An Opportunity:

Now is the time to promote and facilitate treatment for Co-Occurring Disorders

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An Equal Opportunity Destroyer.

The following are true stories of two different women who struggled with co-occurring substance use and mental health conditions. Although they came from different backgrounds, both experienced difficulty in getting the treatment they needed to address their substance use and mental health together. Both received treatment services – one from the private sector and one from the public sector. But regardless of background, financial resources, or education, neither person was able to recover from their substance use and mental health conditions until both issues were addressed.

She was a corporate leader who needed to perform at her best. She turned to Adderall to increase her focus and performance, but quickly became addicted. Soon, alcohol and other prescription drugs became part of her habit as well. She came from a wealthy family and had the resources to support her addiction and subsequent treatment, but even the best treatment facilities money could buy wouldn't discuss mental health if she was using any kind of substance. Over and over, she was diagnosed with mental health conditions without any type of assistance for her substance use disorder.

She was in and out of jail for prostitution and struggled with addiction to heroin. She had no access to resources, no family who could assist with treatment costs, and no understanding of the mental health safety net system. She fell between the cracks and her legal record proved that each of the systems she was involved with, failed her. It took the help of a peer to recognize it was not just substance use she was dealing it. Her trauma that led to her anxiety and depression was also the reason she used.

Stories like these are the reason why this work is so important. Because there are real people – real lives – that are depending on our success. As we work to create a more effective system of care for our community, may we remember that addiction is an equal opportunity destroyer, and our efforts have the power to impact countless lives.

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Acronyms

AMI - Any Mental Illness

CCISC - Comprehensive Continuous Integrated System of Care

COCE - Co-Occurring Center of Excellence

COD - Co-Occurring Disorders

DDCAT - Dual Diagnosis Capability in Addiction Treatment

IDD- Intellectual or Development Disability

MH - Mental Health

PHBHI - Primary Health and Behavioral Health Integration

SAMHSA- Substance Abuse and Mental Health Services Administration

SMI - Severe Mental Illness

SUD - Substance Use Disorder

Dear Community Partners,

On behalf of The Council on Recovery, we are pleased to present this white paper on co-occurring substance use, mental health, and physical health disorders. This paper walks you through the inaugural year of The Center for Co-Occurring Disorders, highlighting what we have learned, adjustments we have made, our impact, and our vision for the future.

As Houston's leading nonprofit provider of prevention, education, and outpatient treatment services for addiction and co-occurring mental health disorders, The Council on Recovery has helped thousands of people enter recovery and families heal. As a leader though, it is our obligation to do more than serve. We need to look to the future, embrace behavioral health innovations that are grounded in evidence, and inspire others in times of uncertainty.

Over the past year, The Council has led just such a charge, through the formation of The Center for Co-Occurring Disorders. The Center is a groundbreaking initiative designed to address co-occurring disorders concurrently. When we launched The Center, we knew there was an urgent need for these services; we also knew that if we wanted this effort to succeed – and to last – we had much more to learn.

Our history in the behavioral health field also told us that our efforts had to be disruptive. There have been far too many efforts to treat co-occurring disorders that have fallen short because those involved held on to the status quo; others could not conceive of how to reconfigure the frameworks they strived to build for decades, despite their imperfections; still others sought a one-size-fits-all solution; and others focused solely on direct services without modifying the systems in which they operate.

We knew The Center had to be different. Our first year was a time to envision, generate ideas, and explore existing service systems. Through this process, we recognized that the approach needs to be multi-dimensional and variable based on setting, diagnosis, environment, and a patient's goals. Moving forward we intend to incubate, test and adapt the best of these service and systemic models.

Today, we hope that this paper will inspire you to join this journey – that you and your organization realize the magnitude our collective efforts can have on the health and well-being of our community.

