Alcohol use disorder and depression: proposed rewording of Choosing Wisely recommendation

This letter is in response to a specific recommendation of the Choosing Wisely campaign.[1] The following is a direct quote:

> Don't routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.[2]

As addiction psychiatrists in Canada, we are concerned that this blanket statement may have a substantial impact on the treatment of patients with alcohol use disorder who have a major depressive disorder. That people can stop drinking, and consequently, any depressive symptoms will resolve is a simplistic view. There is evidence that depressive symptoms resolve with alcohol cessation, but getting those with addiction to abstain is easier said than done. Alcohol use disorder is notable in our society (lifetime prevalence of 29.1%) and is associated with major depressive disorder (adjusted odds ratio [AOR] 1.3, 95% confidence interval [CI] 1.15–1.39) and all other mood disorders (AOR 1.5, 95% CI 1.37–1.63), even with adjustments in sociodemographic characteristics and in other psychiatric disorders.[3] Patients with depression and alcohol use disorder are at higher risk of suicide attempts,[4] and not treating their depression may have deleterious effects, especially in the elderly.[5]

Guidelines affect physician practises,[6] and this Choosing Wisely recommendation could lead to primary care physicians not treating patients with alcohol use disorders.

This is very concerning, given that so many people with substance use disorder do not seek help.[7] If patients do reach out for help for depressive symptoms, being told that they need to be sober before they can be treated could be invalidating, which would be a barrier to treatment.

Patients with alcohol use disorder are sometimes stigmatized by health professionals, which can contribute to suboptimal health care.[8,9] A recommendation to not treat patients' depressive symptoms could further stigmatize them.

The research around the treatment of alcohol use disorder with comorbid depression is still inconclusive: a recent meta-analysis[10] showed that depression treatment in alcohol use disorder had large early improvement in depressive symptoms. A randomized controlled trial showed that the combination of sertraline and naltrexone was superior to either alone for achieving abstinence, reducing heavy drinking and improving mood.[11] Adamson and colleagues[12] found no benefit in combining citalopram with naltrexone. Charney and Heath[13] found poorer outcomes with citalopram treatment in alcohol dependence. This inconclusive and conflicting evidence makes it impossible to make a recommendation. It is interesting that citalopram is also associated with poorer outcomes in posttraumatic stress disorder (PTSD) literature and is not recommended in PTSD treatment guidelines.[14] One could likely recommend against the use of citalopram, based on the current evidence.

As described by Nunes and Levin, antidepressant efficacy in alcohol use disorder varies depending on placebo effects. Studies with high placebo response show little to no effect and studies with low placebo response show a moderate to strong effect.[15]

We propose that the Choosing Wisely statement be reworded. This is important because the Province of Alberta has accepted the Choosing Wisely campaign as a guideline for physicians in Alberta. The following is our recommendation:

> In substance treatment, do not routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of abstinence of two to four weeks and subsequent reassessment for the persistence of depressive symptoms.

The American Society of Addictions Medicine specifically recommends treating the depressive disorder, first-line being psychotherapy, and for more severe symptoms, following the Texas Medication Algorithm for antidepressant treatment.[16] The International Society of Addictions Medicine, the Canadian standard of care for addiction medicine, suggests treating the substance use disorder first and if depression continues, then treat.[17] The goal of primary care is to start with a brief intervention, then attempt to have the patient become involved in treatment for alcohol use disorder.

Specifically, treatment is a biopsychosocial–spiritual approach that includes detoxification, anticraving medications and psychosocial interventions, along with comorbid treatment of psychiatric illnesses.

Unfortunately, the blanket statement by Choosing Wisely could have deleterious effects on those with alcohol use disorder, is not evidence-based, could lead to less access to care, and could increase stigma against patients with alcohol use disorder and major depressive disorder or depressive symptoms. The treatment of patients with addictions and mental health problems should focus on reducing stigma and increasing assess to care.

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