General Practice Liaison Officer Program presents

Connecting The Dots

Navigating Mental Health in Primary Care

Alcohol & depression in primary care

A/Prof Mark Daglish | *Clinical Director, Alcohol & Drug Service, Metro North Mental Health*

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Connecting the Dots: Alcohol and Depression in Primary Care

Assoc Prof Mark Daglish

Clinical Director

Metro North Mental Health – Alcohol & Drug Service

Metro North Health acknowledges the Traditional Custodians of the land upon which we live, work and walk, and pay our respects to Elders past and present.

Metro North Health | Queensland Government

A familiar story…

Milo: 43 yr old man

- Presents intoxicated, with suicidal ideation & plan to drive his car off the road
- Always “liked a drink”, mainly with workmates
- Separated from partner 6 months ago – “drinking was part of it”
- Started to feel worse, so drank more then lost his job.
- Low mood, worsening for many months, low energy, poor sleep, “spiralling”
- “Drinking is the only thing that makes me feel better”. “Can’t sleep without a drink”.

Standard Drinks:

How well would we do?

1 Stubbie of full strength beer

- 375ml 5% = 1.5 std drinks

1 Slab of mid beer

- 24*375ml 3.5% = 25 std drinks

Bottle of wine

- 750ml 13% = 8 std drinks

1 Cask wine

- 4L 12% = 38 std drinks

Bottle of spirits

- 700ml 37.5% = 21 std drinks

Bar measure spirits

- 30 ml, 37.5% = 1 std drink

Bottle of RTD

- 340ml 5.5% = 1.5 std drinks

1 Schooner of beer

- ??

What is a standard drink?

Australian Government
National Health and Medical Research Council

LIGHT BEER
425 ml | 2.7% alc/vol

MID STRENGTH BEER
375 ml | 3.5% alc/vol

FULL STRENGTH BEER
285 ml | 4.9% alc/vol

REGULAR CIDER
285 ml | 4.9% alc/vol

SPARKLING WINE
100 ml | 13% alc/vol

WINE
100 ml | 13% alc/vol

FORTIFIED WINE
(e.g. sherry, port)
60 ml | 20% alc/vol

SPIRITS
(e.g. vodka, gin, rum, whiskey)
30 ml | 40% alc/vol

The standard drink is defined in the Australia and New Zealand Food Standards Code.

NHMRC

www.nhmrc.gov.au/alcohol

BUILDING A HEALTHY AUSTRALIA

Screening for Alcohol & Depression

- K-10 (Kessler)
- PHQ-9 (Patient Health Questionnaire)
- BDI (Beck Depression Inventory)
- DASS (Depression Anxiety Stress Scale) 21 or 42
- CSSRS-S (Columbia Suicide Severity Rating Scale – Screen)

- AUDIT-C
- AUDIT
- CAGE
- ASSIST

IRIS - Indigenous Risk Impact Screen
https://insight.qld.edu.au/shop/2023-iris-screening-instrument-and-risk-card

AUDIT-C / AUDIT (WHO)

1. **How often do you have a drink containing alcohol?**

   (0) Never (1) Monthly or less (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. **How many units of alcohol do you drink on a typical day when you are drinking?**

   (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more

3. **How often do you have six or more units of alcohol on one occasion?**

   (0) Never (1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never (1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never (1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never (1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never (1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never(1) less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No (2) Yes but not in the last year (4) Yes, during the last year

Interpretation of the AUDIT

AUDIT Score	
0	Abstainer
1-7	Non-hazardous "low risk" drinking
8-12	Hazardous or harmful alcohol use
13+	Alcohol dependence

AUDIT-C	
< 3	"Normal"
≥ 3	Screen further

Group	Depression	Anxiety	Dep &/or Anx
Tea-total	3.7%	3.9%	6.5%
Ex-drinker	8.1%	5.9%	12%
Current, non-dependent drinker	6.8%	4.8%	9.6%
Alcohol dependent	14%	13%	21%
Dependent use of:	**(AOR)**	**(AOR)**	**(AOR)**
Cigarettes	2.2 (1.9-2.6)	2.2 (1.8-2.5)	2.2 (1.9–2.4)
Alcohol	2.0 (1.6-2.5)	2.7 (2.2-3.3)	2.3 (2.0–2.7)
Illicit	2.8 (2.2-3.6)	2.8 (2.2-3.7)	2.9 (2.3–3.5)