Sincerely,

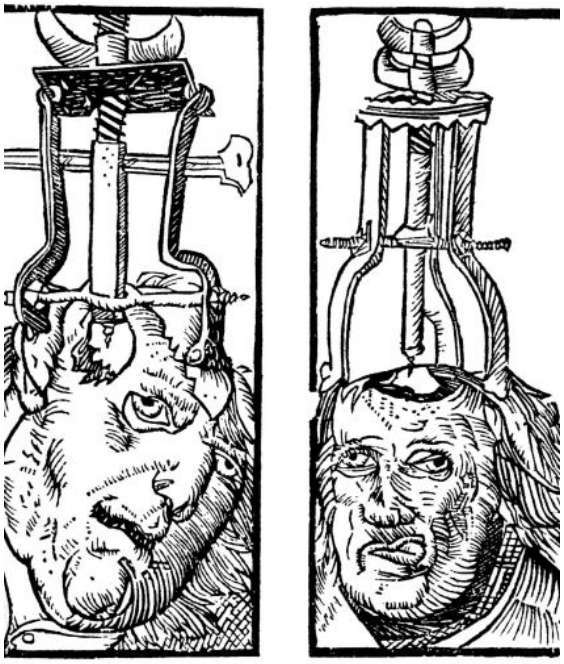
Mary H. Beck, LMSW, CAI
President & CEO

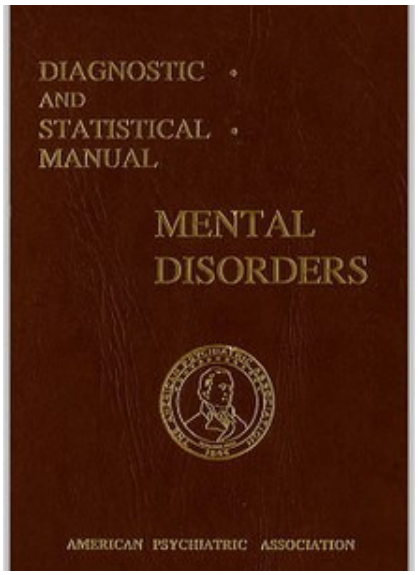
"It's time for state and local systems to begin to systematically implement what is known to routinely provide integrated MH/SUD services for the high risk, high volume, poor outcome populations with complex needs.

It is also time for federal, state, and local research funders, academic institutions, and other entities which routinely evaluate population health efforts to make the same level of investment in the study of systematic mental health and substance use disorder integration efforts as has already been done for Primary Health Behavior Health Integration." (1)

Part 1 – History of Mental Health, Substance Use and Co-Occurring Disorders

It has been recorded that in 6500 BC trephination, the drilling of holes in to the skull to presumably alleviate psychological disorders, occurred. In 1900 BC Mesopotamians would term the condition "wandering uterus" to describe a woman suffering form mental illness. Mental health has been referenced throughout all of history, however a standardization of the diagnosis system can only be traced back to 1883 when German psychiatrist Emil Krapelin developed a system of disorders that consisted of specific symptomatology. This advancement then led the way for the for first Diagnostic and Statistical Manual (DSM) in 1952. (2)

