Position Statement 33: Substance Use, Abuse, or Dependence and Co-Occurring Interactive Disorders

Policy

Mental Health America seeks to embrace the complete integrated treatment of substance use and mental health conditions. Mental Health America recognizes that substance dependence and abuse are mental health-related issues and thus are included within its mission. Co-occurring interactive disorders short of dependence or abuse are a separate problem. Co-occurring disorders of mental health conditions and substance abuse or dependence are truly "interactive" in that they each may exacerbate the symptoms and impact of the other.

A broad cross section of the population in the United States is affected by substance use, dependence or abuse, or co-occurring interactive disorders. These conditions have a dramatic impact on the lives of individual people, their families and partners, and society as a whole. Mental Health America therefore supports developing effective collaboration between stakeholders including mental health and substance dependence/abuse treatment and recovery supportive service providers, consumers, families, and advocacy organizations. Mental Health America affirms the inclusion of both substance dependence and abuse and co-occurring interactive disorders as important issues in its advocacy, programs, services, and public education. Mental Health America advocates for effective and accessible culturally and linguistically appropriate prevention, early identification, treatment, and recovery supportive services for consumers experiencing substance dependence or abuse or co-occurring interactive disorders and their families and partners. Integrated treatment services will serve to improve the quality and outcomes of care and reduce disparities in treatment[1].

Background

Alcoholism and drug abuse and dependence are recognized as primary, progressive, chronic, relapsing and treatable diseases, with clear diagnostic categories in the American Psychiatric Association' Diagnostic and Statistical Manual-Fourth Edition (DSM-IV) and with evidence-based treatment principles and protocols. About half of those with schizophrenia are likely to have a co-occurring substance use disorder over their lifetime; with bipolar disorder, that likelihood increases even more so. People with major depression and panic disorders are likely to have co-occurring substance use disorders at the rates of nearly 30% and 22% respectively as compared with about 15% in the general population. Prescription drug abuse is an area of growing concern. The National Survey on Drug Use and Health estimated that in 2003, 6.3 million Americans aged 12 and older abused prescription drugs (that is, took medications not prescribed for them or took medications solely for pleasure or entertainment) in the month preceding the survey. Most abused pain relievers (4.7 million); others abused tranquilizers (1.8 million), stimulants (1.2 million), and sedatives (0.3 million).[2] The World Health Organization

published a report titled "Neuroscience of Psychoactive Substance Use and Dependence" in 2004. The Report Summary presents the current state of knowledge from neuroscience research and underscores the following points:

- There is a need to increase public awareness regarding the complex nature of the problems and the biological processes underlying drug dependence.
- "...with recent advances in neuroscience, it is clear that substance dependence is a disorder of the brain as any other neurological or psychiatric illness."
- "Substance dependence is a chronic, relapsing disorder with a biological and genetic basis, and is not simply due to a lack of will or desire to quit."
- The greatest barrier to integrated treatment is the "silo" mentality - the fragmentation of mental health and substance use treatment services[3].

Mitigating Stigma by Clarifying Substance Use Conditions:
"Substance abuse and substance dependence are two types of substance use disorders and have distinct meanings."[4] Substance dependence is more serious than substance abuse. This maladaptive pattern of substance use includes such features as an increased tolerance for the substance, resulting in the need for ever-greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health conditions. An additional feature is the cognitive dissonance of persistent desire combined with unsuccessful efforts to cut down or control the substance use. Dr. Kessler, a professor of health care policy at Harvard Medical School, and his colleagues reported from the National Co-morbidity Survey that, "all the mental disorders are consistently more strongly related to dependence than abuse."[5] Although the term is used loosely, substance abuse is identified as a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences as a result of the substance use. Substance abuse does not include dependence, tolerance, withdrawal, or a pattern of compulsive use.

Despite some controversy, especially in the past, most national organizations now have described alcoholism and substance dependence as medical conditions. They include the American Medical Association, the American Psychiatric Association, the American Hospital Association, the American Public Health Association, the National Association of Social Workers, the World Health Organization and the College of Physicians.[6]

Federal agencies have also identified alcoholism, substance dependence/abuse as diseases or illnesses. They include:

- the National Institute on Drug Abuse (http://www.nida.nih.gov/)
- the National Institute on Alcohol Abuse and Alcoholism (http://www.niaaa.nih.gov/); and
- the Substance Abuse and Mental Health Services Administration (http://www.samhsa.gov/).

Co-occurring Treatment is Effective:
Twenty-six studies show that integrated treatment is more effective than traditional separate treatment[7].

