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Burden and Psychological Distress in Caregivers of Persons with Addictions

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Abstract: Addiction is a complex psychosocial problem that has significant psychosocial effects on family members. The aim of this study is to gain insight into the burden and psychological distress suffered by caregivers of drug abusers. Ninety-nine caregivers of hard drug addicts participated in this study. The test group consisted of 50 participants and the control group had 49 participants. The participants filled out the General Demographic Questionnaire; Caregiving and the Experience of Subjective and Objective Burden; SCL-90-R; and WHOQOL-BREF. Caregivers of addicts who were preparing to join the community exhibited a significantly higher objective burden, subjective burden, subjective stress burden and greater psychological distress in comparison to caregivers of addicts in the community, and their quality of life was poorer ($p < 0.001$). The following showed to be risk factors for psychological distress: families with a greater number of children, marital, employment and economic status and duration of addiction. The protective factors were better quality of life, long-term marriage and higher education level of caregivers. Caring for addicts who are living with their families is a significant responsibility and burden for caregivers.

Keywords: addiction; caregivers; caregiver burden; psychological distress

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1. Introduction

Over the past two decades, the focus of mental health care has shifted from institutionalization to community-based programs and shorter hospital treatment. This change means that there is an increased role of caregivers, mostly family members, in the treatment of people with mental illness. Although there is evidence to support the benefits of deinstitutionalization, there are also indications of a substantial burden experienced by caregivers [1]. Social sensitivity to substance abuse varies and occurs on several levels (individual, interpersonal and social). Interdisciplinary collaborations between basic and behavioral sciences have facilitated the investigation of biological factors that interact with social and societal factors to place individuals at risk of developing substance use disorders. Chronic exposure to stressors and a maladaptive stress response to those stressors can influence the development of physical dependence and substance use disorders [2].

Families are the basic social unit. Therefore, families will inevitably affect the progress or regression of individuals and, in turn, impact communities and society [3]. Substance use and addiction impact families in different ways. Children exposed to illicit substances are at risk of developing psychiatric issues such as anxiety or depression, behavioral and cognitive difficulties that can affect their learning abilities [4–6]. Furthermore, substance abuse not only affects addicts but also the quality of life of their family or caregivers. The burden can have a devastating effect on the entire family system, adversely affecting the emotional climate and identity of the family, family members' abilities to function and relationships within the family [7].

The effects on the immediate family can be understood through the concept of family burden: objective family burden includes the time and energy a family member spends on health and caregiving; subjective family burden includes the emotional stress that arises from such caregiving situations. Family burden affects many aspects of family members' lives, including social relationships, health, work life and finances [8]. The term "family burden" was initially applied to chronic psychiatric disorders such as schizophrenia, and it was later used for substance abuse [9].

Family caregivers contribute to treatment engagement and adherence, reducing substance abuse and relapse, and increasing the well-being of the person with an addiction disorder. However, caregiving is also associated with negative emotional and physical health outcomes for caregivers [10]. Mental health problems, such as depression and anxiety, have been reported among relatives with a substance use disorder [11,12].

The findings of this study indicate that care for drug addicts, while they live in their families, is a significant objective and subjective burden to their caregivers, and also affects their mental health and psychosocial balance. The way in which our study will contribute to other research in this field is through knowledge about protective factors from the psychological disturbances of the caregivers such as higher quality of life, the health of other children, marital status, marriage length and higher educational degree.

Families are under constant stress, especially primary caregivers (parents) during their care for addicts at home. There is a need for permanent improvement of the skills and knowledge of caregivers in order to reduce their psychological distress and its further potential progression into mental disorders. This would contribute to caregivers better coping with the feelings that arise within themselves during the provision of care. The authors' aim is to gain insight into the burden and psychological distress suffered by caregivers of drug abusers.

2. Materials and Methods

2.1. Participants

The study was conducted in the out-patient center for the treatment and prevention of addictions at St. Peter and Paul's Church in Mostar and in the Community of the Merciful Father in Međugorje, Bosnia and Herzegovina, between April 2021 and April 2022. It was a cross-sectional study, with a test group comprising 50 caregivers (one of the parents) of drug addicts (opioid addicts) who were preparing for inclusion in the community, and a control group comprising 49 caregivers of addicts already in the therapeutic community in Međugorje. The inclusion criterion for the test and control group was: the family member that had been diagnosed as a drug addict, and the exclusion criterion was: previously diagnosed psychotic disorder in addicts or caregivers. All caregivers were informed about the aims of the study, participation was voluntary and signed informed consent was obtained from all participants. The Ethics Committee of the aforementioned institutions approved the study, which conforms with the provisions of the Declaration of Helsinki (as revised in Edinburgh, 2000).

