

13 - Comorbid mental health disorders in AUD

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494 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Coexisting alcohol and nicotine dependence Encourage individuals to stop smoking. Refer for smoking cessation in primary care and other settings. In in-patient settings offer nicotine patches/inhalator during assisted alcohol withdrawal. Always promote vaping as a safer alternative to tobacco smoking.

Comorbid mental health disorders in AUD People with AUD often present with other mental health disorders, particularly anxiety and depression. Public Health England has described it as 'the norm rather than the exception' and encourages a collaborative, effective and flexible approach between front-line services, stating that it is 'everyone's job' and that there is 'no wrong door'.⁴⁶ Substance use disorders, including AUD, should never be a reason to exclude a patient from crisis or specialist psychiatric services after completion of detoxification.

Depression in AUD Depressive and anxiety symptoms occur commonly during alcohol withdrawal, but usually diminish by the 3rd or 4th week of abstinence. Meta-analyses suggest that antidepressants with mixed pharmacology (the tricyclics imipramine or trimipramine) perform better than selective serotonin reuptake inhibitors (SSRIs; fluoxetine or sertraline) in reducing depressive symptoms in individuals with AUD, but the antidepressant effect is modest.^{2,9,47,48} Trazodone may also be effective.⁴⁹ A greater antidepressant effect was seen if the diagnosis of depression was made after at least 1 week of abstinence, thus excluding those with affective symptoms caused by alcohol withdrawal. There is stronger evidence for depression categorised as independent rather than substance-induced.³⁶ As treatment effects are masked by comparatively large placebo effects, which conceal improvements that would otherwise be attributed to medication, there is a need for larger randomised, placebo-controlled trials. Despite the evidence for tricyclics, they are rarely used in clinical practice because of their potential for cardiotoxicity and toxicity in overdose.⁵⁰ SSRIs may not be effective in depression in AUD and may worsen drinking behaviour.⁵¹ Relapse prevention medication should be considered in combination with antidepressants. Pettinati et al.⁵² showed that the combination of sertraline (200mg/day) with naltrexone (100mg/day) had superior outcomes - improved drinking outcomes and better mood - compared with placebo and compared with each drug alone. In contrast, citalopram showed no benefit when added to naltrexone.⁵³ Secondary analyses of acamprosate and naltrexone trials suggest that: ■ ■Acamprosate has an indirect modest

beneficial effect on depression via increasing abstinence. ■ ■ In depressed alcohol-dependent patients, the combination of naltrexone and an antidepressant may be better than either drug alone,⁹ but findings are not consistent.⁵³ Ketamine is an emerging treatment for AUD⁵⁴ and may be helpful in comorbid depression.

Addictions and substance misuse CHAPTER 4 Bipolar affective disorder in AUD Bipolar patients tend to use alcohol to reduce symptoms of anxiety and depression, and comorbid AUD is common. Where there is comorbidity, it is important to treat the different phases of bipolar disorder as recommended elsewhere. It may be worth adding sodium valproate to lithium as the combination is associated with better drinking outcomes than lithium alone. However, the combination did not confer any extra benefit than lithium alone in improving mood (see British Association for Psychopharmacology consensus 2012).⁹ In those who continue to drink, electrolyte imbalance may precipitate lithium toxicity. Lithium is probably best avoided completely in binge drinkers. Adding quetiapine to lithium or valproate has no effect.⁵⁵ Naltrexone should be offered early to help bipolar patients reduce their alcohol consumption.⁹ If naltrexone is not effective, then acamprosate should be offered. In the event that both naltrexone and acamprosate fail to promote abstinence, then disulfiram should be considered, and the risks made known to the patient. Anxiety in AUD Anxiety is commonly observed in alcohol-dependent individuals during intoxication, withdrawal and in the early days of abstinence. Alcohol is typically used to self-medicate anxiety disorders, particularly social anxiety. In alcohol-dependent individuals who experience anxiety it is often difficult to determine the extent to which the anxiety is a symptom of the AUD or whether it is an independent disorder. Medically assisted withdrawal and supported abstinence for up to 8 weeks are required before a full assessment can be made. If a medically assisted withdrawal is not possible then treatment of the anxiety disorder should still be attempted, following guidelines for the particular anxiety disorder. The use of benzodiazepines is controversial¹¹ because of the increased risk of benzodiazepine misuse and dependence. Benzodiazepines should only be considered following assessment in a specialist addiction service. Long-term use is generally not recommended.⁵¹ One meta-analysis suggested that buspirone is effective in reducing symptoms of anxiety but not alcohol consumption.^{9,56} Studies have also shown that paroxetine (up to 60mg/day) was superior to placebo in reducing social anxiety in AUD patients although alcohol consumption was not affected.^{9,56} Either naltrexone or disulfiram, alone or combined, improves drinking outcomes compared with placebo in patients with post-traumatic stress disorder (PTSD) and alcohol dependence.^{57,58} Both acamprosate and baclofen have shown benefit in reducing anxiety in post hoc analyses of alcohol-dependence trials. It is therefore important to ensure that these patients are enabled to become abstinent and are prescribed relapse prevention medication. Anxiety should then be treated according to the appropriate NICE guidelines. Schizophrenia in AUD Patients with schizophrenia who also have AUD should be assessed and alcohol-specific relapse prevention treatment considered, usually either naltrexone or acamprosate. Disulfiram is contraindicated in psychosis.⁵⁹ Antipsychotic medication should be

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