



Alcohol Use Disorders in patients with schizophrenia: Comparative study with general population controls



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HIGHLIGHTS

- In Thirthahalli, a rural south Indian taluk (a local administrative block), significantly smaller proportion of patients with schizophrenia used alcohol in the past year than general population controls. This finding is in contrast to reports from several other parts of the world.
- Domicile in villages and lesser years of education were associated with hazardous use of alcohol.
- Cross-cultural studies are needed to better understand this contrasting phenomenon.

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ABSTRACT

Objective: To compare the prevalence of Alcohol Use Disorders (AUD) among schizophrenia patients with that of the general population in a south Indian rural community.

Methods: Alcohol use pattern of 254 schizophrenia patients in the past year was compared with randomly selected healthy comparison subjects ($n = 350$) from the same community in an administrative block of rural India using the Alcohol Use Disorders Identification Test (AUDIT).

Results: A significantly smaller proportion of patients used alcohol in the past year (10.2%; 95% CI: 6.5%–14.0%) than controls (18.3%; 95% CI: 15.8%–24.1%; OR = 2.2; 95% CI = 1.4–3.5). This was true for AUD (hazardous use and harmful use; total AUDIT score >8) also: 5.5% patients (95% CI: 2.7%–8.3%) and 10.3% controls (95% CI: 7.1%–13.4%) had hazardous use (OR = 2.0; 95% CI = 1.0–3.7). Hazardous use was associated with domicile in villages and lesser years of education. On logistic regression, after controlling for these confounds, the odds of having AUD were 2.7 times more for controls than for patients (95% CI = 1.4–5.2).

Conclusions: Prevalence of AUD is significantly lower in patients than in the general population in this community. Cross-cultural studies are needed to elucidate factors that underlie contrasting results across different countries.

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1. Introduction

Alcohol Use Disorders (AUD), when co-morbid with schizophrenia, are associated with a number of adverse consequences including suicide, violence, housing instability, homelessness, poor money management, greater use of crisis care and greater costs of care (Dixon, 1999; Drake & Mueser, 1996; Gregg, Barrowclough, & Haddock, 2007), more severe depressive symptoms (Potvin, Sepehry, & Stip, 2007),

more relapses and re-hospitalizations (Mueser, Drake, & Wallach, 1998). Further, they pose substantial management challenges.

Co-morbidity of AUD has been observed to be higher among patients with psychiatric disorders, especially in developed countries (Margolese, Malchy, Negrete, Tempier, & Gill, 2004; Regier et al., 1990). For example, in the Epidemiological Catchment Area (ECA) study, the odds of having any addictive disorder were 2.7 times higher for patients with any mental disorder. In a meta-analysis of 60 studies across the world, Koskinen, Löhönen, Koponen, Isohanni, and Miettinen (2009) found that the median prevalence of current and life-time AUD in schizophrenia was 9% and 21% respectively. Notably, only one of the 60 studies reviewed had compared the prevalence of AUD among schizophrenia patients with that of the general population (McCreadie & Scottish Comorbidity Study group, 2002). Even this study

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found the prevalence of AUD to be higher among patients than that among the general population. In the most recent and one of the largest studies comparing patients with severe psychotic disorders ($n = 9142$; 83% with schizophrenia/schizoaffective disorder) and general population ($n = 10195$), Hartz et al. (2014) reported a four-fold higher prevalence of heavy alcohol use among patients.

The above mentioned trend has however, not been observed in many Asian countries (Thirthalli, Kumar, & Arunachal, 2012). In India, urban hospital-based studies have found fairly low co-occurrence of AUD among inpatients (Carey, Carey, & Chandra, 2003) as well as outpatients (Chand, Thirthalli, & Murthy, 2014) with schizophrenia and other psychotic disorders in urban settings. Such regional differences may reflect a complex interplay of socio-cultural and biological mechanisms underlying co-morbid conditions. More than 70% of the population of India resides in rural areas. Existing studies may not accurately reflect the problem of co-morbidity of AUD and schizophrenia among rural, community-dwelling patients. In this paper we report (a) the prevalence of AUD in a sample of community-dwelling schizophrenia patients from a rural South Indian region and (b) the comparison of prevalence among patients and a randomly selected sample from the general population of the same community.