2.2. Measures

The authors of the study used self-rating scales as follows: the sociodemographic questionnaire constructed for this study covered key demographic information about caregivers, their social relationships, marital status and basic information about the addicts. The Caregiving and the Experience of Subjective and Objective Burden Scale consists of 14 questions. Six of these relate to caregivers' objective burden, four relate to subjective demands and four relate to the subjective experience of stress overload. A total objective burden score over 23, subjective demand score over 15 and subjective experience of stress overload score over 13.5 are considered high. The Brief Symptom Inventory—SCL-90 is a self-rating scale to determine the existence of psychiatric symptoms. It consists of 53 items, includes three global indicators of distress and has nine subscales: somatizations, obsessive-compulsive problems, interpersonal sensibility, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The items comprising each of the nine primary symptom dimensions are as follows: (somatization: items 2, 7, 23, 29, 30, 33 and 37; obsession-compulsion: items 5, 15, 26, 27, 32 and 36; interpersonal sensitivity: items 20, 21, 22 and 42; depression: items 9, 16, 17, 18, 35 and 50; anxiety: items 1, 12, 19, 38, 45 and 49; hostility: items 6, 13, 40, 41 and 46; phobic anxiety: items 8, 28, 31, 43 and 47; paranoid ideation: items 4, 10, 24, 48 and 51; psychoticism: items 3, 14, 34, 44 and 53. Items 11, 25, 39 and 52 do not factor into any of the dimensions but are included because they are clinically important. The authors report good internal consistency reliability for the nine dimensions, ranging from 0.71 on Psychoticism to 0.85 on Depression. The test–retest reliability for the nine symptom dimensions ranges from 0.68 (somatization) to 0.91 (phobic anxiety) [13]. The WHOQOL-BREF (World Health Organization Quality of Life) is a measuring instrument to determine quality of life and perceived social support, and it consists of 26 questions.

2.3. Statistical Analysis

SPSS for Windows was used (17.0, SPSS Inc., Chicago, IL, USA) and Microsoft Excel (11, Microsoft Corporation, Redmond, WA, USA) was used for statistical analysis. The normal distribution of continuous variables was tested with the Kolmogorov–Smirnoff test. The median was used to show the mean value and the measure of dispersion, and the interquartile span was used to show distribution that was significantly different from normal. Differences in continuous variables between the two main groups (the test group and control group) were tested with the Mann–Whitney U test, and those between more than two groups with the Kruskal–Wallis test. The possibility of error was $\alpha < 0.05$, and differences between groups were accepted as statistically significant at $p < 0.05$. Linear regression analysis with a grading method was used as the prediction model.

3. Results

As mentioned earlier, the test group consisted of 50 caregivers (one of the parents) of opioid addicts who were preparing for inclusion in the community, and the control group consisted of 49 caregivers of addicts in the community in Medjugorje. The χ^2 test was used for variable differences expressed at the nominal level (data expressed in frequencies), and a t-test was used for variables expressed at the interval level. The sociodemographic characteristics (gender, education, employment, marital status, duration of marriage, parenthood and economic status) of the caregivers are shown in Table 1.

Caregivers in the test group had statistically higher results on all subscales of the Caregiving and the Experience of Subjective and Objective Burden Scale as compared to the control group. Objective burden (MW = 134; $z = -7.621$; $p < 0.001$), burden of subjective demands (MW = 184.5; $z = -6.734$; $p < 0.001$) and burden of subjective stress (MW = 49.0; $z = -7.817$; $p < 0.001$) were statistically significantly higher in caregivers of addicts who were not in the process of psychosocial community rehabilitation as compared to caregivers of addicts who (at the time) were in the community.

