

Regular article

# Screening for mental disorder comorbidity in Australian alcohol and other drug residential treatment settings

Kane Saxon Mortlock, (B.A. (Dist), L.L.B. (Hons), B.Psyc. (Hons))\*,  
Frank P. Deane, (B.Sc., M.Sc., Diploma in Clinical Psychology, Ph.D.),  
Trevor Patrick Crowe, (B.Sc. (Hons), Ph.D.)

*Illawarra Institute for Mental Health and School of Psychology, University of Wollongong, NSW, 2522, Australia*

Received 17 May 2010; received in revised form 23 September 2010; accepted 6 January 2011

## Abstract

There has been much international impetus to address the importance of identifying and treating clients experiencing both a substance use disorder and a mental disorder in treatment settings. Gaps in the literature still exist after a decade of research into this area. There is little research on the prevalence of co-occurring mental disorders (CODs) in the residential alcohol and other drug (AOD) treatment modality. In this study, the mental disorder status of 278 participants resident in AOD treatment settings across Australia was estimated using the Addiction Severity Index—Self Report (J.S. Cacciola, A. Pecoraro, & A.I. Alterman, 2008) and the Mental Health Screening Form III (J.F.X. Carroll & J.J. McGinley, 2001). The estimated rate of diagnosable Axis I mental disorder comorbidity varied from 64% to 71% depending upon which cutoff score was used with the MHSF-III. Missing data emerged as a major limitation of the self-report version of the Addiction Severity Index psychiatric composite score in this population. © 2011 Elsevier Inc. All rights reserved.

*Keywords:* Comorbidity; Co-occurring disorder; Dual diagnosis; Screening; Mental disorder screening; Prevalence

## 1. Introduction

Substance use disorders and mental disorders are significant personal and societal problems. Annually, the estimated cost to society of substance-related problems worldwide is more than US\$200 billion (Fabricius, Langa, & Wilson, 2008). Mental disorders caused more than 18% of disability worldwide according to the Global Burden of Disease study conducted by the World Health Organization (Lopez & Murray, 1998). The burden of mental disorders exceeds the burden of disease caused by all cancers (Alonso et al., 2004). In Australia in 2004, mental disorders were the leading cause of the nonfatal burden of disease and

injury and third only to cancer and cardiovascular disease as the leading overall cause of the burden of (fatal and nonfatal) disease and injury (Begg et al., 2007).

A concurrent diagnosis with at least one or more mental disorders and one or more substance use disorders is necessary for a person to be said to have “co-occurring disorders” (CODs; Center for Substance Abuse Treatment, 2005). Internationally, the problem of CODs was first highlighted by clinicians in the late 1970s to early 1980s (Brunette, Mueser, & Drake, 2004). Over a 25-year period, epidemiological and service utilization data have consistently shown that mental disorders and addictions co-occur as frequently as they exist independently of one another (Davidson & White, 2007).

The prevalence of CODs among the general population is high (Kessler et al., 1996). According to the main epidemiological studies to come out of the United States, around 5 million adult Americans have CODs (Center for Substance Abuse Treatment, 2007). In Australia the estimate

\* Corresponding author. Illawarra Institute for Mental Health, Building 22, University of Wollongong, NSW, 2522, Australia. Tel.: +61 2 4221 4207; fax: +61 2 4221 5585.

E-mail address: [kanemortlock@gmail.com](mailto:kanemortlock@gmail.com) (K.S. Mortlock).

based upon the second National Survey for Mental Health and Well-being suggests the number of people in Australia who misuse drugs nearly every day is 183,900 (Australian Bureau of Statistics, 2007). Of these, almost 2 of 3 (63%) are estimated to have a 12-month mental disorder (Australian Bureau of Statistics, 2007). This is compared to an overall 12-month disorder prevalence of just 20% (Australian Bureau of Statistics, 2007).

Epidemiologically in Australia 35% of individuals with a substance use disorder had at least one co-occurring affective or anxiety disorder (Mills et al., 2009). The prevalence of COD in alcohol and other drug (AOD) “treatment-seeking” populations as a whole is even higher (Whiteford & Groves, 2009). One overview summarized the literature by suggesting that comorbid lifetime mental disorder prevalence in treatment populations is between 50% and 75% (Center for Substance Abuse Treatment, 2007). Much of the research into the prevalence of COD in “treatment” populations, however, reports on collective samples sourced from mixed-treatment modalities (for e.g., public outpatient methadone clinics, outpatient and inpatient drug-free programs, outpatient programs for drug-abusing prostitutes, and residential recovery shelters for women; see Compton et al., 2000). This approach assumes comorbidity across different treatment modalities is monolithic.

