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CEI DUH ECHO: MEDICATION MANAGEMENT OF DEPRESSION AND ANXIETY WITH PATIENTS WITH SUBSTANCE USE DISORDER

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[video transcript]

00:00
I think this topic is really hard to have a traditional didactic for, because there's so little that we really know about in terms of like evidence base. There's just like so many different possibilities of patients that we see. So I hope to give you some helpful information and it'd be also great to know what interests people as we go through these slides. I have no disclosures.

00:35
So these are our learning objectives. So co-occurring psychiatric disorders and substance use disorders are very common. Individuals who present with substance use disorders often have untreated psychiatric disorders, which can hinder their care and increase morbidity and mortality. And then I want to get into a discussion about what we really consider when we're thinking about how to treat these patients. And we'll talk a little bit about the medications involved.

01:04
So what do we mean by dual diagnosis? So dual diagnosis really refers to the co-occurrence of any substance use disorder and any psychiatric disorder. So on the left of the screen, I just listed some of the more common psychiatric disorders. Obviously, this list is not an exhaustive list. This is like the tip of the iceberg. But these are some of the more common things we see, right? Like depression, social anxiety disorder, panic, generalized anxiety, schizophrenia, antisocial, borderline, ADHD, PTSD. And then I put a few of the common substance use disorders we have on the right, so like alcohol, caffeine, cannabis, hallucinogens, list goes on. So the first thing I want you guys to think about when you think of dual diagnosis is think about how many possibilities, right? We're combining, when we look at something from the left and something from the right. Also consider that in the real world, people don't only have like one of each of these diagnoses, people tend to use multiple substances, or they tend to have more than one psychiatric disorder. So there's really as many combinations of these things as people who walk into your door, there's no real like typical patient.

02:22
So why does this matter? So studies have found that when compared to the general population, those with a psychiatric disorder are more likely to have a substance use disorder. And those with a substance use disorder are more likely to have a psychiatric disorder. So basically, put another way, these things occur together more than chance alone would have them occur. So they actually tend to coexist. It's not just someone gets one by chance and another by chance. So this is a lifetime prevalence and odds ratio of substance use disorder comorbidity, in terms of some specific psychiatric disorders. And you can see, I don't know, can you guys see my mouse? Yeah? Okay. The rates are really high, right? They range from 23 to 84% for specific diagnoses. So people with an anxiety disorder, 23% of them are going to have a substance use disorder or dependence. Also, in this paper, it's not in this graph, but 37% of cases who have alcohol use disorder are going to have another mental health disorder. So that means if you, in

your practice, come across three people who have alcohol use disorder, one of them is going to also have a problem with a mental health issue. So these are really high rates, even if you think you're not treating these patients, you are.

03:48
This is a like more snapshot prevalence. So this other graph was like a lifetime prevalence. So this is from the National Survey on Drug Use and Health from 2019. This is like a snapshot in time. In 2018, there were 19.3 million people who had a substance use disorder over the age of 18. 51.5 million who had a mental illness. And this is this group that we're talking about today. 9.5 million, who had both a substance use disorder and a mental illness.

04:18
So why do these things co exist? We obviously don't know, but we have a lot of theories, and probably it's multifactorial. So we know the two conditions definitely have common risk factors. So think about things underlying, like genetic or epigenetic or biologic vulnerability, think about exposure to trauma and stress. And we know that both conditions are affected by shared psychological influences. So think about things like tendency towards like self medication, altered coping skills, levels of distress tolerance. And we also know that just biologically, they share underlying neural circuitry. So things like alterations in the mesolimbic reward pathway, alterations in prefrontal cortex functioning, you know all these things are involved in both conditions. Really complicated, which I'm sure that you guys have seen this in different ways, as they interact at different levels and in complex ways throughout the illness course. So I just like, from the top of my head, put some examples. So, example, depression may keep someone from pursuing care for a substance use disorder. I feel like probably, many people here have seen that. Self medicating with substances may keep someone from pursuing mental health care. And then think about it on a systems level, a lot of treatment options are actually limited due to exclusions of people with mental health issues or substance use issues. And this isn't even true for like clinical practice, this is true for research as well. How many studies do we see exclude people who have major mental illness or exclude people who have a substance use disorder? So that's part of the reason why there aren't even that many studies in this population.

06:08
Raising the stakes even more. So there's this question of is this dual diagnosis, or is this multimorbid? Because when you consider this group of patients, they also tend to have a much higher medical burden with higher rates of things like obesity, diabetes, cardiovascular disease, chronic respiratory illness, HIV, Hep C, STDs, suicide, and trauma. On the flip side, think of this as an opportunity, because maybe these are the reasons why people are entering medical care. So it's good to know how to identify these things and sort of know a jumping off point, if there are things that we can do to help.

