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Differences in help seeking rates after brief intervention for alcohol use disorders in general practice patients with and without comorbid anxiety or depressive disorders

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Abstract

Aims: *To examine, if the utilization of help for problematic drinking after brief intervention (BI) differs between general practice (GP) patients with and without comorbid depression or anxiety disorders.* Methods: *Longitudinal data of 374 GP patients, who met the diagnostic criteria of alcohol dependence or abuse according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) and criteria of at-risk drinking or binge drinking, were drawn from a randomized controlled BI study. Participants were randomly allocated to either a control or one of two intervention groups, receiving a series of alcohol related BI. Of the sample, 88 participants were diagnosed with comorbid anxiety and/or depressive disorders. At 12-months follow-up, differences in utilization of formal help for drinking problems were assessed between comorbid and non-comorbid individuals.* Results: *BI were significantly related to an increase in utilization of formal help in non-comorbid patients ($\chi^2 = 4.54$; df = 1; $p < 0.05$) but not in comorbid individuals ($\chi^2 = 0.40$; df = 1; $p = 0.60$). In a logistic regression analysis, comorbidity [odds ratio (OR) = 1.81; 95% confidence interval (CI) = 1.14–2.88; $p = 0.01$) and previous help seeking (OR = 15.98; CI = 6.10–41.85; $p < 0.001$) were found to be positive predictors for utilization of formal help.* Conclusion: *BIs do not seem to significantly support help-seeking in the comorbid. As comorbid anxiety and depression constitute a positive predictor for help-seeking, individuals with problematic drinking and comorbid anxiety or depressive disorders might benefit from more specialized support exceeding the low level of BI. Copyright © 2008 John Wiley & Sons, Ltd.*

Key words: utilization of help, problematic drinking, comorbidity, anxiety, depression

Introduction

Brief interventions (BIs) have been proven to be effective methods to reduce heavy alcohol consumption (Bien et al., 1993; Moyer et al., 2002). To reach even the high proportion of individuals with problematic drinking behaviour, who do not seek help (Grant, 1997), BI may be usefully applied in primary health care settings (Bertholet et al., 2005). Aims of BI are to reduce problematic drinking and to enlarge the motivation to seek professional help where applicable.

High rates of comorbid anxiety and depression have been found in various samples of individuals with

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alcohol use disorders (Kessler et al., 1997). Comorbidity has not yet been examined as a moderator of BIs for problematic drinking. Since studies have shown a higher utilization of treatment services for comorbid individuals (Kessler et al., 1996), gaining further insight into the relationship between BI and help seeking in individuals with problematic drinking behaviour and comorbid anxiety and/or depressive disorders might enhance pro-active intervention strategies. This study aims to examine, if the utilization of help for problematic drinking after BI differs between general practice (GP) patients with and without comorbid depression or anxiety disorders.

Methods

Procedure

Within the study "Stepped Interventions for Problem Drinkers (SIP)", data were collected by trained project staff in 81 general practices in the north German city of Lübeck and its 46 surrounding communities and also in four practices in the north German city of Kiel during the period 2001 and 2003 [recruitment rate 49.4%, for details see Bischof et al. (2005)]. To minimize time for data collection within the practice, the procedure was three-fold: screening within the practice and administering telephone diagnostic assessments outside the practice. Additional data, which are not subject to this analysis, were collected via postal questionnaire.

GP patients aged 18 to 64 attending for a GP consultation were contacted in the practice waiting room and asked to fill out a screening questionnaire. Patients with a positive screening result were asked for written informed consent to participate further in the study. On average two days after screening, participants who had consented were sent a questionnaire on alcohol related problems and readiness to change variables. Two to four days after sending, participants were contacted to partake in a telephone diagnostic baseline assessment of alcohol related disorders and problematic drinking. Patients who had been in alcohol specific treatment within the last four weeks were excluded from the study. Participants meeting the criteria for alcohol dependence or abuse according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (American Psychiatric Association, 1995), at-risk drinking [defined as an average consumption of >20/30 grams of alcohol per day for women/men within the last four weeks (British Medical Association, 1995)] or binge drinking [>60/80 grams of alcohol for women/men on at least two occasions within the last four weeks (Babor et al., 1992)] were included in the final study sample and a standardized diagnostic assessment of comorbid anxiety and/or depressive disorders was administered. Additional data, including utilization of formal help for drinking problems, were collected during the assessment. On average, the baseline telephone contacts lasted 30 (range 10 to 90) minutes.

Final study participants were randomly allocated to either the control group, receiving no alcohol related intervention, or to one of two intervention groups. Intervention group 1 received a standardized amount of four 30-minutes counselling sessions based on Motivational Interviewing (MI) (Miller, 1983) and behavioural change counselling (BCC) (Rollnick et al., 1999), to enhance motivation to reduce problematic drinking. Depending upon the success of the previous BI, intervention group 2 received a maximum of three brief counselling sessions based on MI and BCC of 30 to 45 minutes each session. In case of a reduction of drinking below criteria of problematic drinking, the intervention was discontinued. Of the sample, 88 participants were diagnosed with comorbid anxiety and/or depressive disorders according to DSM-IV. At 12-months follow-up, differences in lifetime utilization of formal help for drinking problems were assessed between comorbid and non-comorbid individuals. Utilization of formal help for drinking problems was operationalized as a dichotomous variable using the following categories: alcohol-specific advice/treatment by professionals other than GP, alcohol detoxification/treatment and self-help group visits.

Participants

In total, 10,803 patients were screened (refusal rate: 5.9%), of which 2239 (20.7%) screenings were positive. Of these, 1410 patients subsequently agreed to participate further in the study (63.0%). Later, 7% of these withdrew further participation and 13.6% had to be excluded for other reasons (e.g. no telephone access). Among those individuals with whom the baseline diagnostic interview could be conducted, 664 patients (59.3%) did not meet a diagnosis of alcohol use disorders or criteria of at-risk or binge drinking. Another 47 individuals refused study participation or did not return the baseline questionnaire collecting additional data

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which is not subject of this analysis. Finally, 408 participants fulfilled the study inclusion criteria of alcohol dependence, abuse, at-risk drinking or binge drinking. Of these, 278 participants (68.1%) were male and 130 (31.9%) female. The mean age was 36.9 [standard deviation (SD) = 13.44; range 18–64 years). For 12-months follow-up, 27 participants could not be reached (6.6%), three had passed away (0.7%), and four individuals (1.0%) withdrew their further participation. Complete data sets for the analysis could thus be obtained from 374 (91.7%) participants.

Findings

Rates of utilization of formal help for drinking problems did not significantly differ between the two intervention groups and the control group ($\chi^2 = 0.06$; df = 1; $p = 0.884$). Compared to non-comorbid patients, comorbid participants were significantly more often alcohol dependent as opposed to alcohol abusers, at-risk drinkers and binge drinkers ($\chi^2 = 42.1$; df = 3; $p < 0.001$) and more often female ($\chi^2 = 17.0$; df = 1; $p < 0.001$).

Utilization of formal help, including self-help group visits, alcohol detoxification/ treatment and advice by professionals other than GP was significantly higher for comorbid than for non-comorbid individuals at baseline and follow-up ($\chi^2 = 34.01$; df = 1; $p < 0.001$ $\chi^2 = 34.67$; df = 1; $p < 0.001$). BIs were significantly related to utilization of formal help in non-comorbid patients ($\chi^2 = 4.54$; df = 1; $p < 0.05$) but not in comorbid individuals ($\chi^2 = 0.40$; df = 1; $p = 0.60$). In a logistic regression model, the predictivity of the variable comorbidity and an interaction term group comorbidity was analysed. Results show, that the interaction term was not significant for utilization of help [estimator = 0.145; 95% confidence interval (CI) = 0.019–1.126; $p = 0.065$], whereas comorbidity was (estimator = 0.196; CI = 0.092–0.416; $p < 0.001$).

As comorbid individuals were found to be more often alcohol dependent and female, the predictive value of comorbidity for utilization of help in relation to the variables classification of problematic drinking (dependence, abuse, at-risk drinking, binge drinking) and gender were assessed in a logistic regression model. Previous help seeking, group allocation (control/intervention) and adverse consequences from drinking as a measure of symptom load for alcohol use disorders were also included in the model. Only comorbidity and previous help seeking were found to be positive predictors for utilization of help (Table 1).

Conclusions

Findings show that comorbid anxiety or depressive disorders in individuals with problematic drinking positively predict utilization of help for drinking problems. However, a series of BIs significantly increased utilization of help in non-comorbid individuals but not in the comorbid. Hence, while BIs seem to be a useful method of applying low-level support to increase utilization of further help for non-comorbid individuals, they do not seem to add anything new to the process of help-seeking in the comorbid. Instead, as comorbid anxiety and depression poses a positive predictor for help-seeking,

Table 1. Logistic regression analysis to predict utilization of help for problematic drinking[1]

Independent variables	Odds ratio (OR)	95% Confidence interval (CI)
Comorbidity	0.28	0.11–0.76
Prior utilization of help	0.07	0.023–0.20
Gender (reference category: female)	0.86	0.32–2.27
Alcohol use disorders/problematic drinking (reference category: dependence)		
Binge drinking	1.16	0.233–5.75
At-risk drinking	1.67	0.43–6.51
Alcohol abuse	1.43	0.26–7.97
Group allocation (control/intervention)	0.39	0.13–1.18
Adverse consequences from drinking	1.067	0.98–1.17

[1] Test of significance: Wald statistics.

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individuals with problematic drinking and comorbid anxiety or depressive disorders might benefit from more specialized support.

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Declaration of interest statement

No conflict of interest declared.

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