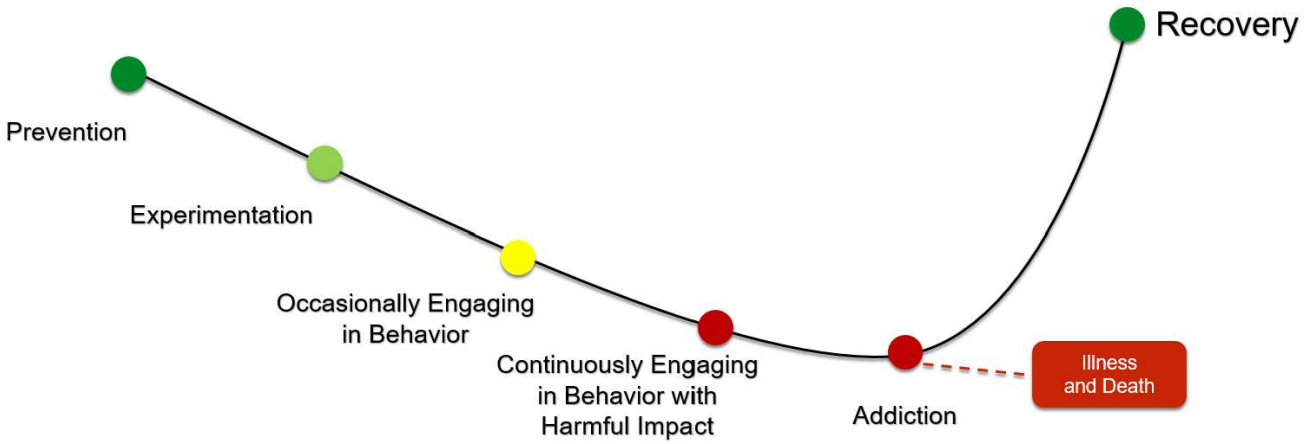




Currently on it's 7th revision the DSM - V is "The handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. The DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions," according to psychiatry.org (3)

Part 1 – History of Mental Health, Substance Use and Co-Occurring Disorders

Substance use, similar to mental health, has been around as long as recorded history. However, the standardization to classify it as a disease, came in the early 19th century. Like mental health, substance use nosology has had a rather complex history that has been influenced by religion, culture, industrialization and sociopolitical factors. In the first DSM (1952) substance use disorder was conceptualized as a symptom of a broader underlying disturbance, specifically arising from a primary personality disorder. However within seven years, alcoholism was recognized for its severity and declared to be a medical disorder. However, the milestone came in the DSM III (1980) when substance use disorders were acknowledged as a disease on a continuum. The Jellinek Curve developed by EM Jellinek in the 1950s concedes that there are several stages to the progressive and chronic disease ranging from prevention to addiction to recovery. (4) The Council on Recovery, acknowledges this continuum and proudly serves clients at each of these stages.



Part 1 – History of Mental Health, Substance Use and Co-Occurring Disorders

Selected Diagnostic Considerations Comparing DSM-5 to earlier versions related to Alcohol and Substance Use Disorder(s).

Category	DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV	DSM-5
Terminology	Alcoholism: Drug Addiction	Alcoholism: Drug Dependence	Substance Use Disorders; Substance Abuse, Substance Dependence	Psychoactive Substance Use Disorders; Substance Dependence, Substance Abuse	Substance-Related Disorders; Substance Use Disorders, Substance Dependence and Substance Abuse	Substance-Related and Addictive Disorders [a]
Categorization	Sociopathic Personality Disturbance	Personality Disorder and Certain other Non-psychotic Mental Disorders	Classified Independently	Classified Independently	Classified Independently	Classified Independently
Role of Personality Disorders (PD) in relation to SUD	Primary. Alcoholism and drug addiction considered a "reaction" (secondary diagnosis)	Primary. Although Alcoholism is secondary, additional/separate diagnosis encouraged	Personality disturbance is listed as "Associated features" which are often present, and may be intensified by the SUD [b]	Personality disturbance is listed as "Associated features" which are often present, and may be intensified by the SUD [c]	Antisocial and Borderline PD are listed as "associated mental disorders" which are often co-morbid with and can complicate SUDs	SUDs are commonly seen in individuals with antisocial PDs which are associated with poorer prognosis
Main Sub-categories	Not applicable [d]	Excessive drinking (Episodic, Habitual) Alcohol addiction	Substance Abuse, Dependence	Psychoactive Substance Abuse, Dependence	Substance Abuse, Dependence	Substance Use Disorders with Severity/Specifiers
Course Specifiers	Not specified	Not specified	Continuous [e], Episodic [f], In remission [g], Unspecified	Partial [h] and Full Remission [i]	Early Full Remission [j]; Early Partial Remission [k]; Sustained Full Remission [l]; Sustained Partial Remission [m]; On Agonist Therapy; In a Controlled Environment	Early remission [n]; Sustained remission [o]; On maintenance therapy; In a controlled environment
Severity Specifiers	Not specified	Not specified	Not specified	Mild, Moderate, Severe [p]	With, Without Physiological Dependence [q]	Mild, Moderate, Severe [r]
Duration	Not specified	Not specified	At least one month [s]	At least one month [t]	Within a 12-month period [t]	Within a 12-month period