06:52
Alright, so we're gonna start getting into the cases that I have created. So I'd like one takeaway to not to be afraid to approach patients who are dealing with both of these issues, because it can seem very overwhelming and chaotic. But if you stick to the basics, I think that that can be really helpful. So I think like I said, there's no helpful algorithm in this talk. But I think we can

identify some pearls and guidelines just to sort of like, center ourselves when things can seem so chaotic. So this is the first case I came up with and start paying attention because I'm gonna be asking for feedback. Angelica, do you mind if you read the case because like, half of my screen is a little bit cut off? I don't know how to like change.

07:46
Okay. Absolutely. So EJ is a 65 year old woman with a history of OA, chronic back pain, and diabetes, presenting with increasing use of alcohol in the setting of COVID restrictions. She reports that since she is now home all day, her drinking has been creeping up. She is now using about one to two bottles of wine per night. She has tried to cut down on this but has struggled to do so. She's spending more money than she would like to on alcohol. Recently, this has been a source of friction with her son whom she lives with. When she tries to stop drinking, she feels anxiety. She has also noticed that she's starting to feel tearful much more often than usual, and that she has a lot of irritability. She feels very guilty about her increased drinking and is having trouble sleeping.

08:42
Thank you. Sorry to put you on the spot.

08:44
No, you're good.

08:49
Okay, so I made this one a little bit obvious. So what are our initial diagnostic thoughts? If we have our top thing, like what's our can't miss, most obvious diagnosis? Somebody humor me and tell me what you think it is? Anybody?

09:12
Substance abuse, alcohol?

09:14
Yeah, that's exactly right.

09:18
I have some also responses here in the chat. Anxiety disorder, depression, alcohol use disorder, and anxiety and insomnia.

09:27
Perfect. All right. So to remind people, I put alcohol use disorder as the thing we're sort of like going to tackle first. Just to remind people, the actual DSM criteria of alcohol use disorder because I know sometimes we even lose sight of like, how do we diagnose that? I put in red, all the ones that I sort of thought she would have endorsed, and that is six or more. So she has a severe alcohol use disorder. And if we want to read them, so she's using longer and larger than she intended, she can't cut back, she's having some difficulty managing her social responsibility, she is continuing to use despite not wanting to, she's using even though she has negative

consequences, and she has perhaps some tolerance and withdrawal. So then other diagnoses to consider I heard you guys, you're thinking exactly right. You said anxiety, the depression, and insomnia.

10:29
So let's go down that track. Can you read it again? It just like the top of the screen is like gone!

10:35
Of course, no, no worries. You asked EJ if she's been feeling more depressed lately. She reports that she is very irritable and tearful, she lies awake at night with a lot of racing thoughts. This is a trigger to drink. She has a hard time clarifying her sleep schedule. It's been hard to focus on tasks and she feels she's been more forgetful lately. She's feeling down that she's unable to see her grandchildren, who normally give her a lot of pleasure. She's less interested in doing the things that normally give her pleasure.

11:10
All right, thank you. So we are aware of the PHQ-9, which is a simple, easy screen that you can give to anyone in your office, which screens for depression. So we give her the PHQ-9, she has 16. So that falls into the category of moderately severe, which is consider pharmacologic treatment. Alright, so we're pretty sure she has alcohol use disorder. So what do we do about this mood component? So I think the first thing we want to think about is, is this a substance induced mood disorder, or an independent depressive disorder? This is sort of like our first junction in thinking about this case. So we're going to go into why this matters and how we start to think, how do we determine which is which?

12:01
Dr. Schwartz, we have a comment with a question in the chat. That's due to tolerance buildup, isn't it? Not sure if they're referring to the anxiety or the two bottles?

12:17
I am not sure either. If we're saying is her mood related to the tolerance build up? Let's get let's keep going a little and if that person still has that question, then we'll get back to it. Maybe they can clarify what they mean. So first of all, this is a very challenging situation, because these things, as we just spent the first like five minutes talking about, interact with each other and have a lot of overlap. Easiest way to do it is think about the timing. So gonna dig a little bit deeper, are symptoms present before or during abstinence from, or like significant reduction in the substance use? Has there been a prior episode that is better explained by an alternate diagnosis? Sometimes collateral information can be really helpful, although I know, we always don't have time to do it, it can be really helpful in untangling the two. So I said there's no algorithm, but this is a helpful picture. So this is a timeline of the relationship between substance use, substance induced mood disorders, and more primary disorders. So up in this gray, this is sort of an oversimplified period of substance use. So during the substance use period, there's going to be symptoms from intoxication and withdrawal, right? Like that's going to be happening on its own time course. If the patient can have a period, so if they can stop using or significantly reduce using, there's going to be this period of withdrawal, which is going to come with its own

symptoms. A lot of times symptoms like anxiety. And then if they can get through this month, where'd my mouse go? So here is this month period. If symptoms are really lasting past a month, we're going to start to think of this as its own separate thing. Probably its own primary mood disorder. Pretty amazingly, substance to substance, if the mood issues get better in that first month, then it's likely substance induced depression or anxiety, or psychosis, or what have you. And then this line underneath it is just showing, did it start beforehand? Then obviously, it's probably going to be its own thing as well. And of course, this is like an oversimplified picture, things like if someone's been drinking heavily and are now in a period of not drinking, there's going to be mood symptoms that lasts for like six months. But even in that case, there's going to be a change in that first month. Usually.

