. Trainers have a significant role in becoming system change agents. Integration starts with the principle of no wrong door and the need for qualified co-occurring disorder assessors to make sure the client go directly to where they need to go to obtain the maximize benefits from their treatment.

The model requires the development of a strategic plan that includes each program implementing a specific area of Dual Diagnosis Capable or Dual Diagnosis Enhanced competency for serving individuals with co-occurring disorders.

San Mateo County, San Diego County and Oklahoma have implemented the CCISC model. In San Mateo there was a noted decrease in use of in-patient treatment and an increase in outpatient treatment. Clients are able to function in the community with fewer hospitalization, which results in reduced cost to the county.

In summary, CCISC is compatible with Santa Clara County’s mission to improve the health and well-being of its community members by assisting individuals in accessing the necessary treatment for multiple needs.

Summary view

SAMHSA EBT Kit-Integrating Treatment for Co-Occurring Disorders

The Kit is part of a series of Evidence-Based Practice KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services.

Areas covered	Description
<p>EBT Kit Formal Framework</p>	<p>Principles of Treatment</p> <ul style="list-style-type: none"> • Long term perspective • Comprehensive care plan • Consumer driven • Assertive community outreach • Motivational theoretically grounded • Whole continuum of services <p>Services and treatment is consumer driven. Consumers are treated with respect and compassion, and the integrated treatment specialist is responsible for engaging consumers and supporting their recovery.</p>
<p>Overview of system components</p>	
<p>Access & referral</p>	<p>No wrong door Services at same location at entry, but not necessarily throughout continuum of care. Integrated assessment for mental health & substance abuse disorders exemplified by the Comprehensive Integrated Diagnostic Interview</p>
<p>Treatment approach</p>	<p>Seven practice principles guide treatment in this integrated model:</p> <ul style="list-style-type: none"> ■ Mental health and substance abuse treatment are integrated to meet the needs of people with COD. ■ Integrated treatment specialists are trained to treat both substance use disorders and serious mental illness ■ Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages ■ Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage ■ Substance abuse counseling, using a cognitive behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages. ■ Multiple formats for serves are available, including individual, group, self-help and family ■ Medication services are integrated and coordinated with psychosocial services.
<p>Integration approach</p>	<p>Several service components are identified as constituting an Integrated System. A system with all of the following would be considered fully integrated. Mental health and substance use disorders treatment are evaluated and addressed by the same team, at the same location and the same time. However, the emphasis is not on co-location, but rather the organization of and availability of services to clients</p>

	<p>(both organizational and clinical integration).</p> <ul style="list-style-type: none"> • Multidisciplinary teams • Integrated treatment specialists • Stage wise interventions • Access to comprehensive services • Time-unlimited services • Outreach • Motivational interventions • Substance abuse counseling • Group treatment for co-occurring disorders • Family interventions for co-occurring disorders • Alcohol & drug self-help groups • Pharmacological treatment • Interventions to promote health • Secondary interventions for non-responders
Financial considerations	<p>Developers recognize that financing has to correspond to integrated services and integration will be achieved only if it has funding.</p> <p>Reimbursement has to be realistic and will probably come from a combination of state MH/SA dollars, SAMHSA block grants, Medicaid and other insurance.</p> <p>Anticipated start-up costs: Training: training all staff, integrated treatment specialist, etc Consultation: For 1 to 2 years</p>
Management issues	<p>A broad range of management activities are required to create an integrated system. Tasks specifically discussed include:</p> <ul style="list-style-type: none"> • Developing staff and community support for the program • Selecting appropriate program leaders • Hiring and/or training integration specialist • Developing effective policies and procedures for; <ul style="list-style-type: none"> ○ Screening, assessment, discharge, treatment plans that are integrated ○ Staffing criteria ○ Communication among staff ○ Core service components ○ Documentation of client records • Monitoring program continuously for fidelity to the model • Monitoring staff performance • Reviewing program budget and figuring out how to finance integrated services
Cultural competency	<p>Cultural competency is broadly defined and includes race/ethnicity, gender, sexual</p>