Note: for the purposes of space and due to the similarity of DSM-IV and DSM-IV-TR, the latter was not included in this table. [a] "... the word [addiction] is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation" [22]. [b] "For example, antisocial personality traits may be accentuated by the need to obtain money to purchase illegal substances. Anxiety or depression associated with Borderline Personality Disorder may be intensified as the person uses a psychoactive substance in an unsuccessful attempt to treat his or her mood disturbance (Compton et al., 2005)" [12] (p. 171); [c] "For example, antisocial personality traits may be accentuated by the need to obtain money to purchase illegal substances. Anxiety or depression associated with Borderline Personality Disorder may be intensified as the person uses a psychoactive substance in an unsuccessful attempt to treat his or her mood disturbance (Compton et al., 2005)" [12] (p. 171); [d] Alcoholism and Drug addiction viewed as a likely manifestation of other underlying disorder(s) (e.g., PD); [e] "More or less regular maladaptive use for over six months" [1] (p. 168); [f] "A fairly circumscribed period of maladaptive use, with one or more similar periods in the past" [1] (p. 166); [g] "Previous maladaptive use, but not using substance at present. The differentiation of this from no longer ill use from the other course categories requires consideration of the period of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation or prophylactic treatment" [1] (p. 169); [h] "During the past six months, some use of the substance and some symptoms of dependence" [13] (p. 168); [i] During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence" [13] (p. 168); [j] No criteria for Abuse or Dependence met for at least one month but less than 12 months; [k] One or more criteria for Abuse or Dependence met for at least one month but less than 12 months (full criteria for Dependence not met); [l] No criteria for Abuse or Dependence met for 12 months or longer; [m] Full criteria for Dependence not met for 12 months or longer however one or more criteria for Abuse and Dependence have been met; [n] No criteria met for at least 3 months but less than 12 months (exception made for "craving" criterion); [o] No criteria met 12 months or longer (exception made for "craving" criterion); [p] Grouped under Criteria for Severity of Psychoactive Substance Dependence. In contrast to DSM-5, objective numerical count not provided; [q] Applies to Dependence only; [r] Mild: Presence of 2–3 symptoms, Moderate: Presence of 4–5 symptom, Severe: Presence of 6 or more symptoms; [s] Minimum duration. Specified for Abuse only: Abuse, Dependence.

This Table represents the changes within the DSM versions regarding Substance Use Disorders and highlights the complexity of this disease alone. What it doesn't highlight is how difficult it can be to establish causality or directionality when it comes to co-occurring disorders.