Addiction Treatment Is Effective:
Addiction treatment reduces substance use, illegal activity, and suicidal ideation. The outcomes are generally stable for clients at five-year follow-up.8 The conclusion that treatment is effective is found in over 600 published scientific papers.9 Relapse rates for treatment of alcohol, opiates, and cocaine are less than those for hypertension and asthma, and equivalent to those of diabetes (all chronic conditions). Compliance rates for treatment of alcohol, opiates, and cocaine are greater than compliance for hypertension and asthma.10

Recent cost-benefit studies have found that the benefits to society (i.e. decreased crime, improved health, increased employment, and increased overall social functioning) are greater than the cost of treatment. For every additional $1.00 invested in treatment, the taxpayer saves at least $7.46 in costs to society (including the cost of incarceration). When adding the savings in healthcare costs, for every $1.00 spent for treatment, society benefits more than $12.00.11

In the first release of findings from an evaluation of California's Substance Abuse and Crime Prevention Act, UCLA researchers reported that the law enacted by voters as Proposition 36 placed more than 30,000 drug offenders in treatment during the first year -- more than half in treatment for the first time. It is estimated that the legislation will save $1.5 billion in five years in addition to increasing the number of licensed and substance abuse "slots" by 68%. Other states passing similar legislation include Washington DC, Arizona and Hawaii.12

Treatment Capacity is Insufficient:
Of the 6.1 million people who needed treatment, only 1.1 million people (17.3 %) receive treatment.[13] The people who could have benefited from treatment but did not receive it continue to suffer ongoing personal problems and consequences in their lives. The impact to public health and safety is exacerbated by the lack of adequate recovery opportunities provided for those who receive addiction treatment. Between 20-30 percent of patients seen in American hospital emergency departments have alcohol problems. According to the SAMHSA DAWN 2005 report, of the 108 million emergency department visits, 31 percent involved illicit drugs only and 27 percent involved pharmaceuticals only. Over half, 56 percent, of all drug misuse/abuse emergency department visits involved an illicit drug alone or in combination with another drug, (with the highest rates involving cocaine and marijuana).[14] It is unknown how many patients have other substance use conditions.[15] However, most emergency departments do not routinely screen for alcohol and other substance use conditions. As few as 15 percent of emergency department patients with alcohol problems have their drinking behavior addressed while in the emergency department or through a referral for problem drinking.[16],[17]

Nearly half of alcohol-related deaths are the result of motor vehicle crashes, falls, fires, drowning, homicides, and suicides.[18] Alcohol use is associated with 1/3 of all suicides.[19] 25,000 people are killed each year from alcohol-related traffic accidents.[20] 708,000 persons are injured in alcohol related car crashes, and 74,000 of those suffer serious injuries.[21] The burden of untreated alcohol abuse and dependency is enormous. Although harder to quantify, the burden of untreated abuse of and dependency on other drugs is at least as great.

Lastly, Hepatitis C Virus (HCV) and HIV can be contracted through intravenous drug use, and continued alcohol or drug use can exacerbate the two illnesses leading to further complications. Today, an estimated 920,000 people are infected with HIV. An estimated 4 million are infected with HCV and approximately10-12,000 die each year[22]. According to the CDC, the number of HCV related deaths is expected to triple over the next 10-20 years.

Addiction and Homelessness:
Approximately 70 percent of participants in a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) demonstration project identified substance abuse problems as the primary reason for their homelessness in both the first and most recent episodes. Among those in shelters, 86 percent are estimated to have alcohol problems, and 60 percent have problems with illicit drugs.[23]

Early Alcohol and Drug Use:
Fetal Alcohol Spectrum Disorder (FASD) refers to a range of effects that can occur to a person whose mother consumed alcohol during pregnancy (e.g. physical, mental, behavioral, and/or learning disabilities)[24]. FASD is also associated with a range of secondary problems that include depression, psychotic episodes, anxiety disorders, eating disorders, posttraumatic stress disorder, and alcohol or drug problems. An estimated one third of people with FASD have had alcohol or drug problems, with more than half requiring inpatient treatment.[25]

More than 1/4 of all children in the United States are exposed to alcohol abuse or dependence by the time they are 18 years of age. Adolescence is the transition between childhood and adulthood. During this time, significant changes occur in the body, including rapid hormone alterations and the formation of new networks in the brain.[26] A psychoactive drug produces an intoxicating effect by acting on one or more chemical messenger systems in a person's brain.[27] Early alcohol use may have lasting consequences. People who begin drinking before age fifteen are four times more likely to develop alcohol dependence at some time in their lives compared to those who have their first drink at age twenty or older.[28] Early use of marijuana showed substantial effects on later incidence of alcohol dependence, substance use conditions, and major depressive disorder in a NIDA funded longitudinal study of more than 700 individuals from early childhood into their late twenties.[29]