	<p>orientation, urban/rural residence, disability</p> <p>Staff should reflect the cultural diversity of the communities in which they operate.</p> <p>More important, integrated treatment specialists must be aware of and sensitive to cultural differences and consumer preferences.</p> <p>Integrated Treatment programs should include bilingual integrated treatment specialists as needed to reflect the cultural diversity of the communities in which they provide services. If bilingual staff is not available, translators should be provided as needed.</p> <p>Staff should be capable of working with both sexes, people of different backgrounds such as disability status, sexual orientation, etc.</p> <p>EBP should be tailored to the cultural groups that make up the consumer base.</p>
Outcomes	<p>Integrated treatment of COD is associated with positive outcomes:</p> <ul style="list-style-type: none"><i>Reduced substance use</i><i>Improved psychiatric functioning and symptoms</i><i>Decreased hospitalization</i><i>Increased housing stability</i><i>Reduced arrests</i><i>Improved quality of life</i> <p>The approach as consumer-driven appears open to and malleable for cultural considerations; empirical studies remain limited.</p>
Implementation barriers/problems	<p>Implementation barriers/problems:</p> <ul style="list-style-type: none">• Inflexibility of funding streams & billing—i.e., Medi-Cal• Developing consensus among key stakeholders• Federal and local regulations and policy• Failure to implement all core components due to insufficient incentives• Adequate training across the system to meet client needs

Implementation of EBT model - Examples

We were unable to locate examples of EBT implementation as a stand-alone system. However, we were able to find systems that were attempting integration or exploring integration of SUD/MH and the use of EBT's. In Washington State, integrated treatment was found to produce significant cost savings over standard treatment (Aos et. al., 2006). EBP treatment of these disorders produce about \$3.77 in benefits for each dollar invested in treatment. This is equivalent to a 56 percent rate of return on investment. From a narrower taxpayer's-only perspective, the ratio is roughly \$2.05 in benefits per dollar of cost. The potential for savings across the system is significant. It is estimated that a reasonably aggressive implementation policy could generate \$1.5 billion in net benefits for people in Washington (\$416 million are net taxpayer benefits).

Narrative- Integrated Treatment for Co-Occurring Disorders

Overview: SAMHSA’s EBT Kit for Integrated Treatment for Co-Occurring Disorders (henceforth EBT Kit) offers a framework for organizing services for clients with co-occurring disorders within an integrated behavioral health system. This model of integration also requires a set of core services that represent the recovery-oriented philosophy that undergirds this integrated treatment approach. Integrated treatment differs from traditional treatment in some important ways.

- Services are organized to provide integrated treatment from a client’s first contact with the system i.e. common assessment instrument and continuing through the entire episode.
- Services are organized so that clients’ substance abuse and mental health issues are treated simultaneously and seamlessly by counselors trained in integrated treatment, who work with interdisciplinary teams to provide appropriate treatment.

As consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team, they receive one consistent message about treatment and recovery. Treatment is informed by seven practice principles that guide clinical decision-making in an integrated system (see below under treatment approach). Staff training, effective and appropriate policies and procedures, and monitoring staff and program performance are required to ensure that practice principles are consistently applied in treatment. Finally, integration requires management expertise in the form of a program leader to administer an integrated system and adequate funding to support the range of services that make up an integrated system.

Access & referral: The developers strongly recommend the “no wrong door” approach to treatment entry and integrated assessment of clients’ treatment needs. Although the Comprehensive Integrated Diagnostic Interview is recommended, it is not mandatory as long as the alternative meets the criteria for integrated assessment.

Treatment approach: Treatment for co-occurring disorders is guided by seven practice principles:

- Mental health and substance abuse treatment are integrated to meet the needs of people with COD. COD should be treated by an integration treatment specialist (ITS) in conjunction with a treatment team.
- ITSs are trained to treat both substance use disorders and serious mental illness. ITS is trained in psychopathology, assessment, and treatment strategies for both mental illness and substance use disorders. In addition, mental health practitioners should be cross-trained to understand the substances of abuse, their effects on person with COD and the long term and short term effects of substance abuse.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages. Integrated treatment recognizes that clients with COD go through stages of treatment and the stage could differ for mental illness and substance abuse. (The four stages of treatment are engagement, persuasion, active treatment and relapse prevention).
- Motivational interventions are used to treat consumers in all stages but especially in the persuasion stage. Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment.

- Substance abuse counseling, using a **cognitive behavioral approach**, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help and family. Clients benefit when multiple formats are available for different phases of treatment.
- Medication services are integrated and coordinated with psychosocial services. Medical staff that prescribes medications should be trained to treat COD. They should participate in teams and work closely with the ITS.