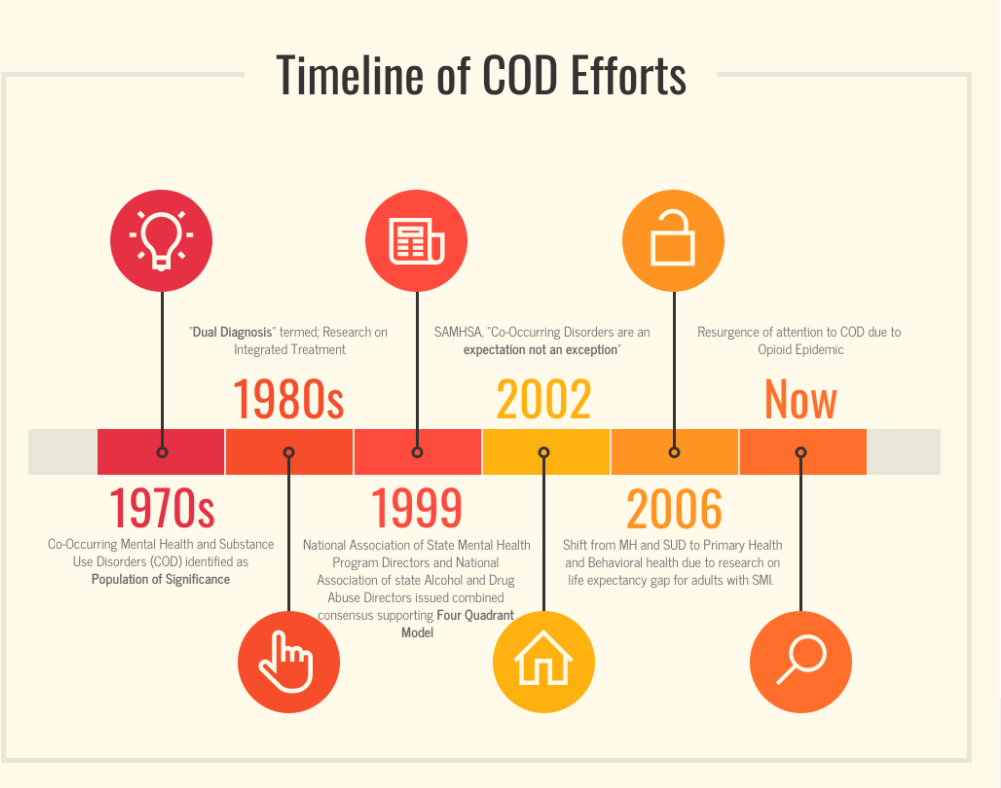
Co-occurring disorders is the coexistence of both a mental illness (changes in thinking, mood, and/or behavior) and a substance use disorder (when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home). There are plenty of terms that are related to co-occurring disorders (i.e. dual diagnosed0; however, for the purposes of this paper, we will use the term co-occurring disorders as it is aligned with person-centered terminology.

Part 1 – History of Mental Health, Substance Use and Co-Occurring Disorders

It is important to note that one does not need to meet criteria for a diagnosable mental health disorder to be considered having co-occurring disorders. One may be experiencing a mild to moderate mental illness and not reach the strict definition of mental diagnosis.

Not only does the combination of mental health and substance use disorders have a more negative impact on an individual by increasing their risk of suicide, poor health outcomes for physical co-morbidities and higher risk of incarceration, this additionally has an impact on health care systems and subsequently, the community at large. Potentially due to the complexity of each disorder, mental illness and substance use have been one of the leading causes of disability/death in the United States, however healthcare systems have only sporadically delivered treatment concurrently for these disorders (5).

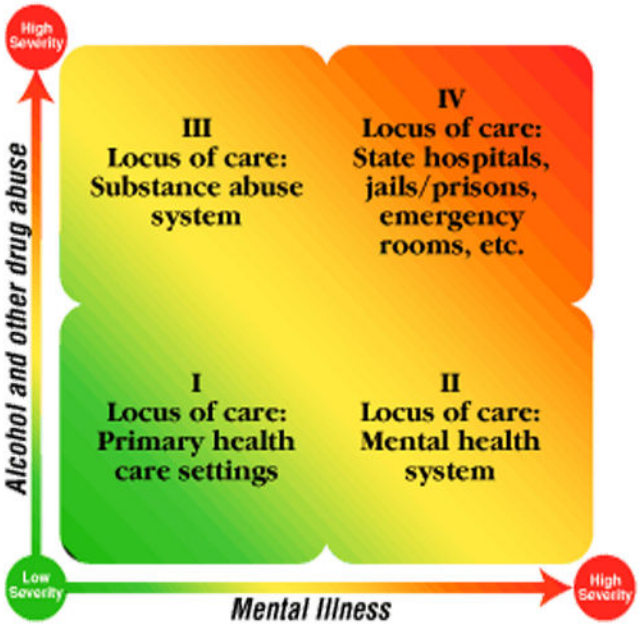
Throughout the last couple of decades, specific funding was provided to academic institutions to research COD best practices, including services, programs and systems to enhance their local/state infrastructure. More recently, federal funding has gone to addressing integration of mental health into primary care. (3)



Part 1 – History of Co-Occurring Disorders - Planning Frameworks

Three systems have emerged as frameworks to address COD, according to SAMHSA's Co-Occurring Center of Excellence (COCE). (6)

The Four Quadrant Model, (7) developed in 1999, divides populations by severity of alcohol or other drug use on the vertical axis and severity of mental illness on the horizontal axis. By utilizing this framework, systems of care can appropriately identify the best setting and level of care for an individual.