Alcohol & Mood Disorder Prevalence

Kandel et al 2001

Suicide & Substance Use Disorders

Multi-national review of studies on substance use and suicide

Alcohol use disorders

SMR 979 (95%CI: 898 – 1065)

- Males – SMR 483 (95%CI:444–524)
- Females - SMR 1690 (95%CI:1246–2241)

Heavy Alcohol Use

SMR 351 (95%CI: 251 - 478)

- Males – SMR 39 (95%CI:5-140)

Opioid use disorders

SMR 1351 (95%CI: 1047 – 1715)

- Males – SMR 756 (95%CI:440–1210)
- Females - SMR 357 (95%CI:9–1990) – only 1 suicide

Wilcox et al 2004 doi:10.1016/j.drugalcdep.2004.08.003

“True” Dual-Diagnosis

Major Depressive Disorder & Alcohol Dependence

(No clear criteria for substance-induced mood disorders in ICD-10 or DSM-III-R)

DSM-IV, ICD-10-CM & ICD-11

- Depressive symptoms pre-dating alcohol problem
- Episodes of depression
  - during abstinence (even 1 week)
  - before onset of alcohol problem
- Strong family history of mood disorders
  - with/out substance disorders?

DSM-5 Substance - Induced Mental Disorders

A. The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder

B. There is evidence from the history, physical examination, or laboratory findings of *both* of the following:
   1. The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
   2. The involved substance / medication is capable of producing the mental disorder.

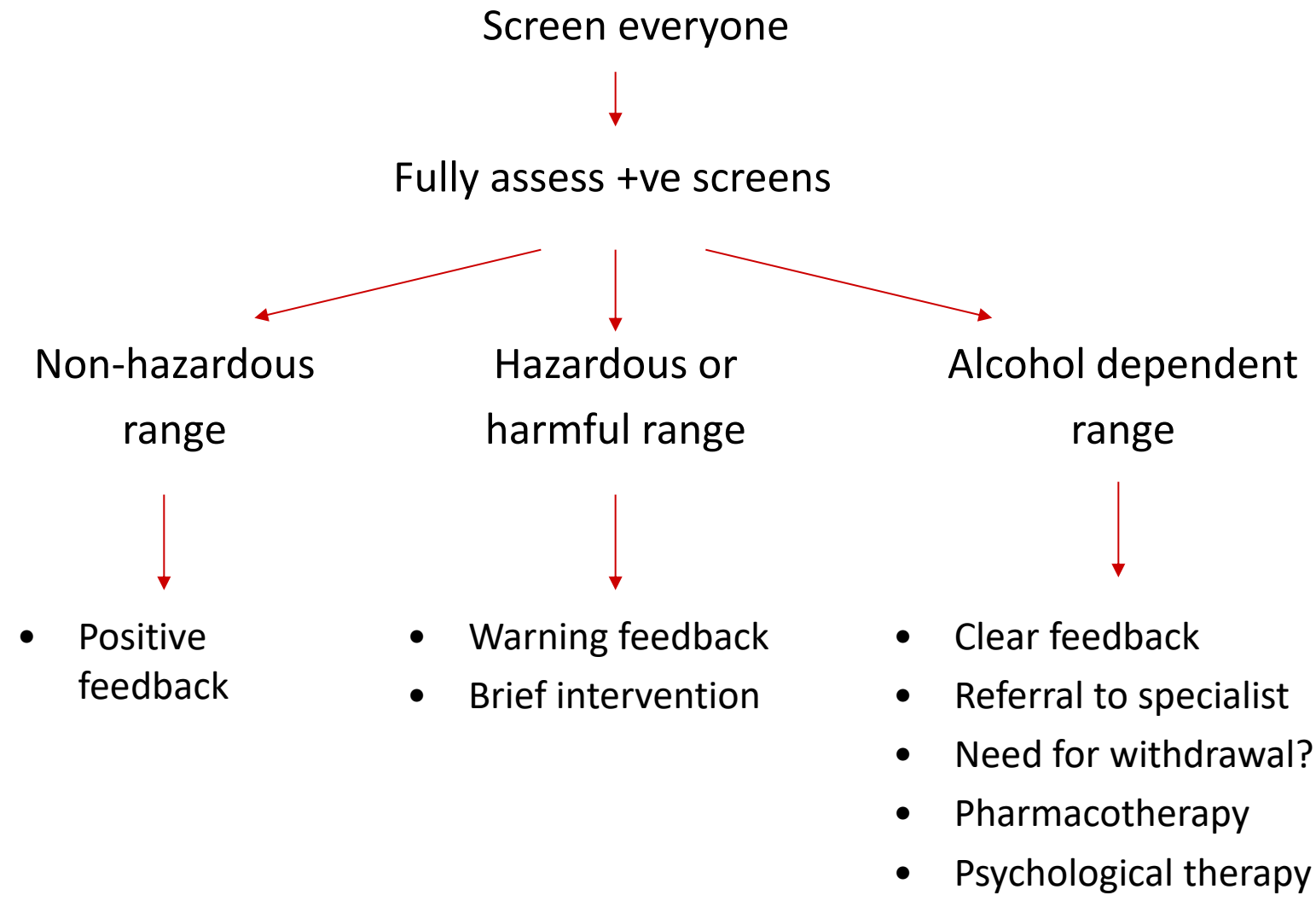
C. The disorder is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-induced). Such evidence of an independent mental disorder could include the following:
   1. The disorder preceded the onset of severe intoxication or withdrawal episode or exposure to the medication; or
   2. The full mental disorder persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication. This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persists beyond the cessation of acute intoxication or withdrawal.