Integration approach: A recovery oriented philosophy governs the organization of services in an integrated treatment system. A recovery oriented philosophy departs from the standard biomedical model that emphasizes abstinence, reducing symptoms and preventing relapse. Recovery means that people with COD will have a life in the community, and not simply maintaining abstinence or compliance with mental health treatment. The principle service components of this integrated treatment of COD require the following:

- *Multidisciplinary teams* composed of psychiatrists, nurses, residential staff, case managers, employment specialists and rehabilitation specialists who work on mental health teams.
- *Integrated treatment specialists* works with mental health teams and models COD treatment skills and trains other staff in evidence-based practices and skills.
- *Stage wise interventions* means that services are tailored to a consumer's stage of treatment (engagement, persuasion, active treatment and relapse prevention).
- *Access to comprehensive services* in the community such as transportation, housing, employment, etc. The goal is to meet a range of needs such as the capacity for independent living, employment, managing anxiety and quality of relationships with friends and family. Minimally services should include residential services & supportive housing, supported employment, family interventions, illness management and recovery (IMR) and Assertive Community Treatment (ACT).
- *Time-unlimited services* are offered and the intensity of services is tailored to the consumer's needs.
- *Outreach services* are used to connect consumers to services they need and keep them engaged in the treatment program.
- *Motivational interventions* (motivational interviewing, motivational counseling, and motivational treatment) govern all interactions with consumers.
- *Substance abuse counseling* is offered to consumers in active treatment or relapse prevention.
- *Group treatment for co-occurring disorders* is specifically designed to address both mental health and substance abuse.
- *Family interventions for co-occurring disorders* involve educating family members and others about COD, providing coping skills training and stress reduction strategies.
- *Alcohol & drug self-help groups* are used for consumers in active treatment or relapse prevention stage of treatment.
- *Pharmacological treatment* is provided by medical staff who are trained in EBPs, COD and use the 5 specific strategies: prescribe psychiatric medications for substance abuse clients, work closely with clients and the treatment team, focus on adherence to psychiatric medication

- *Interventions to promote health* are designed to (a) reduce high-risk behaviors and situations that can lead to infectious diseases, (b) improve diet and promote exercise and (c) find safe housing.
- Secondary interventions for non-responders to basic COD treatment should be provided based on an evaluation of the situation.

Financial considerations: The question of financing of integrated services is directly addressed in the discussion. The developers recognize that funding is required to implement an integrated system and that lack of reimbursement can derail integration. The developers propose that policy makers consider a mix of funds to finance integrated treatment: state mental health and substance use dollars, SAMHSA block grants, Medicaid and other insurance.

Management issues: Management issues are also directly addressed in the discussion. The developers view the organizational structure as the critical element in implementing an integrated treatment system and offer concrete guidelines for key management tasks. The key management/administration tasks are:

- *Developing staff and community support for the program:* The authors propose that an advisory group be convened to build support for the program, increase program visibility and provide advice about ongoing planning efforts. It is preferable that the advisory group consist of state agency members (staff from mental health, substance abuse, Medicaid), leaders from partner agencies and representatives from consumers and their families.
- *Selecting appropriate program leaders:* A program leader is a mid level manager with both clinical and administrative expertise. A program leader will oversee administrative tasks such as hiring staff, developing programs and policies, monitoring fidelity to the model, providing feedback to state holders and oversee quality control and financial flows. Clinical tasks include providing COD services, weekly group and individual supervision.
- *Hiring and/or training integration specialist* capable of providing COD treatment, participating in team meetings and training other program staff.
- *Training staff in integrated treatment:* Staff generally needs ongoing training in EBT protocols because there is confusion about the key components of the model. A range of staff need to be trained in EBT by outside trainers or by the ITS.
- *Developing effective policies and procedures* is a key management task. Policies and procedures must ensure that program standards are maintained and conform to the EBPs selected. Policies and procedures must be developed for:
 - *Adhering to the recovery oriented philosophy* of integrated treatment
 - *Screening, assessment, discharge, treatment plans* that are integrated
 - *Staffing criteria* such as the number of ITS as the recommendation is to have one ITS per team.
 - *Communication among staff* but mainly how the ITS should communicate with the multidisciplinary treatment team that communicates frequently and meets weekly.
 - *Core service components* (stage wise interventions, access to comprehensive services, outreach for consumer engagement, group treatment, interventions to promote health and protocol for nonresponders).
 - *Documentation of client records* – the recommendation is that records should be compliant with a national standard such as the Joint Commission or CMS (Centers for Medicaid and Medicare Services).
- *Monitoring the program* continuously for fidelity to the model: Monitoring and evaluation are considered vital functions in an integrated system. The developers provide extensive guidance

