



Hazardous alcohol use among patients with schizophrenia and depression



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ARTICLE INFO

Article history:

Received 5 October 2016

Received in revised form

18 July 2017

Accepted 18 July 2017

Keywords:

Hazardous alcohol use

Alcohol use disorders identification test

Asian

Depression

Schizophrenia

ABSTRACT

Aims: The current study aimed to 1) report the prevalence of hazardous alcohol use in an outpatient population among those with schizophrenia and depressive disorders, 2) assess the sociodemographic and clinical correlates of hazardous alcohol use, 3) examine the association of hazardous alcohol use with severity of depression, anxiety and smoking, and 4) assess the association of hazardous alcohol use with quality of life.

Methods: Three hundred ten outpatients seeking treatment at a tertiary psychiatric institute with a diagnosis of either schizophrenia spectrum disorder or depressive disorder were included in the study. Patients were assessed for hazardous alcohol use using the Alcohol Use Disorders Identification Test. Information on sociodemographic correlates, clinical history, severity of symptoms of depression and anxiety, as well as quality of life (QOL) was collected.

Results: The overall prevalence of hazardous alcohol use among the sample was 12.6%. The prevalence of hazardous alcohol use among patients with depression and schizophrenia was 18.8% and 6.4%, respectively. Compared to those who were students, patients who were gainfully employed or unemployed were more likely to engage in hazardous alcohol use (Odds Ratio (OR) = 5.5 and 7.7, respectively). Patients with depression compared to those with schizophrenia (OR = 11.1) and those who were current smokers compared to those who had never smoked (OR = 14.5) were more likely to engage in hazardous alcohol use. Hazardous alcohol use was associated with lower QOL in the physical health domain ($p = 0.002$).

Conclusion: Given the significant prevalence of hazardous alcohol use in this population, routine screening for hazardous alcohol use and brief interventions could be an effective way of managing this comorbidity. There is a need to develop and evaluate culturally appropriate brief interventions based on patient preference in this setting.

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Introduction

Hazardous alcohol use has been defined as a pattern of alcohol consumption that places the individual at an increased risk for acute or chronic harm (World Health Organization, 2000). Individuals who engage in hazardous alcohol use are at increased risk of alcohol dependence (Saha, Stinson, & Grant, 2007) and physical conditions such as hypertension, cardiovascular disease, and cirrhosis (Centers for Disease Control and Prevention, 2014).

The prevalence of alcohol-use disorder (AUD) is high among those with psychiatric conditions (Conway, Compton, Stinson, & Grant, 2006; Grant et al., 2004; Subramaniam et al., 2012), with comorbid AUD adversely affecting both the course and treatment outcomes of the psychiatric disorder (Schuckit, 2006; Vuorilehto, Melartin, & Isometsä, 2009). Studies have similarly found that hazardous alcohol use is common among those with mental health problems. A study from Sweden found that among patients attending a general psychiatric clinic, 28.3% of the women and 31.3% of the men had engaged in hazardous alcohol use (Nehlin, Fredriksson, & Jansson, 2012), while a study from the United Kingdom reported that 48.5% of patients consecutively admitted to

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acute general psychiatry wards had hazardous alcohol use (McCloud, Barnaby, Omu, Drummond, & Aboud, 2004). Hulse and Tait (2002) screened Australian psychiatric inpatients and found that 23% had hazardous alcohol use. Prevalence of hazardous alcohol use reported among patients in Asian countries is lower as compared to figures reported by Western studies. A study from Taiwan showed that the lifetime prevalence of hazardous alcohol use was 10.5% among those with schizophrenia and mood disorder (Huang et al., 2009), while a study from rural India found that 5.5% of patients with schizophrenia had hazardous alcohol use in the previous year.

It is important to identify psychiatric patients with hazardous alcohol use, because brief interventions could improve their overall management and outcomes (Hulse & Tait, 2003; Nehlin, Grönbladh, Fredriksson, & Jansson, 2012), as well as prevent the development of AUD in these patients (Hulse & Tait, 2002) and improve their overall quality of life.

Singapore is an island city-state in Southeast Asia, with a multi-ethnic population of about 5.6 million, 3.9 million of whom are Singapore citizens and permanent residents (Statistics, Singapore, 2016). The resident population comprises Chinese (74.3%), Malays (13.4%), Indians (9.1%), and other ethnic groups (3.2%). While population data on hazardous alcohol use is lacking, a study by Lim et al. (2013) revealed a prevalence of 12-month heavy drinking of 12.6%, and lifetime heavy drinking of 15.9% (heavy drinking was defined in this study as the consumption of 4 or more drinks in a day for women, or 5 or more drinks in a day for men) (Lim et al., 2013). A recent study by Tay et al. (2016) among non-psychiatric inpatients found that 2.8% of patients with previous year alcohol use scored above the hazardous levels for the Alcohol Use Disorders Identification Test (AUDIT). However, to date, no study has examined the prevalence and correlates of hazardous alcohol use among psychiatric patients in Singapore.

