

Substance Use & Co-Occurring Psychiatric Disorders In The US

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Introduction

The contribution of substance abuse disorders (SUD) to mortality and morbidity has increased substantially not only in the United States but worldwide. In 2014, drug overdose caused more than 47,000 deaths, and it has remained a leading cause of mortality in the US. An estimated one out of every ten US adults develop SUD, which involves the abuse of cocaine, cannabis, heroin, opioids, hallucinogens, tranquilizers or sedatives, and stimulants, among others (Grant et al., 2016). The occurrence of SUD is overrepresented in individuals with psychiatric disorders. In the early 90s, the World Health Organization (WHO) introduced the term dual diagnosis to refer to the coincidence of mental disorders and SUDs. In recent years, the term [co-occurring disorder](#) has been used to refer to this condition.

As published in the “Journal of the American Medical Association”, research has established that approximately 50% of the severe cases of psychiatric disorders are also substance abusers, and 53% of all individuals with SUD are also diagnosed with at least one grave mental ailment (NAMI, 2012). Additionally, amongst all mentally ill individuals, 29% are either alcoholics or drug abusers (Mohamed et al., 2020). A majority of the population with a higher prevalence of SUD constitutes individuals with depression, bipolar disorder, and anxiety disorders. These include the patients diagnosed with generalized anxiety disorder, post-traumatic stress disorder, and panic disorder. Moreover, attention-deficit hyperactivity syndrome, antisocial personality disorder, and borderline personality disorder are also commonly diagnosed in individuals with substance abuse disorder. Alcoholics and tobacco abusers have a generally higher prevalence of schizophrenia diagnoses (Kelly & Daley, 2013). Deaths resulting from drug overdose are on the rise, and in 2019, 70,630 deaths were recorded in the US resulting from drug overdose, with 72.9% of mortalities attributed to opioid overdose (Centers for Disease Control and Prevention, 2021). In a survey conducted in 2019, nearly 9.2 million adults in the US were identified as suffering from co-occurring disorders (US Department of Health and Human Services, 2019). The statistics of a survey conducted in 2020 reveal that approximately 7.3% of females and 6.2% of males from the US population aged 18 years and above suffer from a co-occurring mental illness and SUD (Elflein, 2021). It is, therefore, imperative to identify the related treatment needs and barriers, diagnosis and treatment methods, and recommendations that may help improve access and quality of treatment services.

Needs And Barriers

Numerous health disparities are associated with the treatment of co-occurring psychiatric conditions. These disparities are often experienced by the socially disadvantaged members of the population. Although the need for treatment of SUD and co-occurring mental illness is high, these needs are often unmet owing to different reasons. The results of the “National Survey on Drug Use and Health” conducted with 325,800 adults indicated the presence of co-occurring mental disorders in 3.3% of the US adult population, thereby signifying a great need for treatment interventions (US Department of Health and Human Services, 2013). However, the treatment needs of 52.5% of this population remained unmet as neither mental health care nor treatment for substance abuse was administered to them. The percentage of the population (9.1%) that received both treatments were the ones with severe mental health illnesses and physical comorbidities (Han et al., 2017). Moreover, these individuals were treated under the criminal justice system (Saloner et al., 2016). A contributing factor to low rates of treatment may be the “low perceived needs and barriers to care for both disorders” (Han et al., 2017).

The barriers to care service access may be categorized into two types, namely, “personal characteristics barriers and structural barriers” (Priester et al., 2016). The barriers to care that relate to the personal characteristics of individuals are related to personal beliefs and vulnerabilities. While personal beliefs pertain to the attitude and motivation of individuals to seek treatment, vulnerabilities are the individual characteristics that may worsen the symptoms of the condition, leading to psychosocial instability. An example of this form of personal vulnerability barrier is the substance abusers with schizophrenia. Such individuals are vulnerable as they suffer from impaired cognition and lowered energy and often lack social interaction skills. Their lack of motivation acts as a barrier to care access (Little, 2001). Multiple sizes of populations have demonstrated individual belief as a hindrance to care access. Cultural beliefs, perceptions about care providers, and stigma associated with psychiatric disorders and substance abuse are the common factors. Cultural beliefs are a more prevalent barrier in males of colour and individuals belonging to low socioeconomic status (Eliason & Amodia, 2006). This marginalized population is also additionally impacted by the stigma associated with these conditions. In most cases, the perceived stigma hinders adolescents’ access to treatment as either they or their parents associate disgrace and shame with substance abuse and psychiatric disorders (Hawkins, 2009). Research indicates that approximately 90% of adolescents associate shame, secrecy, and social distancing with mental health issues, and approximately 6 to 9 million do not receive proper treatment (Kranke et al., 2010)

The structural barriers to care are rooted within the social, legal, political, and service systems. These obstacles pertain to the availability of services, provider training, ethnic disparities, and policy, i.e., insurance-related barriers (Priester et al., 2016). Ethnic and racial discrimination is a notable obstacle to care. A study related to correctional facilities indicates that among drug-dependent inmates, co-occurring mental health diagnosis and treatment is more commonly a part of the sentence for Whites as compared to people of colour or those belonging to other ethnicities. Treatment referrals are also

impacted by similar discrimination (Nowotny, 2015).