15:04
Sure, would you like me to read it?

15:06
Yeah. Is that okay?

15:07
Sure. So EJ feels that the depression started before the time her drinking picked up. Furthermore, she had an episode of depression in her 30s for which she was treated with an SSRI, which was helpful. No suicidality is present, and she has never had a manic episode, ruling out bipolar disorder.

15:30
So does someone want to plunge in? Tell me if you think it was independent, or substance induced, and why. Or in the chat.

15:46
Hi, Elizabeth, this is Stacey.

15:48
Hi Stacey.

15:49
I would say that she had been self medicating. And I feel like with many of the folks that we work with, often their substance use is related to self medicating and as a coping. So since she said it started before, and since she had the episode in her 30s, my sense is that she's been managing her issues with alcohol.

16:11
That is my sense as well.

16:13
And we're getting some folks in the chat. Jules, Amy, and Kathy, thank you. Independent, she had the depression in the past.

16:24
Exactly.

16:28
We also have Leona sharing initial feelings of depression could have increased her alcohol use.

16:36
Yeah, so it sounds like we're all sort of thinking this depression piece seems like its own thing. And then, like COVID happened, and then drinking was perhaps a way to help with even more feelings of depression. But it seems like it is its own thing that has a life of its own.

16:53
Elizabeth, this is Jeff, I wanted to pick up on a comment from Jules to make it more complicated. Is it possible it's both? So that there was a pre existing condition, but that there are also mood induced at least symptoms, if not a disorder?

17:11
If it's both independent and induced?

17:15
Yeah. Is that possible?

17:17
I mean, I think like, going back to, like, are these things probably building on each other? A little bit, right? Sure. Like in the real world, this is a very over simplistic case to sort of help us understand the big picture separation. And we'll talk about this a little bit how this is not like necessarily a typical case. But I think it's still helpful to think, like, is this really just occurring in the context of the substance? Or is there enough background that we think that maybe this person was like, already struggling with depression, or sort of like prone to depression before the substance use part even happens?

18:01
Thanks. So maybe the best way to think about it is if it's pre existing, then it's also going to become more complex after substance use is introduced.

18:12
Exactly, good, definitely gonna become more complex. Because as we all know, a lot of our patients talk about this, in terms of like it's a cycle, right? Like what came first, the chicken or the egg? But if you can still hone in and try to figure out and untangle them, and we'll talk about why it's even important to untangle them, we'll get to that part. But for EJ, we think this is independent, right? We've talked about it enough that we're like, this is its own thing.

18:40

So EJ is wondering about an antidepressant. So let's talk about antidepressants in this case. So I think that this is like getting into why do we even care if it's, like, mixed or if it's substance induced or not? So antidepressants are only really going to be helpful if it's an independent disorder for the most time. Of course, like we said, this is hard to determine, it helps to see a patient more than once, it helps to get collateral, it helps to get a good history. But if it's independent, then the antidepressant is going to have as good of a shot that it can have. In terms of which antidepressant, SSRIs because they have the lowest side effect profile, again, we're gonna rule out bipolar first. So why not just start an antidepressant for like everybody who has depression or anxiety and substance use disorder? So first of all, we don't want to go handing out these diagnoses to anyone, right, like, we've all seen people's medical lists, and these are like real conditions, and it's important not to do that. I think it's also important to provide education to people about how if it's not independent, and if it's really based on the substance like people deserve to know that about what they're going through, right? Because it might be the thing that helps to motivate them to like, make a change that will be helpful. Also, interestingly, there are several trials showing that SSRIs, particularly for people less than 25 can actually make drinking worse. We don't really know like, why that's the case, but does it get them, like feeling better and being less inhibited? It's not really clear. So in cases like that, if you're starting antidepressant, it's important to be like, pretty mindful and follow up. Did the drinking get worse after doing that?