D. The disorder does not occur exclusively during the course of a delirium.

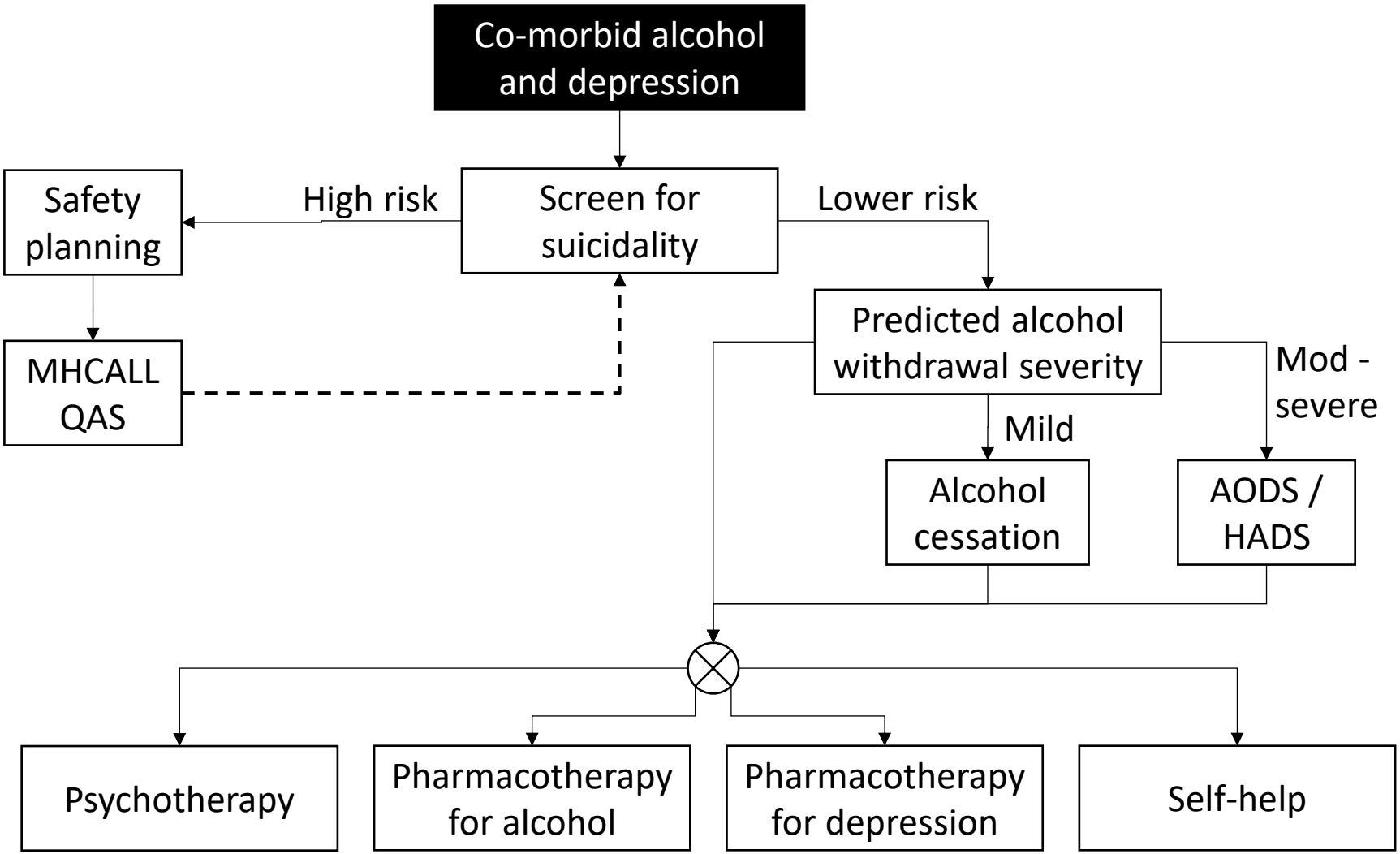
E. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Equivalents are not in ICD-10, but are in ICD-10-CM and ICD-11

