Dual Diagnosis in Older Adults: Prevalence and service user experiences

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Outline

- What is dual diagnosis?
- Initial research: the prevalence of dual diagnosis in a community mental health service for older adults
- The perspective of service users
- Future challenges
Dual diagnosis in older adults

- Co-occurring mental illness and substance use disorder.
- A simple term: the reality is a complex number of social and medical factors in addition to a mental illness and drug or alcohol use (Hartz et al, 2014).
Caulfield Hospital MAPS

- Provides community case management, assessment and liaison to aged care facilities and general practitioners.
- Specifically for adults aged 65 years and over.
- Covers bayside Inner Melbourne.
- Total population 265,142. Over 65s 34,113 (2011 Census data).
- Multidisciplinary team with a predominantly outreach focus.
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“You’ll be disappointed here. We don’t get much substance use at all.”
Is there a dual diagnosis population in our service?

- This phase of the project involved a file audit of assessments conducted by MAPS clinicians over the past two years (June 2012-14: N=593).
- Completed file auditing shows a prevalence of 15.5% dual diagnosis in MAPS – in real terms, this is 92 individuals over a two year period.
  - However, there is no screening tool and interpretations of problematic alcohol or drug use are poor – particularly in relation to Commonwealth Government alcohol guidelines.
Prevalence

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Substances Recorded

- Cannabis and Benzodiazepines
- Benzodiazepines and Opiates
- Alcohol, Benzodiazepines and Opiates
- Alcohol, Cannabis and Others

### Graph

![Substance Consumption by Gender](chart.png)

**Y-axis:** Consumers

**X-axis:** Substances Recorded

**Legend:**
- Male
- Female
Primary Diagnosis

- Eating Disorder
- Personality Disorder
- Schizoaffective Disorder
- Bipolar Affective Disorder
- Mental State for Assessment (Undefined)
- Depression
- Behavioural and Psychological Symptoms of Dementia

Dual diagnosis

- Yes
- No
For lovers of stats…

- Significant association between gender and AOD use ($x^2(1) = 19.21, p=<0.001$). OR of male AOD use 5.45 times higher than females.

- Dual diagnosis group also younger (mean 72.82) than those who did not use AOD (mean 79.24), (-6.629, 95% CI [-8.340, -4.508], $p=<0.001$).

- Significant association between gender and substance preference – males recorded predominantly alcohol use, females spread between polysubstance, benzodiazepine and opiate use as well as alcohol (41, $p=<0.001$).
The perspective of service users

- Qualitative interviews with 6-10 consumers of MAPS:
  - Identified by case managers as being challenging dual diagnosis cases.
  - Voluntary process – participants reimbursed $25 per interview in accordance with health service policy.
- 11 identified and approached, six agreed:
  1. 72 year old female, depression and heroin use.
  2. 64 year old male, paranoid schizophrenia and cannabis with prior amphetamines/heroin.
  3. 67 year old male, schizophrenia with long amphetamine, alcohol, hallucinogen history. Current cannabis use in supported accommodation.
  4. 73 year old male, schizophrenia and binge drinking.
  5. 65 year old male, bipolar affective disorder, current binge drinking. Prior methamphetamine, heroin and prescription opiate abuse.
  6. 73 year old male, depression and alcohol abuse.
An example of the complex factors involved in dual diagnosis in older adults
The participants had a long history of involvement with mental health services, with evidence of “self medication” of symptoms or medication side effects:

“I couldn’t sleep from the injections, the pills and that sort of thing. I started drinking as soon as I got bored. I bought a bottle of whisky once, a cheap bottle of whiskey to put me to sleep ... then I fell asleep and that was alright.”

“Back in about 1968 I was first diagnosed ... I had my first smoke of dope in about 1973 so that was about 5 years after that ... in 1986 I was in there, and the diagnosis was drug induced psychosis. I was in and out of hospital for 40 years.”
Also noted was a history of complex medical conditions, requiring treatment alongside mental illness and substance use disorder:

“I’ve given up on pain killers. They don’t work … It’s not that they don’t work, it’s getting the bloody prescriptions all the time.”

“I have medical problems, my legs won’t walk more than half a kilometre … and I feel pain and that sort of thing.”

“People die … all my friends who’ve died in the last ten years, none of them have overdosed. They’ve just died of … cancer and heart attacks.”
Stigma has been shown to reduce health seeking behaviour (Conner and Rosen, 2008).

“I just refuse to let doctors and those people get away with… not recognising people like me and my friends. So I would tell them loud and clear, I use heroin, so from the outset they know. Still, a lot of my friends are very careful about which people they tell.”
Alcohol and other drug use was a large part of the participant’s lives, however five of the six expressed a desire to change their substance use, or had recently reduced:

“8 years I’ve been stoned every day … $40 a day … I just go without [food and essential items] … I wish I didn’t do it.”
Five of the participants lived alone, some with few social networks and activities outside of drug use:

“I get on with people alright, we talk and laugh. One of the dealers reckons that I’m a laugh a minute. I used to have about 8 dealers and I’ve lost 5 of them. They’ve moved. It’s got too hot where they’re living so they’ve moved somewhere else.”
Adaptive substance use was identified in a number of participants:

“But I don’t use every day now. Payday, pension day, I live for. And I have various people that might come and ask if you can get on for them. And then I get a hit … I’m not using every day, once a fortnight if I’m lucky.”

“Yes, so that, in the morning I don’t wake up with that feeling I want to get on … Just because, when you’re using, when you wake up the first thing on your mind is getting on. And it’s horrible.”
Future Challenges

- Harm reduction in older adults.
- Enhanced assessment, both in AOD and mental health settings as well as primary care/hospital settings.
- Older adult specific treatment services.
- Cognitive impairment.
Thank you

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