2. Materials and methods

2.1. Setting and sample

2.1.1. Patients

The sample for this study comes from the Community Interventions in Psychotic Disorders (CoInPsyD) programme. The details of this programme have been published elsewhere (Thirthalli et al., 2009). Briefly, the aim of this programme is to identify, treat and follow-up all schizophrenia patients in a taluk (a local administrative block). Thirthahalli taluk consists of 1324 villages and a town that serves as the headquarters. The town has a population of about 14,000 and the total population of the Taluk is about 150,000. Seven primary health centres are the sources of health care for the villages of the taluk; a hospital in the town caters for the town population and is also the referral centre for the primary health centres.

Initially, community-level health workers of Thirthahalli taluk ($n = 54$) were trained to identify patients with severe mental disorders in the community. They were asked to refer all such patients to the research staff. The research staff interviewed the health workers about persons with symptoms of psychosis in households under their purview. In addition, we interviewed key-informants in the villages and used snow-balling technique (Wig et al., 1993) to identify persons with symptoms of schizophrenia. Research psychiatrists interviewed all such patients using the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to confirm the diagnosis. Under this programme, all identified patients were prescribed antipsychotics. Additionally, psycho-education covering all aspects of the illness was provided.

Since 2005, we have identified 350 patients in the CoInPsyD programme. Thirty-two patients have died following recruitment; 11 were excluded from the analysis, as their diagnosis was revised to some other psychiatric disorder; 18 had migrated, along with their families, from the region; 12 patients did not consent to participate in the study and 6 were not contactable as they had wandered away from home. Out of the remaining 271, the AUDIT could be administered in 254 (93.7%) patients. All interviewed patients were living along with their families, who could provide reliable collateral information regarding the patients' symptoms, disability and alcohol use.

2.1.2. Controls

Adults from the general population of the taluk formed the controls. All villages that come under each of the primary health centres were listed in alphabetical order. One village pertaining to each primary

health centre was selected randomly using a computer-generated random number. Similarly, all wards of the town were listed alphabetically and one ward was selected. Thus, we selected six villages and one ward. Every household in these villages and the town ward were visited and participation of all adults residing in those places was solicited. 382 persons consented for participation. Out of these, data related to alcohol use in 32 controls was lost due to inadvertent misplacement during travel from remote rural places. Hence, in this paper, data from 350 controls is presented. As was the case with patients, all controls lived with family members. Instances of inconsistency between the subjects' (both patients and controls) and their family members' report regarding substance use were very rare. In such rare cases, we considered the report provided by family members. This is because, substance abusers are known to under-report the magnitude of their substance use (Harrison, Haaga, & Richards, 1993).

The study was approved by the Ethics Committee of the National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore. Written informed consent was obtained from patients and controls.

2.2. Assessments

2.2.1. Alcohol Use Disorders Identification Test

(AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001): AUDIT was used to identify alcohol use and its related problems. AUDIT is one of the most popular measures to screen for excess drinking and measure the risk associated with alcohol problems across gender, age and cultures. This brief (10 questions) and flexible screening instrument was designed specifically for use in primary care settings. It focuses on recent alcohol use and identifies the following patterns of alcohol problems: (i) hazardous alcohol use (a drinking pattern that increases the risk of harmful consequences for the user or others) (ii) alcohol dependence and (iii) harmful alcohol use (alcohol consumption that results in consequences to physical and mental health). The AUDIT is consistent with ICD-10 version of alcohol dependence and harmful use. Total AUDIT scores ≥ 8 suggest harmful and hazardous drinking and require advice on reduction. Total score of ≥ 16 indicates severe alcohol problems. In addition, patients were assessed for psychopathology and disability as follows.

2.2.2. Psychopathology

The positive and negative syndrome scale (PANSS; Kay, Fiszbein, & Opler, 1987) was used to assess psychopathology once in six months. Psychiatrists were trained in the administration of PANSS at the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore. While rating patients on PANSS, symptoms during the past month were taken into account.

2.2.3. Disability

The Indian disability assessment and evaluation scale (IDEAS; Rehabilitation Committee of Indian Psychiatric Society, 2002) was used to assess the disability level both at baseline and once in six months. It assesses disability across four domains: self-care, interpersonal relationships, communication and understanding and work. Disability is scored from 0 to 4 for each domain (0 = no disability; 4 = profound disability) and the sum of the four item scores gives the total disability score. IDEAS had been originally developed for measuring and certifying disability for psychiatric patients in India. IDEAS has good face validity, criterion validity and internal consistency and has been used for research studies (Thara, 2005; Thirthalli et al., 2009).

3. Results

Table 1 shows comparison of socio-demographic details between patients and controls. Clinical details of patients were as follows: Mean (SD) age was 40.4 (11.7) years; they were chronically ill (mean $\pm$ SD duration of illness = 175.2 ± 112.7 months). At the time

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