On the SCL-90 scale, caregivers of addicts who were in the community had statistically significantly lower levels of the following: somatizations (MW = 268; $z = -6.713$; $p < 0.001$); obsessive-compulsive symptoms (MW = 294.5; $z = -6.534$; $p < 0.001$); sensitivity in human relationships (MW = 410.5; $z = -5.728$; $p < 0.001$); depression (MW = 140; $z = -7.613$; $p < 0.001$); anxiety (MW = 207; $z = -7.167$; $p < 0.001$),); hostility (MW = 409; $z = -5.73$; $p < 0.001$); phobia (MW = 352.5; $z = -6.131$; $p < 0.001$); paranoid ideas (MW = 403; $z = -5.781$; $p < 0.001$); psychoticism (MW = 337; $z = -6.242$; $p < 0.001$); PSD (MW = 7.5; $z = -8.524$; $p < 0.001$); and GSI (MW = 88; $z = -7.993$; $p < 0.001$), as compared to caregivers of addicts who were preparing for inclusion in the community. Only the PSDI index (MW = 1096.5; $z = -0.899$; $p = 0.368$) did not show a statistically significant difference between the test and control group (Table 2).

Table 1. Sociodemographic characteristics and differences between the test and control groups.

	Test Group	**Control Group**	χ^2	***p***
Employment			0.713	0.401
Unable for work	6 (12.00)	1 (2.00)		
Unemployed	12 (24.00)	18 (36.70)		
Employed	17 (34.00)	25 (51.00)		
Temporary jobs	11 (22.00)	3 (6.10)		
Retired	4 (8.00)	2 (4.10)		
Marital status			17.086	<0.001
married	21 (42.00)	41 (83.70)		
divorced	17 (43.00)	4 (8.20)		
widowed	6 (12.00)	4 (8.20)		
separated	6 (12.00)	0		
Duration of marriage			1.238	0.269
<10 years	3 (6.00)	0		
10–20 years	10 (20.00)	4 (8.20)		
20–30 years	28 (56.00)	41 (83.70)		
>30 years	9 (18.00)	4 (8.20)		
Parenthood			5.324	0.023
One child	20 (40.00)	1 (2.00)		
Two children	19 (38.00)	42 (85.7)		
Three and more children	11 (22.00)	6 (12.3)		
Economic status			6.019	0.015
Low	25 (50.00)	9 (18.40)		
Average	21 (42.00)	38 (77.60)		
Good	4 (8.00)	2 (4.10)		

Table 2. Presence of main psychological symptoms according to the SCL-90 questionnaire in the test and control group.

Main Psychological	**C–Median [Q-Interquartile Span]**			
Symptoms	**Test Group**	**Control Group**	***z***	***p* ***
	(n = 50)	**(n = 49)**		
Somatization	2.3 [0.6]	1.4 [0.9]	−6.71	<0.001
Obsesive-compulsive	2.5 [0.5]	1.5 [0.8]	−6.534	<0.001
Sensitivity in interpersonal				
relationships	2.3 [0.8]	1.0 [1.8]	–5.728	<0.001
Depression	2.5 [0.5]	1.3 [0.7]	–7.613	<0.001
Anxiety	1.5 [0.3]	1.3 [1.1]	–7.167	<0.001
Hostility	2.5 [1.0]	1.4 [1.3]	–5.730	<0.001
Phobia	2.4 [0.8]	1.0 [1.2]	–6.131	<0.001
Paranoid ideas	2.0 [0.8]	1.0 [1.1]	–5.781	<0.001
Psychoticism	2.0 [0.7]	1.2 [0.8]	–6.242	<0.001
PST	2.3 [0.2]	1.4 [0.4]	–8.524	<0.001
GSI	48 [2]	28 [7]	–7.993	<0.001
PSDI	2.6 [0.2]	2.5 [0.5]	–0.899	0.368

* Mann–Whitney (MW) test. PST—total number of symptoms. GSI—average intensity of all symptoms. PSDI—average intensity of present symptoms.

As can be seen in Table 1, 79 caregivers were female and 20 were male. Table 3 shows differences in presence of the main psychological symptoms among caregivers, taking gender into account.

Table 3. Differences in presence of the main psychological symptoms among caregivers, taking gender into account.

