

Co-Occurring Mental Health & Substance Use Disorders

Topical Brief Series: Vol. 1, Issue 3

What are Co-Occurring Disorders?

Co-occurring disorders and dual diagnosis are two common terms for people suffering simultaneously from substance use and mental health disorders or illness. Co-occurring disorders are inextricably linked¹ and often involve multiple substance use and more than one mental disorder.^{2,3}

The negative impacts associated with co-occurring disorders include more severe health outcomes compared to either disorder alone,⁴ poor treatment outcomes,⁵ violence, incarceration, homelessness, serious infection,⁶ suicide,⁷ and effects on family functioning.^{8,9}

Because both mental illness and substance use disorders vary so widely in type and severity, so do the potential combinations. Additionally, substance use can lead to symptoms of mental illness or disorder, and conversely mental illness or disorder can lead to substance use.

Brad Sjostrom from West Pines Behavioral Health, a Colorado facility licensed for co-occurring disorders,

explained, “There are people who have a primary substance use disorder ... who develop psychiatric symptoms as a consequence (substance-induced psychosis, substance-induced depression). [Also] there are people who have a strong trauma history who have addictions as a sequela – It’s not valuable to put them all together conceptually. Although treatments are similar, [there are] still particularities.”

Co-occurring disorders also often operate bi-directionally, with one disorder magnifying the other.^{10,11}

The following sections provide an overview of the prevalence of co-occurring disorders in Colorado and the barriers to documenting and providing treatment for co-occurring disorders.

Substance Use and Mental Health in Colorado

Prevalence data at the state-level for co-occurring disorders are limited; however, looking at trends in poor mental health and heavy substance use (not diagnosed disorders) for Colorado adults and adolescents highlights areas for further attention.

“People living in Colorado affected by the combination of mental health and substance abuse problems face nearly overwhelming life challenges including finding specialty care matched to their needs and individual circumstances.”

- Jerry Evans, Ph.D.

Director of Research & Evaluation Community Health Initiatives

The Behavioral Risk Factor Surveillance System (BRFSS) is one of Colorado's primary data sources for understanding the prevalence of adult substance use. The Colorado BRFSS is a brief phone survey that provides representative, population-based results on health conditions and behaviors of Colorado adults, including core questions from the Centers for Disease Control and Prevention. The BRFSS survey collects data on past month use of alcohol, marijuana, and tobacco and limited data on mental health.

Alcohol and marijuana are among the most commonly used substances in Colorado. Binge drinking (4+ drinks for a female or 5+ drinks for a male on a single occasion), heavy drinking (8+ drinks for a female or 15+ drinks per week for a male in a week) and daily or near daily marijuana use (20+ days in a month) all have documented health and safety concerns. Binge drinking and heavy drinking have many serious risks, including injuries from accidents and violence, increased risks of overdose from

Figure 1. High school students who have experienced a major depressive episode in the past year are more likely to use alcohol, marijuana, and prescription drugs.



Data source: Healthy Kids Colorado Survey, CDPHE, 2017

combining with other substances, several types of cancer, and other chronic disease.¹² Daily or near daily use of marijuana is strongly associated with memory impairment, future psychotic symptoms, psychotic disorders (like schizophrenia), and withdrawal symptoms.¹³

In Colorado, adults who reported their mental health was not good on 14+ days of the past 30 were more likely to engage in heavy drinking, binge drinking, and/or daily or near daily marijuana use. In 2018, adults experiencing poor mental health had 70% higher rates of heavy drinking, 25% higher rates of binge drinking, and 25% higher rates of daily or near daily marijuana use.¹⁴

The Healthy Kids Colorado Survey (HKCS) asks students in Colorado if they have experienced a major depressive episode in the past year. In 2017, high