- on establishing the baseline measures, fidelity measurements, process measurements and outcome measurements for integrated treatment. An entire volume is devoted solely to this function.
- *Monitoring staff performance* is also viewed as a key component of successful program implementation. Regular clinical supervision is the primary method for monitoring staff performance, particular with the ITS. The ITS function is difficult to understand and requires extensive training and modeling to master.
 - *Reviewing program budget* and figuring out how to finance integrated services.

Cultural Competency: Cultural competence is defined as an approach to treatment that assumes that services are more effective when provided with the most culturally meaningful, gender sensitive and age appropriate context. Cultural competence is a set of guiding principles that increase the ability of systems to meet the needs of diverse communities, including racial and ethnic minorities. EBPs should be modified to provide meaningful treatment. Some examples of culturally competent services include:

- Understanding the racial/ethnic/cultural demographics of the client population
- Having a cultural competency advisory committee
- Translating forms and brochures
- Training staff in culturally responsive communication or interviewing skills
- Offering to match with a practitioner with a similar background
- Incorporating cultural awareness into assessment and treatment
- Awareness of different beliefs about causes and treatment of illness

Outcomes: Outcomes are based on integrated treatment of co-occurring disorders using specific evidence-based interventions such as Assertive Community Treatment (ACT). Assertive Community Treatment which involves integrated treatment for severely mentally ill persons is the most researched type of integrated treatment. Most of the evidence for integrated treatment comes from research from Drake et al, which shows that clients who receive integrated treatment exhibit *reduced substance use, improved psychiatric functioning and symptoms, decreased hospitalization and arrests and increased housing stability and quality of life*. Small studies of integrated treatment have shown positive outcomes for persons with co-occurring substance use disorders, and SMI and bi-polar disorder.

Implementation barriers/challenges: The challenges in implementing an integrated system stem primarily from management and financial issues involved in rolling-out a complicated and new protocol. Funding integrated programs is challenging if state or federal reimbursement rules do not recognize the service structure of integrated treatment. Further, there are costs associated with training staff and hiring consultants to assist with design of specific features of the treatment program. Additional costs will be incurred for outreach and secondary interventions for nonresponders.

For managers responsible for implementing changes, challenges will stem from the inability to implement all components of the model, establishing basic program standards, ensuring an adequate level of training for staff, training the Integrated Treatment Specialist, and hiring program leaders.

RECOMMENDATIONS FOR INTEGRATED BEHAVIORAL HEALTH SYSTEM
Consensus statement

The Integration Models Workgroup recommends that the Steering Committee consider adopting a hybrid model of integration based on elements of both **CCISC (Comprehensive Continuous Integrated System of Care) and the EBT (Evidence Based Treatment) Kit**. After extensive review and discussion, the Integration Models Workgroup concludes that no single model has the scope to cover the range of issues that an integrated behavioral health department will face in Santa Clara County. Given this situation, the most efficient approach would be to combine components from both models in a manner that best fits the conditions in Santa Clara County. A hybrid approach also offers other workgroups ample latitude to design programs that are tailored to the needs of different groups of clients.

There are **two important reasons** for recommending a hybrid or blended approach. Firstly, both models focus on the co-occurring population, more so in the case of the EBT than CCISC. Both models explicitly or implicitly recognize the spectrum of disorders and co-occurring disorders routinely seen in mental health and substance abuse treatment systems, and discuss methods for providing integrated treatment to those who need it. Secondly, both models focus on clinical integration, more so in the case of CCISC than EBT, and less on the administrative and financial issues involved in integrating systems. However, the EBT manual provides more specific guidance in a manualized way to programs that are contemplating integrating mental health and substance abuse treatment services.

The hybrid or blended approach is also recommended because of the overlap in proposed solutions in each of the major areas shown in the summary matrices: Access & referral, treatment approach, integration approach, financial considerations, management issues, cultural competency, outcomes and implementation barriers/challenges. (see the Matrix Summary) Both models have several points of similarity and different strengths and weaknesses. The matrix summarizes these broad differences.