Co-Occurring Disorders:
The best estimate of the prevalence of co-occurring substance dependence or abuse and mental condition is contained in the combined data from the Epidemiologic Catchment Area (ECA) Survey and the National Comorbidity Survey (NCS):[30] Based on these studies, up to 10 million persons in the United States have at least one mental health condition and at least one substance-related condition in any given year. If not treated early and effectively, these conditions "may become chronic; may lead to other disorders; may increase symptoms by interacting with each other; may cause disability; and are likely to increase the cost of care."[31] NCS indicates that 3 million persons who are experiencing co-occurring disorders are affected by at least three disorders and 1 million individuals are affected by four or more disorders: "As the number of disorders increases, the likelihood of serious persistent mental illness, disability, and heavy use of health and social services also increase."[32] The most common cause of psychiatric relapse today (in the dually diagnosed population) is the use of alcohol, marijuana,

and cocaine. The most common cause of relapse to substance use/abuse is untreated psychiatric disorder.

Both substance use and mental health conditions have biological, psychological, and social components. Part of the difficulty in treating these conditions when they co-occur is that they affect the same part of the body-the brain -- a factor that complicates treatment, including the use of medications.[33] Approximately 39 percent of people who are homeless have a mental health condition, and 50 percent of adults with a serious mental health condition who are homeless have a co-occurring interactive substance abuse condition.[34]

Treatment programs, peer support programs, and self-help organizations (Including Alcoholics Anonymous, Narcotics Anonymous, Dual Recovery Anonymous, Methadone Anonymous, SMART Recovery, Inc. and Women for Sobriety) provide an array of recovery supports. It is important to understand the roles and boundaries of programs and organizations. William White's seminal work, Slaying the Dragon: The History of Addiction Treatment and Recovery in America, is an important resource to gain an understanding of addiction treatments, peer support programs, and self-help organizations.

Recent Developments:
Recovery-oriented systems transformation is extending to the addiction recovery field and may offer important opportunities.

- The National Summit on Recovery was sponsored by SAMHSA / CSAT to develop new ideas to help transform policy, services, and systems towards a recovery oriented paradigm that is more responsive to the needs of seeking recovery, as well as their family members or significant others. An important issue is the development of a system called "recovery supportive services".
- SAMHSA FY 2006 Grant RFPs include:
    - Access to Recovery, a program whose purpose includes providing client choices among clinical and recovery support service providers.
    - Recovery Community Services Program, whose purpose is to develop, design, deliver, and document peer-driven recovery support services.

Call to Action

Mental Health America encourages its affiliates and other mental health and substance dependence/abuse service stakeholders to advocate for mental health and substance dependence/abuse service systems that are recovery and wellness oriented, family and partner supportive, consumer driven, integrated and comprehensive, and culturally and linguistically competent, by:

- Advocating for the involvement of consumers of mental health and substance dependence/abuse services in the planning, implementation and evaluation of early identification and intervention, treatment, and recovery support services for mental health conditions, substance dependence/abuse conditions, and co-occurring interactive disorders.

- Advocating for integration of mental health and substance dependence/abuse recovery and general health services for persons experiencing co-occurring interactive disorders regardless of service delivery setting.
- Initiating community based coalitions to address the availability and accessibility of treatment and recovery services for substance dependence and co-occurring interactive disorders. In addition, recognizing and addressing the need for early detection and intervention programs.
- Building and developing core curricula, including appropriate training and experience in mental health and substance use.
- Educating the public about substance dependence/abuse and co-occurring disorders in order to mitigate stigma and prejudice that limit appropriate services.
- Advocating for appropriate and effective recovery-oriented treatment for both mental health and substance use conditions and for an end for discrimination in the treatment of those conditions (eg, HR 1424 in the 110th Congress).
- Monitoring outcomes of diversion for substance-related offenses.

Effective Period:

This policy was approved by the Mental Health America Board of Directors on October 6, 2007. It will remain in effect for five (5) years and is reviewed as required by the MHA Public Policy Committee.

Expiration: October 6, 2012

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http://www.facesandvoicesofrecovery.org/, and the National Council on Alcoholism and Drug Dependence http://www.ncadd.org/.

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24. *SAMHSA Fetal Alcohol Spectrum Disorder (FASD) Center of Excellence*

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