Main Psychological	**C–Median [Q-Interquartile Span]**			
Symptoms	**Female**	**Male**	χ^2	***p*** *
	(n = 79)	**(n = 20)**		
Somatization	1.9 [1.1]	2.1 [1.0]	2.629	0.230
Obsesive-compulsive	2.2 [1.2]	1.9 [0.8]	7.563	0.834
Sensitivity in interpersonal relationships	2.0 [1.5]	1.9 [1.4]	9.028	0.976
Depression	2.2 [1.3]	1.8 [0.8]	21.005	0.594
Anxiety	2.3 [1.2]	2.4 [1.5]	9.261	0.478
Hostility	2.0 [1.6]	2.4 [0.8]	4.956	0.037
Phobia	1.8 [1.4]	2.2 [1.0]	3.344	0.259
Paranoid ideas	1.8 [1.0]	1.6 [1.0]	2.591	0.362
Psychoticism	1.8 [1.0]	1.5 [1.3]	14.260	0.157
PST	2.1 [1.0]	1.8 [0.7]	14.352	0.931
GSI	46 [20]	36 [19]	13.404	0.363
PSDI	2.6 [0.3]	2.5 [0.4]	3.224	0.906

* Kruskal–Wallis test. PST—total number of symptoms. GSI—average intensity of all symptoms. PSDI—average intensity of present symptoms.

Female caregivers ($\chi^2 = 3.956$; ss = 1; $p < 0.037$) had significantly lower scores for hostility compared to male caregivers, whereas for other psychiatric difficulties (somatization, obsessive-compulsive symptoms, sensitivity in human relationships, depression, anxiety, phobia, paranoid ideas and psychoticism), as well as for total indicators on the SCL-90-R scale, there was no statistically significant gender difference ($p > 0.05$) (Table 3).

Married caregivers had statistically lower levels of: sensitivity in human relationships ($\chi^2 = 9.028$; ss = 3; $p = 0.029$); depression ($\chi^2 = 21.005$; ss = 3; $p < 0.001$); anxiety ($\chi^2 = 9.261$; ss = 3; $p = 0.026$); psychoticism ($\chi^2 = 14.26$; ss = 3; $p = 0.003$); PST ($\chi^2 = 14.352$; ss = 3; $p = 0.002$); and GSI ($\chi^2 = 13.404$; ss = 3; $p = 0.004$) compared to those who were divorced, widowed or separated.

Objective burden ($\chi^2 = 11.313$; ss = 2; $p = 0.003$), burden of subjective demands ($\chi^2 = 17.483$; ss = 2; $p < 0.001$) and burden of subjective stress ($\chi^2 = 12.584$; ss = 2; $p = 0.002$) were statistically lower among caregivers who had two children compared to caregivers with one or three or more children.

Scores for objective burden ($\chi^2 = 24.086$; ss = 3; $p < 0.001$), burden of subjective demands ($\chi^2 = 12.43$; ss = 3; $p = 0.006$) and burden of subjective stress ($\chi^2 = 19.844$; ss = 3; $p < 0.001$) were statistically significantly lower in caregivers whose children had been addicts for longer than 5 years, as compared to those whose children had been addicts for less than 5 years (Table 4).

Table 4. Caregivers' burden considering the duration of children's opioid addiction.

Caregivers Burden	**C–Median [Q-Interquartile Span]**				
	<1	**1–3**	**3–5**	**>5**	***p* ***
Objective burden	26 [1.25]	27 [1]	26 [3.5]	22 [4]	<0.001
Burden of subjective demands	12.5 [4.6]	14 [3]	13.5 [3.3]	10 [6]	0.006
Burden of subjective stress	17.5 [2.3]	17 [3]	17 [2]	9 [8.8]	<0.001

* Kruskal–Wallis test.

Caregivers whose children had been addicts for longer than 5 years had statistically lower levels of the following: somatization (χ^2 = 17.64; ss = 3; p = 0.001); obsessive-compulsive symptoms (χ^2 = 11.651; ss = 3; p = 0.009); sensitivity in human relationships (χ^2 = 8.44; ss = 3; p = 0.038); depression (χ^2 = 16.274; ss = 3; p = 0.001); anxiety (χ^2 = 19.743; ss = 3; p < 0.001); hostility (χ^2 = 16.316; ss = 3; p = 0.001); phobia (χ^2 = 19.116; ss = 3; p < 0.001); paranoid ideas (χ^2 = 17.382; ss = 3; p = 0.001); psychoticism (χ^2 = 8.042; ss = 3; p = 0.045); PST (χ^2 = 20.446; ss = 3; p < 0.001); and GSI (χ^2 = 18.790; ss = 3; p < 0.001) compared to caregivers whose children had been addicts for 5 years or less. Caregivers who did not have any other children addicted to drugs or alcohol had a significantly lower level of subjective stress burden (χ^2 = 7.285; ss = 2; p = 0.007) as compared to caregivers with other children who were addicts. Caregivers with positive psychiatric history of treatment had a significantly higher level of subjective stress (χ^2 = 4.045; ss = 1; p = 0.044) than caregivers who had not previously received psychiatric treatment. Caregivers who reported being treated for one or more somatic illnesses had a statistically higher level of burden of subjective demands (χ^2 = 5.399; ss = 1; p = 0.02) as compared to caregivers without somatic illness.