Workgroup observations - CCISC & EBT Kit

	CCISC & EBT Kit Compared	Workgroup comments
<i>Access/referral/assessment</i>	Both recommend no wrong door and integrated assessment EBT recommends the CIDI as the integrated assessment tool	Both models recommend similar approaches to welcoming clients into the system. Although EBT recommends CIDI, any integrated assessment form can be used provided it functions as intended. Similar organizational impact under each model
<i>Treatment approach</i>	Both models require staff to be cross-trained in both disciplines. The EBT model calls for new job category called the Integrated Treatment Specialist (ITS), which has specifically defined responsibilities in the integrated system. The EBT also calls for a program leader to lead teams. This position requires a combination of clinical and	Both models recommend cross-training counseling and other staff to develop co-occurring competency. If the EBT model was selected for the treatment approach, it would require restructuring treatment into treatment teams each with its own ITS and program leader. EBT also specifically identifies CBT as the preferred treatment model. If CCISC is selected, each program would need to

	<p>administrative skills. CCISC requires all staff to be trained in co-occurring disorder core competencies.</p>	<p>identify a change agent to represent clinicians and consumers.</p>
<p><i>Integration approach</i></p>	<p>The overall integration philosophy (as the basis for organizing services) is similar i.e recovery-orientation. CCISC is organized around the 4 quadrant model which represents combinations of high and low levels of mental illness and substance abuse disorders. EBT model is more specific about linking core services to the treatment philosophy.</p>	<p>EBT identifies the core service components required for an integrated treatment system (see above matrix). CCISC does not specifically identify core service components. CCISC is designed to be implemented in an existing system of care, and strategies serve to change services within the existing structure.</p>
<p><i>Financial considerations</i></p>	<p>Both models consider braided funding as the key factor in implementing an integrated system.</p>	<p>Both models pose similar funding problems as both propose integrated services. CCISC developers state that implementing this model does not require blended funding (although it may be desirable to have braided funding for integrated services).</p>
<p><i>Management issues</i></p>	<p>CCISC is focused on clinical integration and the discussion does not cover management issues. EBT discusses a number of management issues involved in implementation.</p>	<p>Both models will require managing the implementation. EBT provides more guidance to program managers.</p>
<p><i>Cultural competency</i></p>	<p>The EBT Kit addresses cultural issues and concerns whereas the CCISC model does not.</p>	<p>Santa Clara County will need to monitor all aspects of service delivery to ensure that they are culturally relevant for each population.</p>
<p><i>Outcomes</i></p>	<p>Similar outcomes for integrated treatment.</p>	<p>Outcomes depend on implementation. Both CCISC and EBT Kit have provisions for baseline measurement, monitoring and evaluation of outcomes. The EBT Kit contains public domain measures that can be used for monitoring and program evaluation.</p>
<p><i>Implementation barriers/challenges</i></p>	<p>CCISC has a 12 Step model implementation framework that represents all stages of implementation. EBT also provides guidance for a staged implementation of integrated treatment.</p>	<p>Integration plans are similar. CCISC has been implemented in a number of jurisdictions (states and counties), funded by COSIG (Co-Occurring State Incentive Grants) dollars from SAMHSA. The EBT Kit does not appear to have been implemented as a stand-alone model. We were not able to find examples of EBT except in Washington State.</p>

The Integration Workgroup would like to point out that four of the key components of Integrated Treatment model are already in place (in some form) in either the Mental Health Department or Department of Alcohol & Drug Services in Santa Clara County.

- A consumer-driven approach, where individual needs are met with appropriate levels of care and intervention
- Comprehensive care plan
- Assertive outreach to community linkages for all services, which may not necessarily be located under one roof
- Whole continuum of services which includes a continuum of care strategies and inter-disciplinary teams

In order to create an integrated system, several additional components would need to be added to the existing system. Individual workgroups focused on specific system issues and populations are the better suited to identifying solutions to problems specific to their domains. However, some service components have system-wide implications and we identify a few of these below:

- Streamlined screening, assessment and referral process which is consumer friendly and easily navigated
- All staff will be trained in core COD competencies and each program will have a(n) Integrated Specialist(s) who is trained in mental health and chemical dependency dual diagnosis expertise.
- Services at same location at entry point, and optional co-location at other points along the continuum of care
- Centralized care coordination