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

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Key learning outcomes:

This webinar will provide attendees with a practical understanding of:

- How to identify comorbid depression in patients with substance use disorder
- The current evidence-based practise for treating comorbid depression and substance use disorders
- Practical treatment strategies for comorbid depression and substance use disorders
- The key challenges associated with treating comorbid depression and substance use disorders

Prevalence

1 in 3 individuals with AOD have a comorbid major depressive disorder (Carey, 2019).

Depression increases the risk of relapse after withdrawal (Goesling et al., 2015; Sullivan, 2016; Feingold et al., 2018).

A review of 23 studies found a consistent impact of depression on the severity of alcohol abuse (Arnaud et al., 2022)

The severity and duration of depressive symptoms are greater if people with depression have AOD use (Scherrer et al., 2016a,b).

Why is this comorbidity important clinically?

- Worse outcomes
- Don’t respond well to standard treatment
- Treatment drop-out

Models explaining comorbidity:

self-medication

chronic AOD use lowers mood (neurotransmitters).

How to identify comorbid depression

Screeners- *"In the past month, have you lost interest or pleasure in things you usually like to do?", "Have you felt sad, low, down, depressed or hopeless?"*

Assessment tools e.g. DASS21, BDI, Hamilton Rating Scale for Depression, Patient Health Questionnaire-9 , K-10, Hospital Anxiety & Depression Scale

Structured clinical interviews e.g. SCID, CIDI

Symptom overlap with AOD use/withdrawal

Types of depressive disorders

- DSM5 **Depression** – sad, empty or irritable mood, somatic and cognitive changes that significantly affect the person's capacity to function

- DSM-5 **Substance Induced Depressive Disorder** AOD related etiologically to the mood disturbance . Can be due to active AOD use, intoxication or withdrawals e.g. AOD withdrawal from ice, alcohol.

- Which one ? 1 month AOD cessation

Current evidence-based practise

- The 2 disorders are highly prevalent but few studies!!
- **Integrated not siloed approach**
- Cochrane Review 2019 – 7 studies N=608, poor quality studies (no controls or pharmacotherapy combined trials, lengthy treatments)
- Clients receiving integrated depression and AOD treatment with the greatest change in depressive symptoms also had the greatest change in frequency of AOD use across time. Worley et al (2012)

Improvements in one lead to improvements in the other disorder

Starting Integrated Treatment

- Motivational Interviewing
- Assess readiness to change AOD & depression separately
- Goal setting- SMART goals
- Psychoeducation- link between AOD use and depression
- Additions : groups, e-health & pharmacotherapy

Motivation to change

- May differ for changing depression to changing AOD use
- Assess each one *separately*
- Readiness Ruler
- Specific Scales e.g. Readiness to Change Questionnaire- cannabis revision

Thinking About Change

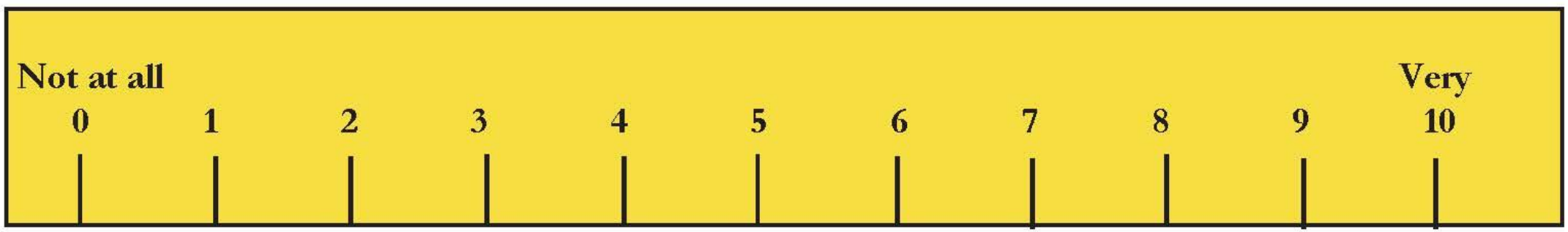
What change(s) are you considering?

How important is it that you make this change?

How confident are you that you are able to make this change?

How ready are you to make this change?