Alcohol Decision Tree



Possible Decision Tree



Alcohol Withdrawal Early Symptoms

< 12 hours

TREMOR

SWEATING

NAUSEA

ANOREXIA / REDUCED APPETITE

INSOMNIA

MUSCLE CRAMPS

MOOD DISTURBANCE - ANXIETY, DEPRESSIVE, FEARFUL

PERCEPTUAL DISTURBANCES E.G. HALLUCINATIONS

Alcohol Withdrawal treatment

- Use a withdrawal scale
- Enough diazepam
  (oxazepam if compromised liver)
  - Example reducing regime
    - 10mg qid + PRN on day 1
    - reducing to zero over 5-7 days
- Plenty of thiamine
  - ≥ 100mg tds oral
  - Add some magnesium
- Bloods
  - ELFTs, Mg, FBC
  - Coag & BBV (if worried about liver)
  - Phosphate & vitamins (malnutrition screen)

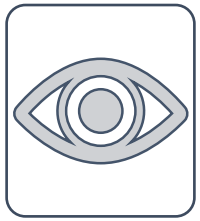
Problems with withdrawal

- (Untreated) Alcohol withdrawal is dangerous
- Detox ≠ cure
- Relapse feels like failure
- Repeated cycles of withdrawal & relapse may be more damaging to the brain than continued drinking
- Rehab is set up for addiction rehab not mental health rehab
- Many AOD rehabs are high EE environments

The 4 key ingredients in Recovery

Vaillant 2003

Finding a non-pharmacological substitute



Compulsory supervision

New relationships

Involvement in spiritual programs

Depression & Alcohol Psychosocial Treatment

- Limited evidence
- Some form of concurrent treatment seems to be better than single-focused depression treatment
- “Parallel” or “integrated” seem to be equivalent
- Most trials show an effect simply from being in a trial and getting follow-up
- Exercise seems to help both

What about AA?

- 1 yr abstinence 25-50%

- Vaillant (1983) reported 100 patients with alcohol dependence and AA 10 yr follow up:
  - 29% achieved 3 yrs abstinence
  - 24% drank intermittently
  - 49% continued high alcohol intake

Tel: 1300 222 222 or https://aa.org.au

SMART Recovery

- Self-Management And Recovery Training
- Group self-help / mutual aid model
- Trained/peer facilitators
- Based on CBT principles

- https://smartrecoveryaustralia.com.au

SMART Recovery Australia

Residential Rehab

- Multiple different treatment models
  - 12-step / MMM
  - TC
  - Religious
  - Lived experience
  - Evidence-informed programmes
- Multiple different service models
  - Payment models
  - Staffing models
  - Withdrawal, short-stay, long-stay, half-way house, step-down
- Multiple different governance models
- Multiple different outcomes

Community Rehab ("Dayhab")