The Comprehensive Continuous Integrated System of Care model (CCISC) provides 4 characteristics, 8 principles for systems to follow and 12 steps of implementation to build a more comprehensive care system. Essentially, this framework acknowledges that humans are complex; however they should be at the center of their own treatment. (8)

Additionally, SAMSHA (Substance Abuse Mental Health Services Administration) - HRSA (Health Resources and Services Administration) has developed a 6-level integration framework to assist agencies who would like to become integrated, measure their level of integration.

Part 1 – History of Co-Occurring Disorders - Planning Frameworks

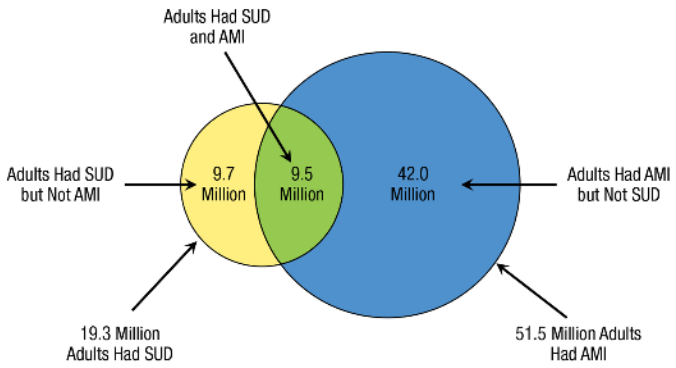
The goal of this framework is to create a common language to discuss integration, progress, and financing. Through assessments and benchmarking efforts, this framework is a more concrete way to explain to all stakeholders the differences in partnering organizations and more importantly where an agency stands and where they would like to go. (9)These frameworks are what have built the current efforts in COD, both nationally and locally.

SAMHSA-HRSA 6 Levels of Integration Framework

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Part 2 – Current Efforts - National Level

According to SAMHSA, results from the 2019 National Survey on Drug Use and Health: Key Findings Report, 9.5 million adults aged 18 and over had a SUD and AMI and 3.6 million had a SUD and SMI (10). Unfortunately, the percentage for young adults and adults with both AMI or SMI and an SUD increased over the last 5 years, while remaining stable for older adults.



61.2 Million Adults Had Either SUD or AMI

Although a study of 256 programs showed most were operating at either the Addiction Only or Mental Health Only service level, most providers suggest they address co-occurring disorders. This information aligns more closely with patient surveys asserting these programs are not likely to address both illnesses adequately (12). This indicates the need to continue efforts to develop and implement best practices for COD treatment.

Despite the numbers above, few programs can state they are functioning at a level that would be considered Dual Diagnosed Enhanced when completing the Dual Diagnosis Capability in Addiction Treatment (DDCAT). These programs have a higher level of integration of substance abuse and mental health treatment services and these programs are able to provide unified substance abuse and mental health treatment to clients. Enhanced-level services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content. (11)

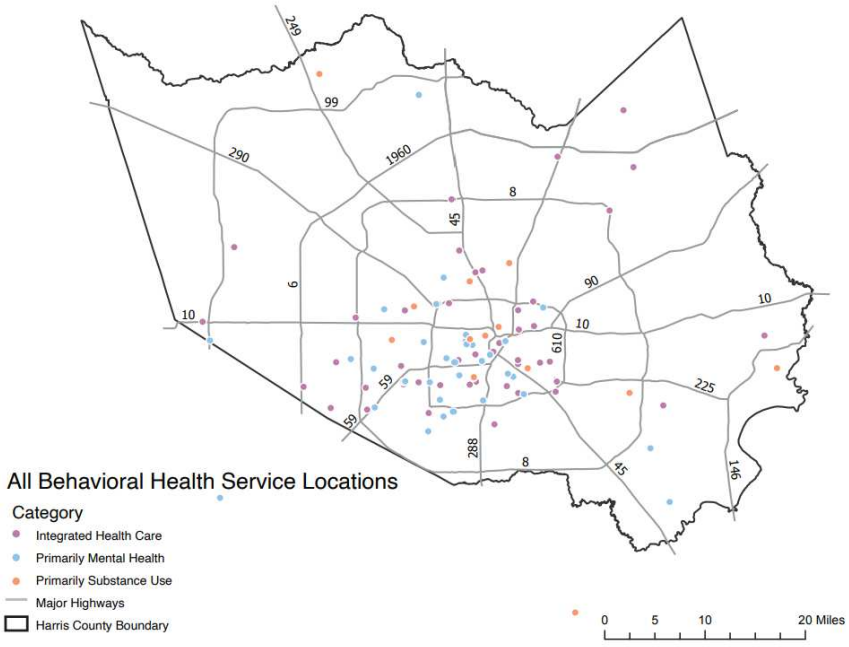
Part 2 – Current Efforts - National Level

