



**NCADD**

National Council on Alcoholism and Drug Dependence, Inc.  
Sacramento Region Affiliate

*Sacramento*

## Co-Occurring Disorder Treatment Services

In order to provide welcoming, accessible, integrated, continuous, and comprehensive services to individuals with co-occurring substance and psychiatric disorders, the National Council on Alcoholism and Drug Dependence, (NCADD) Sacramento Region Affiliate has adopted the **Comprehensive, Continuous, Integrated System of Care (CCISC)** model for designing systems change to improve outcomes within the context of existing agency resources. This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000) which espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system:

1. Co-occurring Disorders are an expectation, not an exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
2. The core of treatment success in any setting is the availability of empathic, hopeful treatment relationships that provide integrated treatment and coordination of care during each episode of care, and, for the most complex consumers, provide continuity of care across multiple treatment episodes.
3. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.
4. Within the context of any treatment relationship, case management and care, based on the individual's impairment or disability, must be balanced with empathic detachment/confrontation, and opportunity for contingent learning, based on the individual's goals and strengths, and availability of appropriate contingencies. A comprehensive system of care will have a range of programs that provide this balance in different ways.
5. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is required. Both disease processes should be understood as exacerbating the symptom profile of the other, including the course and vulnerability to rapid deterioration.
6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement, and motivational enhancement, prolonged stabilization and

relapse prevention, rehabilitation and growth) and stages of change. Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change. Appropriately matched interventions may occur at almost any level of care.

7. Consequently, there is no one correct co-occurring disorder program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are co-occurring disorder programs that at least meet minimum criteria of co-occurring disorder capability, but each program has a different "job", that is matched, using the above model, to a specific cohort of consumers.
8. Similarly, outcomes must be also individualized, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

Using these principles, The NCADD Sacramento has agreed to implement the CCISC Model with the following four core characteristics:

1. The CCISC requires participation from all components of the behavioral health system, with expectation of achieving, at minimum, Co-occurring Disorder Capability standards (and in some instances Co-occurring Disorder Enhanced capacity), and planning services to respond to the needs of an appropriately matched cohort of co-occurring disorder consumers.
2. The CCISC will be implemented initially with no new funding, within the context of existing treatment operational resources, by maximizing the capacity to provide integrated treatment proactively within each single funding stream, contract, and service code.
3. The CCISC will incorporate utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with psychiatric and substance disorders, and promote integration of appropriately matched best practice treatments for individuals with co-occurring disorders.
4. The CCISC will incorporate an integrated treatment philosophy and common language using the eight principles listed above, and develops specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in

systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies.

**System Level Change:** The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.

**Efficient Use of Existing Resources:** The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to ICOPSD within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training.

**Incorporation of Best Practices:** The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.

**Integrated Treatment Philosophy:** The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers. This model can be used to develop a protocol for individualized treatment matching, that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

For more information on the CCISC model, visit <http://www.ziallogic.org/CCISC.htm>