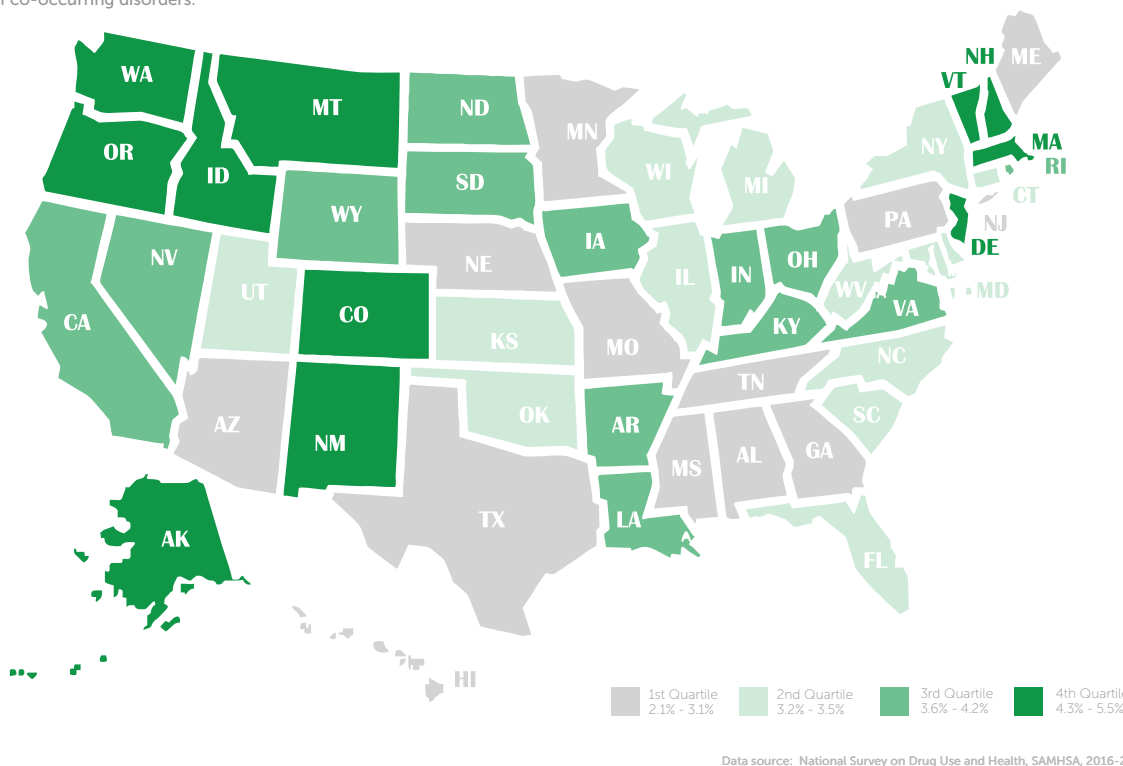
school students who experienced a major depressive episode in the past year were nearly two times more likely to report current use of marijuana or alcohol, including binge drinking or using marijuana 20+ times in the past 30 days. They were three times more likely to report current use of prescription drugs not given to them by a doctor (Figure 1).

Additionally, high school students who experienced a major depressive episode in the past year were more likely to have used multiple substances in their lifetime, compared to students who used only one or zero substances.¹⁵

Prevalence of Co-Occurring Disorders

The National Survey on Drug Use and Health (NSDUH) collects data at the national and state level that allow for estimates of co-occurring disorders. In 2018, 9.2 million adults in the U.S., amounting to 3.7% of the adult population, experienced co-occurring disorders, which represents an increase from 2016. Nationally, 18-25 year olds had the highest rates of co-occurring disorders (7.2% in 2018). In Colorado, 4.6% of adults reported co-occurring disorders according to a 2016-17 NSDUH analysis. The national average for this time period was 3.4% (Figure 3).¹⁶ Measurement

Figure 3. Colorado is in the top quartile nationally for prevalence of co-occurring disorders.