Physical health (MW = 222.5; z = -7.058; p < 0.001), psychological health (MW = 16; z = -8.499; p < 0.001), social relations (MW = 392.5; z = -5.938; p < 0.001) and perception of own environment (MW = 358; z = -6.108; p < 0.001) were statistically significantly better among caregivers of addicts who were in the community as compared to caregivers of addicts who were preparing to live in the community again (Table 5).

Table 5. Results for the quality-of-life scale and perceived social support among test and control groups.

Quality of Life	**C–Median [Q-Interquartile Span]**			
	Test Group	**Control Group**	***z***	***p* ***
	(n = 50)	**(n = 49)**		
Physical health	54 [11]	36 [4]	–7.058	<0.001
Psychological health	67 [8]	33 [9]	–8.499	<0.001
Social relations	54 [11]	36 [4]	–5.938	<0.001
Environment	50 [9]	38 [11]	–6.108	<0.001

* Mann–Whitney (MW) test.

4. Discussion

This paper highlights the psychosocial consequences that caregivers (parents) suffer when caring for their addicted children at home. It was found that caregivers of addicts who are preparing to enter the community are exposed to significantly higher levels of objective burden, burden of subjective demands and burden of subjective stress, and higher psychological distress. Furthermore, their quality of life is poorer in comparison to caregivers of addicts who are already in the community. The results showed that general psychological symptoms were significantly higher in the test group than in the control group. The following were found to be protective factors, mitigating the burden and psychological distress of caregivers of addicts who are preparing to enter the community: better quality of life, non-existence of addiction in other children, longer duration of marriage, higher education level on the part of the caregiver and non-existence of chronic disease. Caregivers in the test group exhibited greater objective burden, burden of subjective demands and burden of subjective stress as compared to the control group, and their quality of life was lower. Psychological distress was greater in the test group than in the control group. This finding is in line with many other studies focused on understanding the difficulties of caregivers [14,15], which have identified the following as the most common consequences of caring for an ill family member: burnout and a high burden of care, a high degree of stigmatization, lack of social support for caregivers and a poor quality of life [16,17].

It is important to point out that caring for addicts is different from caring for individuals with chronic diseases. Caregivers of persons with mental health or addiction problems were more likely to report that caregiving is incredibly stressful and that they felt depressed, tired, worried or anxious, overwhelmed, lonely or isolated, short-tempered or irritable and resentful because of their caregiving responsibilities [18]. Addicts do not consider themselves patients, and even their families do not see them as patients. Caring for addicts does not usually influence the everyday life of the caregiver (job, home) directly. This is different from caring for chronically ill patients because they are more reliant on the physical presence of the caregiver [19,20]. The emotional well-being of the caregiver of an addict is more threatened than that of caregivers of somatic patients. Addiction in a family can increase the relatives' vulnerability to maltreatment and instability, leading to violence, divorce and the inability to provide for dependents' needs [21]. Caregivers' experiences of emotional burden can cause feelings of confusion, anger, frustration, anxiety, depression, abandonment, fear, embarrassment and guilt [22]. In the investigation of care burden, the general mean was 2.2, and emotional involvement (feelings of shame and anger) and general tension (feelings of responsibility, exhaustion, facing problems that are difficult to resolve, injuries to health, lack of time, among others) were considered predictors of burden [23].