- Multiple different treatment models
  - Levels of intensity
  - Variable components
- Multiple different outcomes
- An option for people who can't do residential rehab
  - Need for community treatment for something else
  - Got pets
  - Got a tenancy / house
  - Got court


Pharmacotherapy

Pharmacological Treatments

- (Comorbid treatments- eg. anti-depressant, mood stabiliser)
- Antabuse (Disulfiram)- effectiveness limited by non-compliance
- Naltrexone- effective, particularly when combined with CBT (or other targeted intervention)
- Acamprosate- effective, particularly when combined with CBT (or other targeted intervention)

Acamprosate and naltrexone both work

Original Investigation

Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings

A Systematic Review and Meta-analysis

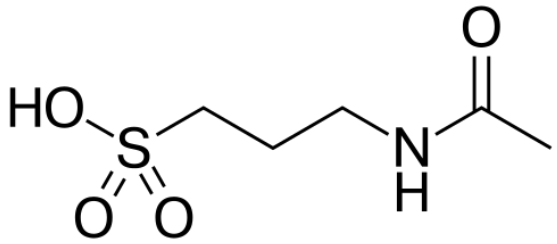
Daniel E. Jonas, MD, MPH; Halle R. Amick, MSPH; Cynthia Feltner, MD, MPH; Georgiy Bobashev, PhD; Kathleen Thomas, PhD; Roberta Wines, MPH; Mimi M. Kim, PhD; Ellen Shanahan, MA; C. Elizabeth Gass, MPH; Cassandra J. Rowe, BA; James C. Garbutt, MD

NNT acamprosate -> any drinking 12

NNT naltrexone -> heavy drinking 12

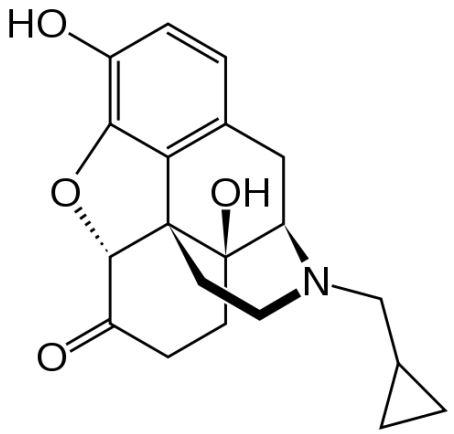
JAMA May 2014

Acamprosate



- Taurine derivative
- Facilitates GABAergic inhibitory neurotransmission
- Antagonist at excitatory NMDA Glutamate receptor
- 6 tablets x 333 mg daily if > 60kg (<60kg 666mg bd)
- Increases abstinence rates by ~ double
- Lengthens time to first drink
- S/E : GI disturbance
- C/I : Severe liver damage
- ?? ‘Anti-craving’
- ? More efficacious in ‘anxious’ people

Naltrexone



- Opiate antagonist (μ,κ, δ)
- Blocks the reinforcing effects of alcohol mediated by beta-endorphin
- Reduces relapse rate post ‘slip’
- Reduces craving / cue exposure related relapse
- 50mg o.d.

- Reduces relapse rate
  - >5 days drinking/week
  - >5 drinks/occasion
- Compliance
- C/I : Check liver function

Cochrane Review:

antidepressants for comorbid depression and alcohol use disorder
2018

33 studies -> 24 included in meta-analysis

Low quality evidence

May benefit depression

May benefit drinking outcomes

All benefits disappear if studies with high risk of bias are removed.

Low quality evidence of lack of adverse effects.

Take Home Messages

- Alcohol problems & depression are both common
- They are twice as likely to occur together
- Alcohol is a common cause of treatment resistance in depression
- Low mood undermines recovery from alcohol dependence
- Arguing about which came first is a great way to avoid progress
- Anti-depressants have little, if any, effect on drinking, even in “depressed alcoholics”
  - They may not even have any effect on depression in this group
- Treating both together can provide a way forward – but this is seldom studied.

Phone advice & information

ADCAS

1800 290 928

- Alcohol and Drug Clinical Advisory Service for health professionals
- 8.00am-11.00pm, 7 days a week
- Addiction Specialist advice – FAChAM or FRANZCP

adis

1800 177 833

- 24 hour advice line for patients, carers, family
- Brief counselling support
- Local treatment services
- Direct referrals into treatment

adis.health.qld.gov.au