CO-OCCURRING SUBSTANCE USE DISORDERS AND PSYCHOTIC FEATURES FROM THE PARENT PERSPECTIVE

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Why This Topic Matters

- Increasing complexity of youth behavioral health presentations
- Growing rates of polysubstance use and high-potency cannabis exposure
- Families often become primary care coordinators and crisis responders
- Fragmented systems contribute to caregiver burnout and delayed intervention

PREVALENCE AT A GLANCE

Substance Use Disorder (SUD) & Psychotic Features

These conditions are common, treatable, and often go unrecognized.

SUBSTANCE USE DISORDER

16.8%

(48.4 million people)

of people age 12 and older in the U.S. met criteria for a past-year SUD in 2024.

Source: SAMHSA, 2024 NSDUH

TREATMENT GAP

1 in 5

Only about 1 in 5 people who needed substance use treatment received care in the past year.

Source: SAMHSA, 2024 NSDUH

CO-OCCURRING MENTAL ILLNESS & SUD

21.2 MILLION

U.S. adults experience co-occurring mental illness and substance use disorders.

Source: SAMHSA, 2025

CANNABIS DEPENDENCE RISK IN YOUTH

10%

of individuals who use marijuana develop dependence.

16–17%

when use begins before age 18.

Source: Volkow et al., 2014

PSYCHOSIS RISK WITH CANNABIS USE

3x

higher odds of psychosis with daily cannabis use.

~5x

higher risk with daily use of high-potency cannabis.

Sources: Di Forti et al., 2015; Behavioral Health News, 2023

FAMILIES MATTER. Family involvement in coordinated treatment is associated with better outcomes, lower substance use, and improved functioning.

NSDUH = National Survey on Drug Use and Health

References: SAMHSA. (2024). *Results from the National Survey on Drug Use and Health.* SAMHSA. (2025). *Co-occurring disorders and other health conditions.* Volkow, N. D., et al. (2014). *N Engl J Med, 370*(23), 2219–2227. Di Forti, M., et al. (2015). *Lancet Psychiatry, 2*(3), 233–238.

Learning Objectives

- Identify common presentations of co-occurring SUD and psychotic features
- Describe caregiver experiences and systems barriers
- Recognize differences between substance-induced and primary psychosis
- Apply family-centered engagement strategies

Understanding Co-Occurring Disorders

- Substance Use Disorders (SUDs) frequently overlap with psychiatric symptoms
- Psychotic features may include hallucinations, paranoia, delusions, and disorganized thinking
- Symptoms may fluctuate across intoxication, withdrawal, and baseline functioning
- Diagnostic clarity often develops longitudinally

Common Clinical Presentations

- Cannabis-associated psychotic symptoms
- Methamphetamine and stimulant-related paranoia
- Sleep deprivation worsening psychotic symptoms
- Trauma, anxiety, and mood instability overlapping with psychosis

Poll Question #1

How confident do you feel differentiating substance-induced psychosis from primary psychosis?

- ❑A. Very confident
- ❑B. Somewhat confident
- ❑C. Limited confidence
- ❑D. Not confident

Parent Perspective: Early Warning Signs

- Withdrawal from family or peers
- School decline or absenteeism
- Sleep disruption and emotional dysregulation
- Paranoia, suspiciousness, or odd beliefs
- Rapid personality or behavior changes

Emotional Experience of Caregivers

- Fear and hypervigilance
- Confusion regarding diagnosis
- Shame and stigma
- Financial and relational strain
- Grief and ambiguous loss

Systems Challenges Families Encounter

- Long waitlists and fragmented care
- Different diagnoses from multiple providers
- Crisis-focused responses without continuity
- Difficulty navigating confidentiality after age 18
- Limited rural behavioral health resources

Detailed Case Vignette

- 17-year-old male with escalating cannabis use and intermittent stimulant use
- Increasing paranoia, school failure, social withdrawal, and sleep reversal
- Multiple ER visits for agitation and bizarre behavior
- Parents uncertain whether symptoms reflect trauma, substance use, or psychosis
- Sibling stress and safety concerns developing within the home

Case Discussion Points

- What are the immediate safety concerns?
- What additional assessment information is needed?
- How should providers engage the family?
- What systems should be coordinated?
- How can harm reduction principles support engagement?

Diagnostic Complexity

- Substance-induced psychosis may resolve with abstinence
- Primary psychotic disorders may persist independent of substance use
- Trauma and mood disorders can complicate assessment
- Providers should tolerate uncertainty while maintaining engagement

Family-Centered Engagement Strategies

- Use nonjudgmental, trauma-informed communication
- Normalize caregiver stress and exhaustion
- Clarify confidentiality boundaries early
- Provide repeated psychoeducation
- Prioritize relationship-building and safety planning

Family-Centered Interventions

- Family psychoeducation
- Motivational interviewing
- Coordinated Specialty Care (CSC)
- Wraparound and peer support services
- School and community collaboration

Poll Question #2

What is the biggest systems barrier families face in your community?

- ❑A. Access to psychiatry
- ❑B. Substance use treatment availability
- ❑C. Coordination between systems
- ❑D. Crisis response limitations

Safety Planning Considerations

- Suicide and overdose risk assessment
- Violence/aggression risk monitoring
- Medication adherence concerns
- Access to firearms or lethal means
- Clear crisis response planning with caregivers

Provider Self-Awareness

- Recognize countertransference and frustration
- Avoid blaming caregivers
- Understand chronic family trauma
- Maintain empathy during relapse or resistance
- Consistency and collaboration improve trust

Key Takeaways

- Families often identify changes before systems respond
- Diagnostic clarity may require time and longitudinal assessment
- Family engagement improves safety and outcomes
- Compassionate communication reduces caregiver burnout
- Coordinated care is essential

Discussion Questions

- How do you approach diagnostic uncertainty?
- What barriers are most common in your setting?
- What strategies help build trust with caregivers?

References

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