Despite the lack of providers prepared to treat COD, there are some current efforts across the country and overseas to address these illnesses concurrently. Below is a list of programs, that at the time of publication were actively providing educational information or actual services for co-occurring disorders:

- Co-Occurring Collaborative Serving Maine, https://ccsme.org/ (13)
- the harris project, https://www.harrisproject.org (14)
- Cadres San Diego, https://www.cadresandiego.org/ (15)
- Here to Help https://www.heretohelp.bc.ca/ (16)

Part 2 – Current Efforts - Local Level

In a current study "Behavioral Health in Harris County: Who's Who and What They Do," (17), completed by the Working Partner and commissioned by 5 local philanthropic organizations, only 8 agencies out of the 40 that participated were considered to be integrated at any level. It is important to note that this integration may be as simple as connecting clients via referral to a substance use provider only, described as level two on the SAMHSA-Levels of Integrated Collaboration, Basic Collaboration from a Distance (18). The map below from the same report highlights how the majority of the participating agencies are still only providing mental health or substance use services across the county. Although there are several locations showing integration, it is uncertain at what level they are providing these services. This study was a response to the communities' conversations around the lack of access to and awareness of resources available for mental health services.



Part 2 – Current Efforts - Local Level

To delve deeper into local efforts being done in the field of co-occurring disorders, the Director of the Center for Co-Occurring Disorders at the Council on Recovery, conducted 8 qualitative interviews with local agencies, Federally Qualified Health Centers, and other net organizations.

Only two were providing a level of integration higher than three - Basic Collaboration based on SAMSHA - Levels Integrated Collaboration. Similar to the national data, it is most likely that treatment programs for mental health and substance use are stating they are integrated. In reality, they only meet the criteria for Co-Occurring Capable services which focus on either a substance use or mental health diagnosis and offer referrals to the other. The programs interviewed would address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning however did not have and program staff that were able to address the interaction between mental and substance related disorders or their effect on the patient's readiness to change . Relapse and recovery was also not often discussed a part of the client's journey. (19) These studies show what an important place the Center for Co-Occurring Disorders has in this time and space.

Part 3 – Our Commitment

The Council on Recovery is committed to being part of the solution in systemically addressing Co-Occurring Disorders. For this reason, The Council has established the Center for Co-Occurring Disorders (CCOD) which is focused on