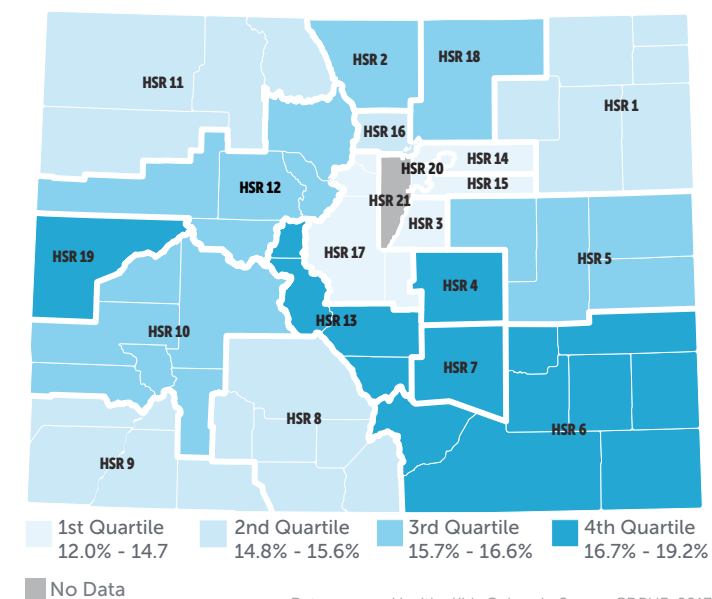


Data source: National Survey on Drug Use and Health, SAMHSA, 2016-2017

of mental health issues for adolescents ages 12-17 differs from adults. For adolescents the presence of a major depressive episode and a substance use disorder is used to estimate prevalence of co-occurring disorders. The prevalence in 2018 was 1.5% and more than twice as many females reported a co-occurring disorder (2.1% vs 0.9%).

Nationally, among adults with co-occurring disorders in 2018, 51.4% received either substance use or mental health treatment. Only 7.0% received treatment for both (Figure 4).¹⁷

Figure 2. Percent of high school students who reported major depressive episode and substance use by health statistic region (HSR).



Data source: Healthy Kids Colorado Survey, CDPHE, 2017

Treatment for Co-Occurring Disorders in Colorado

The data that Colorado gathers on people seeking treatment for mental illness or substance use disorders currently carries many limitations. The state tracking systems for mental health treatment and substance use treatment are separate and thus the prevalence of co-occurring disorders among individuals seeking treatment is difficult to estimate.

One additional way treatment data can be complicated is because diagnoses can change from intake to discharge. Sjostrom said, "[T]here has to be a good diagnosis and to make a

good diagnosis, one has to be off of the substance for at least a period of time Someone can be under the influence of alcohol and be very depressed, ... once they are not drinking alcohol, they may not have those feelings or symptoms as pronounced although an underlying depressive disorder may be identified at that time. Additionally, withdrawal syndrome can lead to depressive symptoms, which further complicates the diagnostic picture."

Licensing affects the type of data facilities collect and report. A provider from a substance use treatment facility stated, "For us, it's really a challenge because we have been licensed as a substance use disorder agency.... That means we have to focus directly on substance use for the primary diagnosis A lot of times [substance use] may be secondary [to a mental health disorder], but because that's the way we're licensed, that's the way we look at it."

Licensing also affects treatment facilities reimbursement rates. Facilities licensed for only substance use might pay higher salaries to staff with training in providing co-occurring treatment, yet receive a lower reimbursement because they only hold a substance use treatment license.

Colorado uses the Colorado Client Assessment Record (CCAR) to collect data on mental health treatment and the Drug/Alcohol Coordinated Data System (DACODS) for substance use treatment data. Current analysis of CCAR shows that 39% of intakes for mental health were also diagnosed

Data Definitions

Mental Health Not Good for Adults, BRFSS

Stress, depression, and problems with emotions in the past 30 days

Major Depressive Episode for Adolescents, HKCS

Feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities

Adult Co-occurring Disorders, NSDUH

Anyone 18+ with both illicit drug or alcohol abuse or dependence and any mental illness in the past year

Adolescent Co-occurring Disorders, NSDUH

Anyone 12-17 years old with both illicit drug or alcohol abuse or dependence and a major depressive episode in the past year

Any Mental Illness for Adults, NSDUH

Any mental, behavioral, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental disorders and SUDs)

Adolescent Major Depressive Episode, NSDUH

At least one period of 2 weeks or longer in the past year when they experienced a depressed mood or loss of interest or pleasure in daily activities, accompanied by problems with sleeping, eating, energy, concentration, or self-worth

Figure 4. National percent of adults receiving both substance use treatment and mental health services.