In this study, the results showed that in the test group, caregivers' scores for somatic health, psychological health, social relations and perception of the environment were significantly lower than those in the control group. Long-term caring for addicts, insufficient understanding of the disease and unrealistic expectations about treatment outcomes can cause chronic dissatisfaction, exhaustion and isolation in many families. Analysis of 81 study results relating to the source of caregivers' stress showed that caregivers felt that they were constantly under strain; 55.5% lost sleep because of worrying about the patient's illness and 80% felt unhappy or depressed [21]. The caregiver's perceptions of their inability to mitigate the addiction's trajectory were expressed as helplessness and hopelessness, which appeared to be further exacerbated by their lack of knowledge of addiction. This conveyed exhaustion of the inner resources needed to mitigate distress and to engage in self-care. Although many caregivers retained the hope that recovery was possible, the painful cycle of relapse or reluctance of the individual with SUD to enter treatment eventually stripped away any thread of hope [24]. A study from Turkey, conducted on 100 patients with opioid use disorders and their primary caregivers, showed that caregivers experienced a greater burden if they were faced with the presence of verbal and physical violence (between patients and other family members) and intravenous drug use [25]. Analysis of a total of 33 articles considering caregivers' burden highlighted three key aspects: self-perception, multifaceted strain and how long the situation lasts. Antecedents included insufficient financial resources, conflict between multiple responsibilities and lack of social activities. The consequences of caregiver burden resulted in negative change, which included decreased care, decreased quality of life and deterioration in physical and psychological health [26]. Caregivers with a high burden of care are more likely to have depression, anxiety and poor quality of life [27]. Caregiver burden was most often reported as moderate to severe in populations with substance use disorder [28].

Our research showed that most caregivers were women. Most of the participant caregivers were family members of the addicted patients, and most were women who were above middle age; mothers or spouses mostly took the responsibility of providing care to addicted individuals [29]. In accordance with traditional gender roles, behaviors that require self-devotion, such as caring, feeding, growing, helping and supporting, are more expected from females from cultures with a patriarchal family structure; caring is perceived as the duty of females, and females are thereby expected to fulfill this responsibility. In light of this information, it is clear that gender is a significant determinant in caregiving [29]. A similar finding is reported by Rospenda et al. [29], who conducted a study to determine the care burden of the families of alcohol abusers and found that most of the caregivers were women.

In a study conducted in Nigeria, depression, schizophrenia and substance use disorder were the main mental disorders of patients of family caregivers, as about two-thirds of the caregiver's patients had one of the three conditions. Globally, these three conditions are among the top mental disorders [30].

This study highlights the importance of specific education for caregivers worldwide, providing psychological support and the need for the development of additional community forms of care for addicts. It shows the importance of the mental well-being of the caregivers and the need to develop and implement strategies on a national level, which can promote mental health and work on its strengthening.

Because of this growing concern on a global level, future research should investigate how psychosocial interventions and specific targeted programs toward caregivers are effective in coping with their psychological distress and the overall effects on their mental and physical health.

5. Conclusions

This study showed that gender does not influence the level of objective burden, burden of subjective demands and burden of subjective stress between two groups. Married caregivers had a lower level of subjective burden, burden of subjective demands and demands of subjective stress as compared to those who were divorced, widowed or separated. Higher quality of life, health of other children, longer marital status and a higher education degree of caregivers turned out to be protective against psychological disturbances. On the other hand, having more children is a risk factor for the development of psychological disturbances. Research thoroughly defines and connects burden, psychological distress and the quality of life in caregivers of opioid addicts to the way in which the treatment is applied. Treatment of addicts in the community contributes to a significantly lower objective and subjective burden and psychological distress and increases the quality of life in their caregivers. It is important for caregivers to seek support and assistance both from healthcare professionals and from their own social networks. Self-care is also important for caregivers and can include activities such as exercise, meditation and maintaining social connections outside of caregiving. By prioritizing their own well-being, caregivers can better manage the challenges of caregiving and provide more effective and compassionate care to their loved ones. There is still a need for the development of treatment programs for the management of mental health problems in caregivers. Public health services and medical care for caregivers are important steps toward addressing caregiver health. Promoting and supporting the mental health of caregivers is important because these interventions help to alleviate the burden of the caregivers, which will lead to better treatment effectiveness.

Some of the limitations of our study could be that the stress/burden levels were self-rated and were under subjective impression.

6. The Future Scope of the Work

According to the report [31], around 284 million people aged 15–64 used drugs worldwide in 2020, a 26 percent increase over the previous decade. Young people are using more drugs. In many countries in Africa and South and Central America, the largest proportion of people in treatment for drug use disorders are there primarily for cannabis use disorders. In Eastern and South-Eastern Europe and in Central Asia, people are most often in treatment for opioid use disorders. In the United States and Canada, there is an epidemic of the non-medical use of fentanyl, which continues to break records.

In the future, this will become an even bigger issue globally, as it shows rapid growth. We must prepare ourselves for the time to come by enhancing health education, organizing specific training and screening of people for psychological morbidity and applying early interventions if needed.

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