Readiness Ruler



Assessing Readiness to Change

- I don’t think I have a *D&A/mood* problem
- I may have a *D&A/mood* problem but don’t want to do anything about it right now
- I have a *D&A/mood* problem but I'm not ready to do something about it right now
- I have a *D&A/mood* problem and am ready to do something about it right now

AOD treatment strategies

- Identifying high risk situations
- Problem solving for high-risk situations
- AOD refusal skills
- Craving management
- Identifying and challenging irrational beliefs about AOD use
- Lapse versus relapse
- Relapse prevention plan

Identifying AOD high risk situations

- Self-monitoring- quantity and frequency
- Timeline follow back
- Self-efficacy scales
- People
- Places
- Moods- low & high

Problem solving for AOD high-risk situations

- Identify high risk situation
- Brainstorm all possible solutions
- Pros and Cons of each solution
- Pick 1 or 2
- Detailed action plan
- Review how it went

**Clients may need help with above steps

AOD refusal skills

- Assertiveness training- ROLE PLAY
- Eye contact
- Short responses “No thanks”
- Don’t hesitate
- Repeat yourself if need be
- Suggest alternative to AOD
- Don’t be vague or give excuses
- Leave if all else fails

Craving management

- Education about cravings
- Triggers – people , places, things, day/time, mood
- Irrational beliefs about cravings
- <u>3 D's:</u>

  Delay

  Distract

  Decide

Behavioural Activation

Lifts mood and reduces AOD use by:

1. Improving structure and setting priorities
2. Helping with decision making
3. Increasing activity occurring
4. Increasing sense of control

Mood Monitoring

- Rationale- evidence of change
- Helps identify link between mood & AOD use
- Journal
- Chart
- Apps
- Online program
- Client preference, convenience, personalised

Cognitive Therapy

Negative cognitive triad of depression (Beck) – self, world, future

Identifying and questioning negative automatic thoughts

What is evidence?

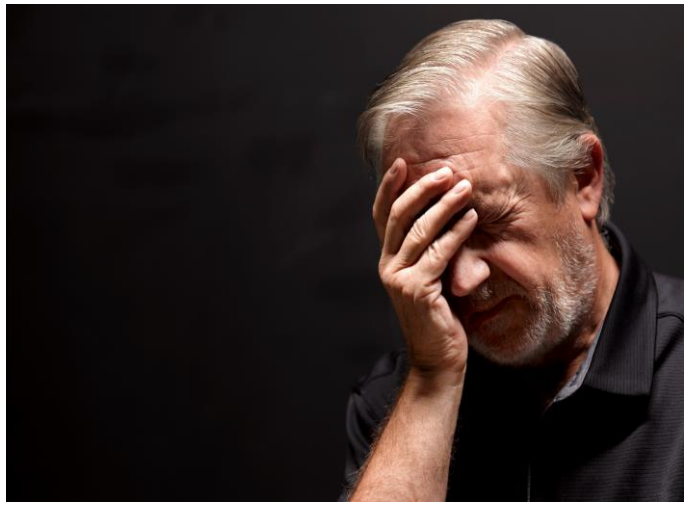
What are alternative views?

What are advantages and disadvantages of this way of thinking?

What are my thinking biases?

Beliefs about AOD use

- AOD use helps my depression/low mood
- AOD is the only way to manage my depression
- AOD use is the only way to feel happy
- AOD use is the only way to manage my pain
- Life is boring without AOD
- I need AOD to function
- I don’t have the willpower to stop



AOD & Depression Relapse prevention plan

- Lapse versus relapse
- Lapses are normal
- Formal plan for AOD relapse AND depression relapse
- Early warning signs
- Identify first signs of lapse/relapse
- Who client can ask for help – list options, contact numbers

Key Clinical Challenges

- Treatment noncompliance & Treatment drop-out
- Motivation to change
- Suicide risk increased
- Helplessness and hopelessness
- Other comorbidities
- Complex psychosocial problems

Treatment Noncompliance & Drop-out

- Remove access barriers
- Assess goals weekly- expect them to change
- Assess satisfaction with treatment regularly e.g. Miller's session rating scale
- Enhance therapeutic alliance
- Make treatment regime less complex
- Drop in motivation to change?
- Therapist compassion fatigue

Substance Use Increases Suicide Risk

- 1 in 5 completed suicide had an alcohol use disorder (Kolves et al., 2017)
- When alcohol is consumed in the minutes or hours before the attempt, suicide attempts are more likely to become suicides.
- 70% of suicide cases contain a positive blood alcohol concentration (BAC) at time of death (Cherpital et al., 2004)
- Alcohol intoxication is linked with more lethal attempts (Park et al., 2017)
- THC lowered risk of suicide in D&A users (Hesse et al., 2020)

Why Increased Suicide Risk?

- Impulsive behaviour due to AOD use
- Disinhibition due to AOD use
- Despair/ hopelessness

Managing Suicide Risk

- Assess risk regularly (even if low risk at assessment)
- Past attempts, protective factors, plans, thoughts, means
- Intoxication risk factor for suicide – more lethal attempts
- Assess role of AOD in suicidality
- Safety plan

Helplessness and hopelessness

- Prevents progress & hinders participation in treatment
- Pessimism about treatment working?

- Enhance self-efficacy
- Convey optimism
- Identify past achievements/successes

Multimorbidity Management

Identify all comorbidities- mental and health

Anxiety most common- panic disorder, OCD & PTSD

Health- hypertension, metabolic disorders, obesity, sleep disorders, pain etc..

Assess and treat (or refer on for treatment)

Continuous monitoring of comorbidities

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