Evidence-Supported Assessment And Treatment

Generally, it is believed that the treatment of SUD and co-occurring psychiatric disorders must be administered together for favourable outcomes. However, numerous challenges are associated with the identification of SUDs comorbid with mental illnesses. Often, co-occurring disorders obscure one another, creating difficulty in an appropriate diagnosis. The behaviours exhibited by patients suffering from anxiety, depression, and ADHD are often represented among those with SUD. For example, abuse of amphetamines and cocaine may result in decreased appetite, sleep loss, grandiosity, and paranoia – symptoms also common to bipolar disorder. Similarly, continued usage of central nervous system depressants, such as alcohol and opioids, may cause depressed mood and irregular sleep patterns (Quello et al., 2005).

To make an effective diagnosis of co-occurring psychiatric illness, abstinence is necessary (Hazelden, 2016). This may last from a few weeks to months, depending upon the duration required for the symptoms and withdrawal to completely subside (Iqbal et al., 2019). Often, practising caution while gathering symptomatic patient history related to periods of abstinence can help the practitioners identify a primary mental illness or one resulting from substance abuse (Iqbal et al., 2019). In the case of concurrent disorders, practitioners may have to use their judgment about the underlying cause. Other means of diagnosis include physical examination, urine toxicology report, history of drug abuse, family history, and premorbid history. Various screening devices for example the “Beck Depression Inventory”, “Hamilton Depression Rating Scale”, and “Addiction Severity Index” may also be employed. Moreover, sessions with family members and consultation with a therapist may help delineate SUD from a psychiatric illness (Iqbal et al., 2019).

Once a diagnosis is established, it is important to develop a treatment plan. To achieve significant outcomes, an integrated approach must be administered utilizing both pharmacological and psychotherapeutic interventions. Administering antidepressants may be recommended for patients with mild to extreme symptoms. Medication is often effective in alleviating depression and possibly leading to reduced use of a substance (Alsheikh et al., 2020). Psychotherapeutic interventions such as 12-step facilitation, cognitive behavioural therapy, community reinforcement approach, and motivational questioning are often considered effective for patients with SUD. However, for co-occurring psychiatric disorders, these psychotherapeutic interventions, when applied in isolation, have limited impact. The safety, accessibility, and tolerability of noninvasive brain stimulation technologies are gaining wider acclaim as an effective measure of treating co-occurring disorders (Gardner, 2013; Kluger & Triggs, 2007). More research is required to institute the efficiency of deep brain stimulation in the diagnosis and cure of SUD and psychiatric disorders. Similarly, an in-depth study of neurobiological processes that may induce clinical improvement is also required in the context of different populations to improve the efficacy of these ground-breaking approaches (Iqbal et al., 2019).

Recommendations

The overlapping symptoms of comorbid disorders often lead to increased difficulty in establishing a diagnosis. Moreover, the disparities in access to care services and provision of quality care pose an additional challenge. Although integrated treatment is deemed the most effective, its implementation is not without challenges, such as licensure requirements, issues of reimbursement, and workforce training. To overcome these problems and to ensure access to quality treatment, the training and licensure requirements must be standardized. This would help in providing a mechanism to monitor the training of practitioners and encourage the dissemination of updated practices through continued education. To provide integrated care, providers often communicate and coordinate the care. However, this coordination is not reimbursable. Additional healthcare financing and funding may support the integrated treatment plans (Yule & Kelly, 2019).

Although the integrated treatment method makes the most intuitive sense for the cure of SUD and co-occurring psychiatric disorders, research-based evidence in this regard is less mature, especially for comorbidities such as depression and anxiety (Yule & Kelly, 2019). Further research is recommended in this regard to address the needs of a heterogeneous population. Future research may address the types of care services, the role of service providers, and the treatment settings. To ensure the availability of experienced staff, educators and policymakers must increase multidisciplinary training and virtual sessions and streamline the accreditation process of educational programs to provide benefits to providers (Danovitch & Mooney, 2018). Adopting computerized interventions can be effective; however, further research is necessary to evaluate its true impact.

Conclusion

The high prevalence of substance use disorder among the US adult population and the development of co-occurring psychiatric disorders, combined with a lack of treatment access, poses a great challenge. An isolated approach may not be suitable to address these issues. Therefore, extensive research and continued innovation are essential to meet the requirements of the population.

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