

Co-occurring disorders: substance abuse and serious mental illnesses essay sample...

[Health & Medicine](#), [Mental Health](#)



The least surprising statistical data presented by the Center for Substance Abuse Treatment (CSAT, 1994) was the high prevalence of substance abuse or dependence issues in combination with other mental disorders. According to surveys and research papers from the 1980s and 1990s, substance abuse treatment programs reported between 50 and 75 percent co-occurring mental disorders among their clients while mental healthcare providers reported the prevalence of co-occurring substance abuse disorders among their patients between 20 and 50 percent (as cited in CSAT, 1994).

The high prevalence of co-occurring disorders is not surprising because substance abuse causes several changes in the frontal cortex of the brain that impact clarity, decision-making, self-regulation, and self-awareness (Goldstein et al., 2009). With those consequences, individuals are at a higher risk for developing other mental health disorders. Even though genes can determine the level of resilience, various factors associated with substance abuse, such as socioeconomic condition and cultural background, are also associated with other mental health disorders (Li & Burmeister, 2010), so it is not surprising that most people can develop multiple co-occurring disorders (CODs) because they are determined by same external factors.

A lot of statistical information regarding the prevalence of CODs is surprising. For example, the difference between binge drinkers who are diagnosed with serious mental illnesses (28.8%) and binge drinkers who are not diagnosed with serious mental illnesses (23.9%) is insignificant (as cited in CSAT, 1994). Although binge drinking was correlated with mental disorders, it appears that using binge drinking as a diagnostic factor is not adequate because it would be difficult to distinguish between binge drinkers who only

engage in substance abuse and individuals with mental disorders.

Furthermore, the low prevalence of co-occurring disorders among the incarcerated population is also surprising. According to surveys, 16 percent of inmates in State prisons, 7 percent of inmates in Federal prisons, and 16 percent of inmates in local jails reported a diagnosed mental health condition or being at a mental health hospital at least once (as cited in CSAT, 1994). That is surprising because research by Kenny and Lennings (2007) shows that alcohol abuse is one of the main predictors of traumatic brain injuries and violent crimes. With that finding in mind, it appears that substance abuse and mental disorders are more prevalent among the incarcerated population, but the surveys show only a slight difference between CODs in the general population and among inmates.

Finally, despite the amount of evidence gathered to support the need for COD treatments, it is surprising that more facilities do not offer COD programming. For example, only 48.8 percent of substance abuse treatment facilities offered COD programming in 2002. According to Schneier et al. (2010), evidence-based practices in substance abuse treatments are rarely effective because individual factors impact the responses to treatment. However, with the progress in COD research and development of individualized approaches, it is surprising that less than half of mental health facilities adopted COD programs in treating their patients.

Although there are some differences between mental health systems and addiction treatment systems, various similarities between them are present as well. For example, both systems have multiple levels of care and treatment settings, which is important for addressing the needs of patients

in different conditions. The mental health system has three different settings designed to address acute, sub-acute, and long-term symptoms (CSAT, 2005). The addiction system treatment offers a variety of services specialized for alcohol and other drug abuse clients (CSAT, 2005). Examples of programs offered include detoxification programs, long-term programs, short-term programs, and forming long-term communities, so all possibilities are covered for patients at different levels of progress. Both systems also show the increasing use of case management to improve treatment outcomes (CSAT, 2005). Case management is useful because it enables both systems to coordinate multidisciplinary teams and individualize programs. The main difference between the mental health system and the addiction treatment system is the choice of medications used in treatment. For example, in the mental health system, medication is mainly used in psychiatric treatments because a lot of medications for mental disorders are psychoactive and mild psychoactive, so they may cause adverse events in patients with substance abuse or dependence history (CSAT, 2005). Addiction treatment systems mainly do not use medication in their treatment programs. Although that is partly because of wrong convictions regarding psychoactive effects of psychiatric medications, the staff usually has a limited understanding of pharmacological treatments and relies on methadone use to encourage abstinence and psychosocial improvement (CSAT, 2005). Furthermore, mental health centers employ mental health professionals, such as psychiatrists, psychologists, registered nurses, and other professions. Only registered healthcare professionals can work in those

centers, but certain adjunctions of the addiction treatment system do not always conform to those rules. For example, consumer-developed groups are a recognized as adjunctions to the professional addiction treatment centers, even though they are not recognized as official addiction treatment facilities, in which only healthcare professionals can work. Similar adjunctions are not present in the mental health system. These consumer-developed groups are also a significant weakness for addiction treatment centers because they may interfere with the treatment processes. For example, interpersonal communication among patients may lead to sharing inappropriate or incomplete information, which can result in lower adherence rates to determined treatment trajectories or false beliefs regarding treatment effectiveness and outcomes.

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