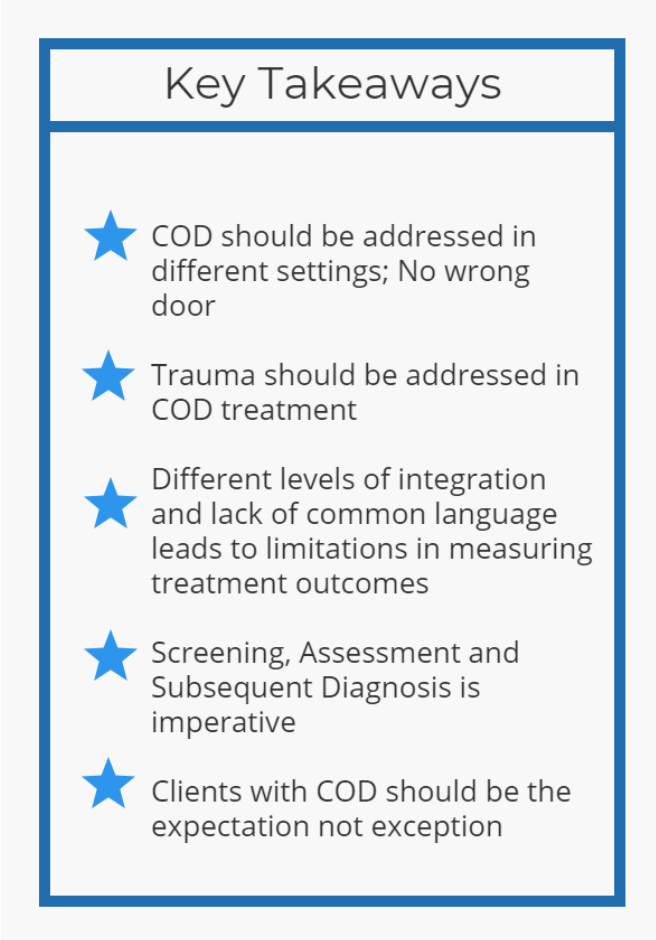
- Piloting and providing quality services for patients/clients presenting with mental health and substance use disorder symptoms
- Fostering strategic systemic change processes aimed at ensuring patients/clients receive access to seamless, coordinated and comprehensive services throughout the community
- Building a team of leaders committed to achieving and sustaining this vision
- Increasing knowledge and awareness among professionals and the community regarding the need for co-occurring disorder treatment, as well as best practices

In the first year of its existence the CCOD has achieved the following:

- An assessment of internal programs using the Dual Diagnosis Capability in Addiction Treatment (DDCAT). Strengths and opportunities were identified and program enhancement is forthcoming.
- The formation of an Advisory Board comprised of individuals from health, psychiatry, addiction, and IDD arenas across the non-profit, government and private sectors.
- The launch of an Educational Series to provide primary care medical providers with knowledge on COD and specialty topics, i.e. Adolescents, Pregnancy, Covid-19 and Suicide.

Conclusion

Our last year of research and planning has provided us with many victories and a better understanding of Co-Occurring Disorders. The history has taught us that there are frameworks on which we can base our program development. The review of national and local efforts exposed gaps within both systems of care, as well federal, state and local policies, especially in funding. Several key takeaways from our learnings are helping us develop next steps for systemic change in the COD arena. First, we have learned that working across disciplines is a must if we are going to improve the health of our community. All individuals regardless of what provider they see first should be assessed for MH and SUD. There should be no wrong door. Secondly, trauma is prevalent in those diagnosed with COD and providers should be trained to respond. Thirdly, partners working together must utilize the same language when treating the COD population, this includes primary health locations as well. Limitations in measuring treatment outcomes occurs because different disciplines come to the table with different lexicons, confusing not only direct care providers but patients as well. Fourth, if screening isn't done at every door, assessments are not utilized and diagnoses are overlooked or incorrectly given. Lastly, the statistics are glaring. Clients with COD should be the expectation not the exception and programs should be developed with that in mind.



About Council on Recovery

The mission of The Council on Recovery is to keep our community healthy, productive and safe by providing services and information to all who may be adversely affected by alcohol, drugs and related issues. Unlike any other organization of its kind, The Council works to accommodate each client's individual treatment needs, regardless of their financial circumstance. Services are provided across the spectrum of substance use and include prevention programming; behavioral healthcare for children affected by addiction in the household; intervention; counseling and referral; outpatient treatment; family therapy; and aftercare and recovery support to help rebuild lives. The Council goes beyond treating addiction alone, focusing on root causes, co-occurring behavioral health conditions, and extending care to the entire family. Importantly, The Council has made a commitment never to turn anyone away, regardless of financial circumstance. Affiliated with the United Way of Greater Houston, The Council receives funding from private contributions and grants, special events, and program fees.

You know someone who needs us.

NEED HELP? 855-942-4100
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