7%
of adults experiencing
co-occurring disorders
received treatment for both

Data source: NSDUH, 2018

with a substance use disorder. Those with co-occurring disorders had higher rates of legal convictions and incarcerations, more acute history of personal violence and negative life events, and higher rates of incomplete treatment.¹⁸ Within DACODS, 52% of intakes for substance use also had mental illness. Those with co-occurring disorders were more likely to use more dangerous substances (such as methamphetamine), use their primary substance with more frequency, have experienced trauma, and have higher rates of incomplete treatment.¹⁹ Colorado would benefit from developing an integrated mental health and substance use data system to improve the state's ability to monitor this issue and others.

Equity Considerations

When summarizing national or state data, it is easy to smooth over nuances. To recognize and address health disparities, we must analyze data in ways that uncover impacts on populations experiencing inequities. When disparities in outcomes are highlighted, providing additional context regarding root causes is necessary to allow the data to point towards solutions rather than further perpetuate stigma.

The data on co-occurring disorder shows clearly that nationally and in Colorado, people who identify as LGBTQ+ report higher rates of co-occurring disorders than heterosexual and cisgender people. Among lesbi-

an, gay, and bisexual people the rate of co-occurring disorders is 11.0% nationally, compared to 3.1% for straight people. In Colorado 3.9% of straight people report a co-occurring disorder, compared to 19.8% for lesbian, gay, and bisexual people.²⁰ Stigmas associated with mental health and substance use act as a dual stigma in addition to the stigma of gender identity and sexuality. As a community that faces extreme prejudice and other biases, they also experience higher rates of poor mental health, substance use, and suicide. Efforts to improve mental health and substance use outcomes for

"If we are talking about client care, we do that [co-occurring] care, but, as far as for us as an agency, that is a real obstacle because we are paying a much higher rate [for co-occurring treatment providers] than what we are getting reimbursed [as a substance only treatment facility]. ... It is very contradictory in what the proposed goals are [in the national treatment conversation], but yet the language in what is coming out ... as far as funding, et cetera, is still the same. It is mental health or it is substance use, and that really is not the goal."

-Colorado Substance Use
Disorder Treatment Provider

people who identify as LGBTQ+ focus on increasing provider competency and supportive practices among providers for LGBTQ+ needs.²¹

Conclusion

While awareness and motivation to improve outcomes for this population have been steadily raised for decades, barriers remain that limit data, treatment, and implementation of evidence-based strategies at a systems level.^{22, 23} Barriers include facility licensing, treatment reimbursement rates, data collection requirements, and focus on individual treatment rather than public health approaches.²⁴⁻²⁶

For more
information
including references,
please visit our website
www.coloradoseow.org