Recent research suggests this is not the case (see Ross et al., 2005). Ross et al. (2005) examined heroin users not seeking treatment and heroin users seeking treatment across three different treatment modalities (detoxification units, residential rehabilitation facilities and outpatient methadone/buprenorphine maintenance agencies). These authors found heroin users in residential treatment services had significantly greater levels of psychological distress, suicide history, Axis I and Axis II disorders (Ross et al., 2005). It was concluded that heroin users in residential treatment represented a hard core compared with those in other treatment modalities (Ross et al., 2005). Whether the same is true of residential clients with substance use disorders other than heroin is currently unknown.

Sources of prevalence rates for mental disorder comorbidity specifically in the residential AOD treatment setting are based on research conducted nearly 30 years ago (see Jainchill, 1994 for a review). This research conducted within therapeutic communities reported a lifetime COD rate of 78% and a 30-day prevalence of just 33.70% (Jainchill, 1994). Both mental health and AOD treatment environments, diagnostic systems and drugs of abuse have changed since this time. Indeed, this research used the old *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III; American Psychiatric Association, 1980)* and *DSM-III-R (American Psychiatric Association, 1987)* diagnostic nosology and screening instruments that are not the standard used in the industry today (see Jainchill, 1994). This research was also conducted before the emergence of pseudoephedrine-based amphetamines and the drug ice, as well as cannabis of far greater potency, all of which are

thought to have a role in psychosis today. Even so, Jainchill’s (1994) review identified a 10-year pattern of worsening psychiatric symptoms among those entering treatment for substance use disorders during 1974 to 1984.

Comorbidity has important consequences for the individual. Problems facing people with CODs include poorer treatment response and an inability to maintain functional stability (Grella & Stein, 2006; Ziedonis & Stern, 2001), higher rates of relapse (Swofford, Kasckow, Scheller-Gilkey, & Inderbitzin, 1996), more hospital visits (Haywood et al., 1995), increased involvement in violence (Swartz et al., 1998), family difficulties and limited social relationships, increased unemployment, victimization (Goodman, Rosenberg, Mueser, & Drake, 1997), incarceration (Abram & Teplin, 1991), homelessness (Drake, Osher, & Wallach, 1991), HIV (Adams, 2008; Brunette et al., 2004; Ziedonis & Stern, 2001), and Hepatitis C (Rosenberg et al., 2001). In 2005, in most cases in Australia where a mental or behavioral disorder was recorded as the underlying cause of death, the abuse of psychoactive substances such as alcohol and heroin was also involved (Australian Institute of Health and Welfare, 2008).

The accurate identification of comorbidity is an important first step towards improving treatment and the effective management of this population (Ziedonis et al., 2005). It has been acknowledged that clients with COD have received poor care due to gaps in service provision (Adams, 2008; Harris & Edlund, 2005). Not treating CODs “contributes to some of the most intractable and expensive social problems” (Davis et al., 2006, p. 263).

Both Australian and international guidelines advocate routine screening for CODs (Center for Substance Abuse Treatment, 2005; Dawe, Loxton, Hides, Kavanagh, & Mattick, 2002; Gordon, 2008; Hawkings & Gilbur, 2004; Mills et al., 2009; NSW Health, 2000). Yet, despite the guidelines, government initiatives, and increasing awareness of the poor outcomes associated with COD, currently clinicians often miss the co-occurrence of mental disorders and substance use disorders because of an absence of routine screening (Croton, 2007; Donald, Dower, & Kavanagh, 2005; Lubman, Hides, & Elkins, 2008). In one large 3-year study that assessed the rates of detection of CODs in an addiction treatment system, CODs were only detected in 22% of actual cases ( $N = 47,379$ ; Hu, Kline, Huang, & Ziedonis, 2006).

The dearth of contemporary data about mental disorder comorbidity in residential AOD treatment is evident in recent reviews (see, for example, Center for Substance Abuse Treatment, 2007; Mills et al., 2009). The little research that has been conducted in recent years has tended to focus on samples with specific drug-problem types, for example, research on heroin-taking populations that only investigated the co-occurrence of anxiety and depression (see Darke & Ross, 1997) and outpatient clients on methadone maintenance (see Callalay, Trauer, Munro, & Whelan, 2001). Such subpopulations linked to opioid

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات