Managing co-morbid alcohol misuse and high prevalence mental health problems

MANAGING ALCOHOL AND MENTAL HEALTH COMORBIDITY IN PRIMARY CARE: A NATIONAL WORKSHOP
The Hilton, Adelaide, Tuesday 23 November

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Outline

1. **Focus on alcohol, anxiety and depression**
2. **What we know**
   - **Evidence**
   - **Common sense**
3. **Wont discuss theories as to why there is co-morbidity**

"Co-morbidity" - there's a lot of it about

12% patients in General Practice settings have co-morbidity

Useful Reference

Co-morbid mental disorders and substance use disorders. Epidemiology, prevention and treatment.

Edited by Maree Teeson, Heather Proudfoot, NDARC.

Published by Commonwealth Department of Health and Ageing, 2003.

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OK Mr Spock, what can we do about this Co-Morbidity problem?

1. At first glance it appears as if we have discovered a new disease!
2. The question is, can we develop an antidote?
3. Actually, what is really needed is more like a course of thoughtful palm reading…studying the lines that connect the two disorders and trying things out.

Evidence – some generalisations

1. Cochrane review (Ley, et al, 2002)
   – No effective treatments ("SMI")
2. Most research has been of co-morbidity with psychotic illnesses and suggests that "integrated care" is best
3. High prevalence disorders are such a heterogenous group that no simplistic statements will be correct for all situations

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Evidence – some more generalisations

4. Assessment for co-morbidity is poorly done

5. Engagement is difficult

6. Outcomes less favourable

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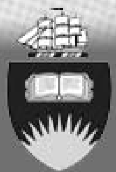
A Case



Graham

44 year old country publican who recently separated from his partner of several years and their 3yo son.

Presents with depression and suicidal ideation

What could be wrong with him?

What more do you want to know?

Does he drink alcohol to excess?

Tell me more about his depression and risk.

What about his developmental history?

Graham

<u>Alcohol</u>

- started drinking when 14 when he started working around hotels
- as his job began to involve serving customers and he became the manager, his intake increased to roughly 10 schooners each day
- in the last 12 months he was drinking 24 - 30 schooners each day
- he said that his work did not suffer as a result
- no periods of significant abstinence ("working too hard for a holiday")
- drinking roughly 6 schooners each day since moving in with his mother

Graham

<u>Depression</u>

- gradually started over the last 12 months which he relates to his father's death 2 years ago
- much worse in the last 3 months since
  - he was caught having an affair
  - he had to go bankrupt because the pub was failing
  - and he had to move to Adelaide and live with his elderly mother because of the above
- has been having suicidal ideation but no specific plans

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Graham

What are his problems?

- **Drinks too much (probably dependent) and has symptoms of depression ie he has "co-morbidity"**

Diagnostically consider:

1. **Depressed mood which could be due to**
   - **Adjustment Disorder with Depressed Mood or Major Depression,**
   - **Alcohol Induced Depression,**
   - **a Personality Disorder/Chronic Dysthymia**
2. **Alcohol dependence**

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Graham

He spoke of suicidal ideas.

Is he at risk?

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Suicide

1. suicide rates for psychiatric illness 10-15%

2. Post Mortem Studies of Suicides
   – detect illicit drugs in 15% and alcohol in 50%

3. Alcohol misuse increases risk of suicide

Graham

He is not easy to engage, unreliable and tends to expect you to perform miracles. He wants you to tell him what to do and at least during interviews creates the impression that he is earnest and will do whatever he is told.

Could he have a “personality problem”?

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Alcohol Dependence and Personality

Temperaments in childhood

- externalising
- internalising

Personality disorders

- Antisocial personality disorder (Conduct disorder) - alcohol dependent are 20 times more likely to meet criteria for an antisocial personality disorder than non-dependent
- Borderline Personality Disorder
- Obsessive Compulsive Personality Disorder
- Avoidant Personality Disorder and perhaps Dependent Personality Disorder

Graham

12 months later Graham has managed to reduce his alcohol intake to 15 schooners over 3 days.

He is taking acamprosate and not interested in stopping his alcohol totally.

He has been tried on a number of different antidepressants and none really help him very much.

He is still doing nothing other than visiting the pub and helping with his mother around the house occasionally. He enjoys the intermittent contact with his son but otherwise has no purpose in his life. He divulges that he gets quite anxious in new social situations so he avoids them.

Is it a surprise that he is still not well?

Alcohol and depression

1. Most commonly depression lifts after detoxification (males>females)
2. Treatment of depression leads to resolution of alcohol dependence in the minority of cases
3. "Mutual influence" changing with time and circumstances
4. Treatment of alcohol dependence (psychological approaches) is effective when depression present
5. Treatment of depression with antidepressants works less effectively when the patient also has alcohol dependence.
6. Better outcomes when treatment is integrated

Alcohol and anxiety disorders

1. **Evidence does not support the stress reduction hypothesis**
   - long term alcohol use actually generates anxiety
   - in 90% cases, anxiety disappears when alcohol ceases
2. **Graded exposure therapy is ineffective whilst the person is drinking**
3. **Treatment of the anxiety disorder alone in co-morbid individuals is unlikely to improve outcomes for the anxiety or alcohol dependence (cf treating depression)**

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Joe : A Youth with Early Onset Problems

Early adolescence - anxious in social settings, drinking heavily, unhappy
Aged 15 - Taken by parents to see the family GP and started on antidepressants

Aged 16 – 17

No improvement in mood or drinking. Difficult behaviour at home. Parents threw out several times. A&E presentation - kept overnight for observations. Discharged to GP care

Aged 17

Family fed up, rejected Joe. Arrange for him to see a Drug and Alcohol Doctor. Joe is suicidal and is referred to a Psychiatric unit, that with some reluctance admitted him. Joe is initially thought to have schizophrenia, which is later revised to Alcohol Dependence and Social Anxiety Disorder.

Following detoxification with minimal diazepam, his anxiety levels settle and CBT commenced. Followed up closely after discharge. Relapse prevention combined with CBT for social phobia. Progressing well.

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Medications for Psychiatric Illness in Co-Morbidity

1. **Efficacy trials of antidepressants and mood stabilisers exclude people with alcohol dependence**
   - **Relatively few studies have been conducted to test their efficacy in co-morbid individuals**
   - **this doesn't stop us prescribing in real life**

2. **Should treatments be different for people with psychiatric disorders and substance use disorders to treatment for those with only one disorder?**

Antidepressants and depressed alcoholics

1. **Mixed results generally showing they help treat depression and may have a less beneficial impact on alcohol intake**
2. **TCAs (desipramine and imipramine) reduce depression (and perhaps alcohol in the desipramine study)**
3. **SSRIs**
   - **effect depends on alcohol typology (type 1 or A do better) and sex (women respond better)**
   - **no effect if depression mild**
   - **reduce depression if moderate in inpatients**
   - **no impact on alcohol intake if dependent only (caution type II alcoholics whose drinking may be made worse)**
4. **Venlafaxine? Reboxetine? Mirtazapine?**

What helps manage patients with co-morbidity

1. Knowing the natural histories of the disorders
2. Confidence that what you are doing is correct or the best treatment available
3. Access to others' expertise

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Management of Co-morbidity in General

1. **Careful assessment establishing time line of onset of the disorders and psychiatric symptoms during periods of abstinence as well as how the two interact.**
2. **Tailored program beginning by formulating the problem with the patient**
3. **An integrated approach – constantly "trim the sails" dealing with problems concurrently but varying the focus according to progress**
4. **Many need a long term perspective**

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Thank you