20:41
This is as algorithmy as it gets. So this is just like what we've been saying. So someone comes in, they're saying they have both substance issues and mood issues. So I think the biggest thing, the most important thing on this whole chart for me, one of them, is start the treatment for substance use right away, right? Because that's gonna help us figure out if we can get the substance use down, we can more determine which class our patient falls in. If they still have depressive symptoms, if the depression is clearly independent, or if it's just really severe, like maybe we don't really know, did this all happen at the same time? Like how mixed is this with the substance? But if it's really severe, I wouldn't withhold treatment in that case. So I would start. If it's less clear, maybe follow them over time for a little bit, see how much they want to do it. If depression really persists, then start an antidepressant. Or I would argue if they're really having a hard time reducing substances, I think it's fair to start considering, well, maybe an antidepressant will be the thing that like, nudges them over into some inroad into them getting better. So that's sort of, I think, an important pearl is don't be afraid to start treatment for substance use disorder, even if there is a big mental health issue going on. Because some people might be hesitant, like, worried, is this going to interact with the mood disorder or like mood medications? It's really not, don't be afraid to do that. I mean, we can't talk about like the whole field of substance use treatment, but like, of course, consider do they need to be inpatient, do they need to be outpatient? Can they be linked with therapy? That would be like a whole other presentation, the importance of like initiating therapy with all this, but that's not really what we're focusing on today. And again, I think this is sort of just saying what I've already said, but for people who have depression in the context of a substance use disorder. For example, when people enter like a methadone clinic, or if they start buprenorphine, their mood is going to get much better very quickly and they're not going to need a medication.

23:09
Hi, I was invited to unmute and say something. This is Jules Levin. I'm not sure, and a very nice talk, I appreciate that. I'm not sure that I'm going to say anything different than what you just said. But clearly, to me, this person needs counseling and therapy.

23:38
100% agree.

23:40
Right. So I mean, I think you just said that because you had just said, first you said start with antidepressant, then you said counseling and therapy, and then you said counseling and therapy and then antidepressant. So I think that is the approach. But I think this person, you know, I mean, there's also AA, there is also NA, I assume during this COVID time there are support groups. So I mean, I think this person needs intensive support and counseling during this time, and perhaps as much as possible hand holding. So I'm not sure that I'm saying anything other than what you would recommend as a great professional that you are. To me, this person had depression, there was a sign of depression in their early life. So they probably have some low level depression throughout their life that they probably coped with. And now things are just so overwhelming with COVID that it's impossible for almost anyone to deal with. And so now they went maybe back to something that they thought might relieve it. Coping mechanism, alcohol or drugs, which I'm sure a lot of people are doing now.

24:53
Yeah, I mean, I think that's really well said and I'm very glad that you said that. I 1000% agree with you, over my 100% agreeing with you a second ago. I think like people need the most support they can get. And we all know that therapy combined with a medication, or even it can be therapy alone, like how powerful that is. I mean, that was one of the hard parts of me coming up with his talk. There's so much that I could talk about, that probably got under emphasized, but thank you for emphasizing it.

25:25
I would just add, I'm not a psychiatrist or a psychologist and Jeff is great too. Jeff Weiss. And but I'm 70 years old now, I've been doing this for 35 years. I have HIV, I've had HIV for 35 years, and I got HIV through injection drug use, I'm clean and sober 35 years. I was in and out of rehabs and counselling and NA and AA for many years. So I have a lot of experience with this. And I'm highly educated, also. And I've done a lot of self looking inside and so forth. And I think, and I'd like your opinion on this, I think during this time, people with backgrounds like this are highly at risk. And I'd like to know if you have any experience during this time seeing people with HIV who have a history of substance abuse going back after being clean, going back to substance abuse because of COVID?

26:36
I don't have any in particular that type of case. But I mean, I think we all know that like overdose rates are going up, and people are really struggling for the reasons that you said. They can't go

to AA anymore. They can't take a walk with their friend anymore. Their therapist is now like a zoom therapist, and that's not really as helpful anymore.

26:59
More support because her son is not happy with her behavior. And she needs more contact with the outside world.

27:07
Yeah, she's isolated.

27:08
Yeah.

27:10
Hello. Can you hear me?

27:15
I hear you.

27:15
Oh, hi, my name is Howard. I kind of agree with what Miss Maria said, because you know, some people don't really know. So sometimes groups are pretty good at the start, because they meet people that has been going down the same road they are and they realize they're not alone. Because sometimes people for the first time get caught up in this mess, they think they're the only ones caught up like this until they speak to other people that's going through it too. That sometimes that kind of helps people to get help. So I think it's a good start.

27:51
Yeah, and again, that's like, I know where I trained there were a lot of groups most days of the week and it was really easy. I mean, it wasn't easy, but it was easier to encourage them to just be like, 'oh, you know, can you hang out for like, an hour. There's a group starting in an hour you can sneak in and see if it's helpful to you.' Again, harder, right? Yeah, super important.

28:18
True.

[End]