Co-Occurring Mental Health and Substance Use Disorders

Topical Brief Series: Vol. 1, Issue 3

References

1. Morisano, D., Babor, T. F., & Robaina, K. A. (2014). Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. *Nordic Studies on Alcohol and Drugs*, 31(1), 5-25. doi:10.2478/nsad-2014-0002
2. Kavanagh, D. J., & Connolly, J. M. (2009). Interventions for co-occurring addictive and other mental disorders (AMDs). *Addictive Behaviors*, 34(10), 838-845. doi:10.1016/j.addbeh.2009.03.005
3. Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., . . . Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469-476. doi:10.1176/appi.ps.52.4.469
4. Morisano, D., Babor, T. F., & Robaina, K. A. (2014). Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. *Nordic Studies on Alcohol and Drugs*, 31(1), 5-25. doi:10.2478/nsad-2014-0002
5. Ibid.
6. Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., and Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469-476. doi:10.1176/appi.ps.52.4.469
7. Brown, E. S. (2017). Introduction to dual diagnosis special issue. *The American Journal of Drug and Alcohol Abuse: Dual Diagnosis Special Issue*, 43(4), 365-365. doi:10.1080/00952990.2017.1330459
8. Brady, K. T., Haynes, L. F., Hartwell, K. J., & Killeen, T. K. (2013). Substance use disorders and anxiety: A treatment challenge for social workers. *Social Work in Public Health*, 28(3-4), 407-423. doi:10.1080/19371918.2013.774675
9. Burdzovic Andreas, Jasmina, et al. "Co-Occurrence between Mental Distress and Poly-Drug Use: A Ten Year Prospective Study of Patients from Substance Abuse Treatment." *Addictive Behaviors*, vol. 48, Elsevier BV, Sept. 2015, pp. 71-78. Crossref, doi:10.1016/j.addbeh.2015.05.001.
10. Brady, K. T., Haynes, L. F., Hartwell, K. J., & Killeen, T. K. (2013). Substance use disorders and anxiety: A treatment challenge for social workers. *Social Work in Public Health*, 28(3-4), 407-423. doi:10.1080/19371918.2013.774675
11. Burdzovic Andreas, Jasmina, et al. "Co-Occurrence between Mental Distress and Poly-Drug Use: A Ten Year Prospective Study of Patients from Substance Abuse Treatment." *Addictive Behaviors*, vol. 48, Elsevier BV, Sept. 2015, pp. 71-78. Crossref, doi:10.1016/j.addbeh.2015.05.001.
12. Centers for Disease Control and Prevention (2018). Fact Sheets – Binge Drinking. Retrieved from <https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm> on 7/9/2020
13. Colorado Department of Public Health and Environment (2018). Monitoring Health Concerns Related to Marijuana in Colorado: 2018. Retrieved from <https://www.colorado.gov/pacific/marijuanahealthinfo/summary> on 7/9/2020.
14. 2018 Behavioral Risk Factors Surveillance System, Colorado Department of Public Health and Environment.
15. 2017 Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment.
16. Substance Abuse and Mental Health Data Archive (2020). 2016-2017 National Survey on Drug Use and Health: Restricted Use Data Analysis System. Accessed on 7/1/2020.
17. Center for Behavioral Health Statistics and Quality (2019). 2018 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.
18. 2016-2018 Colorado Client Assessment Record, Office of Behavioral Health, Colorado Department of Human Services.
19. 2014-2018 Drug and Alcohol Coordinated Data System, Office of Behavioral Health, Colorado Department of Human Services.
20. Substance Abuse and Mental Health Data Archive (2020). 2016-2017 National Survey on Drug Use and Health: Restricted Use Data Analysis System. Accessed on 7/1/2020.

21. Envision: You. Colorado LGBTQ+ Mental Health and Substance Use Disorder Executive Summary retrieved from https://d6565fd5-33c8-4d4b-b916-b56a5d1127ef.filesusr.com/ugd/90d95d_4dc09c7ede99478ab47eba6fd71cd3e4.pdf on 7/1/2020.
22. Drake, R. E., & Wallach, M. A. (2000). Dual diagnosis: 15 years of progress. *Psychiatric Services*, 51(9), 1126-1129. doi:10.1176/appi.ps.51.9.1126
23. McGovern, M. P., Lambert-Harris, C., Gotham, H. J., and Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(2), 205-214. doi:10.1007/s10488-012-0449-1
24. Brown, E. S. (2017). Introduction to dual diagnosis special issue. *The American Journal of Drug and Alcohol Abuse: Dual Diagnosis Special Issue*, 43(4), 365-365. doi:10.1080/00952990.2017.1330459
25. McGovern, M. P., Lambert-Harris, C., Gotham, H. J., and Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(2), 205-214. doi:10.1007/s10488-012-0449-1
26. Morisano, D., Babor, T. F., & Robaina, K. A. (2014). Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. *Nordic Studies on Alcohol and Drugs*, 31(1), 5-25. doi:10.2478/nsad-2014-0002