COMORBIDITY GUIDELINES

Depression and alcohol or other drug use: what clinicians need to know

Webinar attendee questions with answers from Dr Vicki Giannopoulos

Question: Do assessments have impact in service accessibility via public health service referrals related time frame delays?

A formal mental health assessment and/or diagnosis of depression may speed up access to treatment. Traditional siloed approaches to treating comorbid depression and AOD use have often resulted in patients being passed back and forth from AOD to mental health services. Using an integrated approach the first clinician to see the patient is responsible for screening and arranging/proving a formal mental health assessment to check for depression. This same clinician should also treat or refer the patient on for specialist comorbidity care to prevent patients falling through the cracks. Public health services have adopted a "no wrong door" approach to assessing and treating comorbidity to ensure patients receive comprehensive care in a timely manner.

Question: Relationship between Chronic pain/AOD/Depression?

Chronic pain is a common condition in patients with comorbid depression and AOD use. Having chronic pain in addition to depression and AOD use can lead to a worse prognosis overall for all 3 conditions. At assessment it is important to conduct a functional analysis and examine in detail the relationship between Pain and the patients' AOD use and depression- how does pain make the depression better/worse? How does pain make their AOD use worse/better? Its also important to assess the patient's readiness to work on their pain management problem – do they need help with this now or maybe in future? Can they see a link between pain and their comorbidity? Look out for irrational thoughts/beliefs about their ability to manage their pain with and without AOD and their own perceived outlook on their pain condition (are they overly pessimistic about their future). Look out for dysfunctional thoughts such as "drugs are the only way to block out my pain, without them life would be unbearable". Are they feeling overly hopeless about their pain? This group are at heightened suicide risk so need to be aware of this. Also, when encouraging activity scheduling clinicians need to consider the patient's physical or pain issues and tailor pleasant activities accordingly.

Funded by
Australian Government
Department of Health and Aged Care

Delivered by
THE UNIVERSITY OF SYDNEY
Matilda Centre

Question: What are your opinions about shifting a young person's drinking to solely using cannabis that they are already using? Sobriety is not an option at this time.

Working with young people can be challenging especially if their goals are not necessarily "safe" for people their age- often a harm minimisation approach needs to be adopted as opposed to total abstinence. This population is tricky as they drop out of treatment frequently, are often not compliant with treatment and difficult to engage. Motivational interviewing has been found to be the most effective treatment approach with this population as is working on whatever the young person's specific goal is for each substance being used. Furthermore, their AOD goals are likely to change frequently so checking their goals weekly (at every appointment) and being flexible. Also having the young person choose their goals is important (they are more likely to succeed if they select their AOD goal rather than the clinician and are more likely to stay in treatment if they select their treatment goal).