Comorbidity in Detoxification: Symptom Interaction and Treatment Intentions ☆

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A B S T R A C T

Co-occurring substance use and mental health disorders (CODs) are common. However, very little is known about individuals' recognition of, and perception of the relationship between these disorders. The current study aimed to examine problem recognition, perceived disorder relationships, treatment intentions, and treatment preferences of individuals attending Australian detoxification facilities. Questionnaires were completed by 225 participants, including the Mental Health Screening Form III and the Treatment Preferences Questionnaire. Results indicated that 56.4% of participants screened positive for CODs, with only 4.2% failing to recognise their mental health problems. Participants perceived a functional relationship between disorders, where improvement/deterioration of one disorder leads to the improvement/deterioration of the other. Recognition of mental health problems and perception of a functional relationship between disorders, predict high mental health treatment intentions. These findings have important clinical implications when planning treatment programs and counselling individuals with CODs.

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Epidemiological and clinical research has consistently demonstrated the frequent co-occurrence of mental disorders and substance use disorders (SUDs; Davidson & White, 2007). Co-occurring disorders (CODs), or comorbidity, refers to the presence of one or more mental disorders with one or more SUDs (Mills et al., 2009). According to epidemiological research, over a 12 month period 63% of Australians who misuse drugs nearly every day have a mental disorder, compared to 20% of the overall Australian population (Australian Bureau of Statistics, 2007). Among alcohol and other drug (AOD) treatment seeking populations, lifetime prevalence of a mental health disorder is between 50 and 75% (Center for Substance Abuse Treatment, 2007). In line with this, an Australian study found that 64 to 71% of individuals attending a residential substance use treatment facility screened positive for CODs (Mortlock, Deane, & Crowe, 2011). Rates of individuals who screen positive for CODs within AOD detoxification settings are higher than other treatment settings, with rates between 80 and 83% reported from the Netherlands

(Hendriks, 1990) and the USA (Johnson, Brems, Mills, & Fisher, 2007). Prior to the present study, mental health screening for CODs among Australian AOD detoxification facilities has not been conducted.

Individuals with co-occurring mental disorders and substance use disorders experience increased symptomatology, poorer treatment outcomes, and worse prognosis across both disorders when compared to individuals with substance use disorders only (Myrick & Brady, 2003). Addressing mental health comorbidity leads to improved outcomes such as decreased mental health symptomatology and reduced AOD use (Kranzler et al., 1994; Litten & Allen, 1998). However, poor recognition of CODs within treatment settings often precludes appropriate treatment. Research conducted across six outpatient AOD treatment settings indicated that services only recognised 54% of people with CODs. Alarmingly, of these, comorbidities were addressed in only 23% of cases (Schulte, Meier, Stirling, & Berry, 2010). Another study involving individuals attending an inpatient detoxification facility found only 20% of participants were referred to psychiatric services, despite 84% of the sample meeting criteria for a comorbid mental health disorder (Craig & DiBuono, 1996).

Despite detoxification being an ineffective stand-alone treatment for SUDs or CODs (Blondell, Smith, Canfield, & Servoss, 2006; Center for Substance Abuse Treatment, 1995; Mattick & Hall, 1996), many individuals fail to transition into further mental health treatment. This trend is of concern given findings that individuals who receive treatment following detoxification experience better treatment outcomes (McKay, 2005). A major function of detoxification is to

provide individuals with the opportunity to link with further treatment (McLellan, 2003).

One reason for low treatment seeking following detoxification is likely to be problem recognition. A central component of the help seeking process involves recognition of the problem (Meadows et al., 2002). Individuals within detoxification settings have demonstrated recognition of their substance use problems, however, it is unclear whether they recognise their co-occurring mental health problems. In order to recognise a problem, the individual must firstly have an understanding of personal symptomatology. However, there is a lack of research exploring problem perception among individuals with CODs. In turn, it is unclear how an individual's perception of his or her mental health problems, influences intentions to seek mental health treatment following detoxification.

According to Rachman (1991), knowledge of the functional relationship between mental health disorders and substance use disorders is of crucial importance in promoting service providers' understanding of the two disorders. At present, only two small-scale studies have explored the perceived interaction between co-occurring SUDs and post traumatic stress disorder (PTSD), and how this informs the individual's preference for further treatment.