The current study aimed to 1) report the prevalence of hazardous alcohol use in an outpatient population among those with schizophrenia and depressive disorders, 2) assess the sociodemographic and clinical correlates of hazardous alcohol use, 3) examine the association of hazardous alcohol use with severity of depression, anxiety and smoking status, and 4) assess the association between hazardous alcohol use and QOL of psychiatric patients.

Methods

Setting and sample

The study was conducted among outpatients seeking treatment at a tertiary psychiatric hospital, the Institute of Mental Health (IMH), in Singapore. Inclusion criteria included English speaking proficiency, age between 18 and 40 years, and a diagnosis of either a schizophrenia spectrum disorder or depressive disorder. Patient diagnoses were corroborated through their medical records and clinician diagnosis.

The study was approved by the relevant participating institutional review boards – the National Healthcare Group Domain Specific Review Board (NHG-DSRB) and the IMH Clinical Research Committee (CRC). Trained members of the study team explained the study procedures before obtaining written informed consent from both the participants and the guardians/legally acceptable representatives of those aged 18–20 years, as the age of majority is 21 years in Singapore.

Assessments

After the participants had understood the informed consent and agreed to participate in the study, they completed a set of questionnaires lasting approximately 30–40 min. All questionnaires were self-administered and participants were informed that they could approach the researcher if either the meaning of the

questions or the instructions needed clarification. Patients were also informed during recruitment that a researcher could administer the questionnaires if they experienced any difficulty in reading English; however, all respondents chose to do the questionnaires themselves. The set included a socio-demographic questionnaire that collected data pertaining to age, gender, ethnicity, education level, marital status, employment status, and household income as well as the following questionnaires.

AUDIT

This brief screening instrument is designed specifically for use in primary care settings, although it has been used across various settings including psychiatric populations (Maisto, Carey, Carey, Gordon, & Gleason, 2000). Developed from a World Health Organization (WHO) collaborative project as a screening questionnaire for hazardous and harmful drinking, this 10-item self-report questionnaire covers the domains of alcohol consumption (items 1–3), drinking behaviors (items 4–6) and alcohol-related problems (items 7–10). Each question is scored from 0 to 4 with a maximum score of 40, where non-hazardous drinking levels are 0–5 points for women and 0–7 points for men. ‘Hazardous alcohol use’ is defined as 6–12 points for women and 8–14 points for men. Scores of 13–18 in women and 15–18 in men indicate a ‘heavy abuse’. Scores of 19 or more indicate ‘dependence’ (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001; Reinert & Allen, 2002). For the purpose of this study, cut-offs of 6 and 8 were used to identify females and males with hazardous alcohol use, respectively.

Beck's depression inventory-II (BDI-II)

The BDI-II is a 21-item self-report instrument that measures severity of depression in the 2 weeks preceding its administration. Items are related to symptoms of depression based on the criteria found in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) for depressive disorders. Responses to items are based on a scale ranging from an absence of symptoms (0) to severe symptoms (3). A total score is summed for all 21 items, with scores ranging from 0 to 63. Scores of 0–13 indicate minimal depression, 14–19 indicate mild depression, 20–28 indicate moderate depression, and 29–63 indicate severe depression (Beck, Steer, & Brown, 1996).

Beck's anxiety inventory (BAI)

The BAI is a 21-item self-report instrument that measures the severity of anxiety in the past week. Questions in the scale focus on the emotional, physiological, and cognitive symptoms of anxiety. Responses to each item range from ‘not at all’ (0) to ‘severely’ (3). A total score is summed for all 21 items with scores ranging from 0 to 63. Scores of 0–7 indicate minimal anxiety, 8–15 indicate mild anxiety, 16–25 indicate moderate anxiety, and 26–63 indicate severe anxiety (Beck, Epstein, Brown, & Steer, 1988).

WHO quality of life-BREF (WHOQOL-BREF)

This 26-item questionnaire measures QOL based on four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environment (8 items) (WHOQOL Group, 1998). Two items that ask about an individual's ‘overall perception of quality of life’ and ‘overall perception of their health’ are examined separately. The other 24 items contribute to the domain scores. Examples of questions pertaining to the various domains include (physical health) – ‘How well are you able to get around?’ and ‘How satisfied are you with your capacity for work?’, (psychological) – ‘How much do you enjoy life?’, ‘How well are you able to concentrate?’, (social relationships) – ‘How satisfied are you with your personal relationships?’, (environmental) – ‘To what extent do you have the opportunity for leisure activities?’ and ‘How

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