In the first, the interaction between co-occurring PTSD and SUDs among 42 individuals attending an inpatient detoxification facility was investigated (Brown, Stout, & Gannon-Rowley, 1998). The second replicated that study with 23 participants experiencing co-occurring cocaine dependence and PTSD (Back, Brady, Jaaimagi, & Jackson, 2006). The results of both studies indicated that participants perceived their PTSD symptoms and SUDs to be functionally related. According to Back et al. (2006), almost all participants (96%) perceived a functional relationship. Both studies demonstrated a significant relationship between the deterioration/improvement in PTSD symptomatology and subsequent substance use. When PTSD symptoms worsen, up to 86% of participants indicated that their substance use increases. Similarly, when PTSD symptoms improve, up to 79% indicated that substance use decreases (Back et al., 2006; Brown et al., 1998). Furthermore, Brown et al. (1998) demonstrated that 51% of participants endorsed a functional relationship between deterioration/improvement in substance use and PTSD symptomatology. However, Back et al. (2006) did not find a significant association between improvement/deterioration in cocaine use and PTSD symptomatology. Approximately half of the participants across both studies endorsed a preference to seek concurrent PTSD treatment and substance use treatment. Thirty percent of participants endorsed a preference for sequential treatment for substance use first, then PTSD treatment and the remaining 20% endorsed a preference for sequential treatment for PTSD first, then substance use treatment.

These studies provide initial evidence that individuals perceive a functional relationship between their co-occurring PTSD and SUDs. Furthermore, these perceptions are associated with their hypothetical treatment preferences. However, there is a need to broaden our understanding of these relationships beyond PTSD as the specified comorbid mental disorder because individuals entering services present with a wider range of mental health disorders. It is expected that increased understanding of the interactions between perceived symptom relationship, treatment preferences, and intentions to seek treatment will provide valuable information in facilitating the development of strategies to promote help seeking and improve treatment delivery.

In the current study, it was hypothesised that participants who screen positive for mental health disorders will have higher help seeking intentions for further mental health treatment and drug and/or alcohol treatment than those who do not screen positive. Participants who screen positive for mental health disorders, and do not recognise their mental health problems, are less likely to intend to seek mental health treatment when compared to those who screen positive and recognise they have a mental health problem. It was also hypothesised that screening positive for a mental health disorder, recognising co-occurring

mental health disorders, and the perception of a functional relationship between disorders, will predict help seeking intentions for both mental health and drug and/or alcohol treatment.

1. Materials and methods

1.1. Participants

The sample consisted of individuals consecutively admitted to two Australian residential detoxification facilities provided by a non-government organisation (The Salvation Army). Both facilities were located in Queensland Australia. One detoxification centre had 12 male beds and the other had 11 mixed beds. A requirement of entry to the programs was that all individuals have alcohol and/or other substance dependence. The average length of stay at the detoxification program is 7 days, however, this varies depending on the level of care required. Complex medical detoxifications are not admitted for detoxification within the services. Clients were not approached to participate until they had completed at least 2 days in the units. This allowed participants to resolve physical symptoms associated with the detoxification process.

It was estimated that 520 clients accessed the services during the study period, with 225 (43.3%) of clients agreeing to participate. Data were collected from January 2013 to July 2013. There was an even distribution of participants across both sites with 114 (50.7%) coming from one site and 111 (49.3%) from the other. The main reasons for non-participation were unwillingness to participate, being physically unwell, and participants leaving before being approached by staff. No information was collected on participants who did not agree to participate. Of the individuals who agreed to participate, the average age was 39.21 years ($SD = 10.79$), and the majority of participants were male (147, 65.3%). Most participants were born in Australia (78.7%), 1.3% of participants reported a primary language other than English and 3.1% of participants identified as Aboriginal or Torres Strait Islander. Alcohol was the primary substance of abuse (49.3%), followed by amphetamine type substances (16.0%) and cannabis (15.1%). More than half (56.4%) of participants indicated having a prior mental health diagnosis, with the majority reporting depressive disorders (39.1%) and anxiety disorders (21.3%). Twenty eight percent of participants identified having two or more previously diagnosed mental health disorders in addition to an alcohol or other SUD. Demographic information, drug use history, and prior mental health diagnoses are provided in Table 1.

1.2. Measures

1.2.1. Background information

A brief background questionnaire was used to obtain demographic information including age, gender, country of origin, and primary language. Information on substance use was collected including primary substance of abuse, the number of years they have had substance abuse problems, types of substances used in past 12 months, previous substance abuse treatment sought, and type of treatment(s) planned for the future. Participants were also asked to provide information regarding previous mental health diagnoses.

1.2.2. Problem recognition

Recognition of mental health problems was measured by a single item using a 5-point Likert scale. Participants were asked to rate how much they think they have a mental health problem from 0 (*no problem*) to 4 (*very large problem*). Problem recognition was defined as a response of 3 or 4 on this item.

1.2.3. Mental Health Screening Form III (MHSF-III)

The MHSF-III (Carroll & McGinley, 2001) is an 18-item self report screening tool designed to screen for mental health disorder