

- ◆ An exploratory study into drug and alcohol use in a sample of adults aged 55 and older, who have a mental illness
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- ◆ **Theme - Let Us Not ...Develop a Blind Spot with Age ;)**
- ◆ **North East Health Wangaratta**
- ◆ **Winter Conference – Substance Use Across the Lifespan.**
- ◆ **July, 2008**
- ◆ **Kathleen Ryan-NEXUS**

# Dual Diagnosis

- ◆ Setting the Scene .....

## Defining Dual Diagnosis

Simple causal hypotheses may not easily explain the association.

A variety of causal relationships may apply

There is a broad convergence of risk factors for both problematic substance use and mental disorders.

One disorder puts you at higher risk of the other disorder.

# The Concept of Dual Diagnosis

“Co-morbid disorders often appear to be in a relationship of mutual influence, rather than falling neatly into primary vs secondary categories”.

# Dual Diagnosis – Complexity

The heterogeneity of dual diagnosis patients admitted to psychiatric hospitals is very significant.

Lehman et al (1994),

Heterogeneity – Main theme in literature review.

Crawford et al (2003)

The substantial amount of research into aetiology has still left a number of uncertainties and disagreements.

Keene (2001 p 22)

## Responding to Dual Diagnosis

“understanding the cause of a person’s co-existing disorders is important but arguably less clinically useful than understanding the factors that maintain the problem”. Todd et al (1998 p 31).

Too great a focus on cause, on what came first and what came second, results in falling through gaps in systems. Mc Dermott F & Pyett P (1993)

# Prevalence

- ◆ A review of the English language literature of the epidemiology of dual diagnosis –
- ◆ “shows mental disorders to be significantly related to alcohol and drug use disorders”.
- ◆ Kessler (2004)

# Prevalence in Psychiatric Patients

- ◆ “the prevalence of co-existing disorders amongst psychiatric patients has been consistently found to be much higher than in the general population”.
- ◆ Todd et al (1998, p 24)
- ◆ 55.9% of psychiatric inpatients suffered a substance use disorder.
- ◆ Lehman et al (1994)

# Australian Prevalence

- ◆ The 1997 National Survey of Mental Health and Wellbeing Highlighted the Extent of Co-Morbidity in the Population
- ◆ Teeson and Proudfoot eds (2003)

# Prevalence in the Community

National and international population approaches to dual diagnosis have shown consistently high rates of dual diagnosis.

Teeson and Proudfoot eds (2003 p36)

Furthermore, “the greatest numbers of people with co-morbidity in the population are those with the most commonly occurring disorders of anxiety or depression and misuse of alcohol or tobacco”

Degenhardt et al (2001) in Teeson & Proudfoot eds (2003 p78).

## Increased Risk

“On the other hand, the greatest increased risk in Axis 1 disorders is seen in psychosis” (Regier et al 1990) and “these people are more likely to show significant functional deficits from substance use, even at relatively low levels of intake”.

(Drake et al 1989; Drake and Wallach 1993) in Teeson and Proudfoot eds (2003 p78).

# Impact of Dual Diagnosis

There is a great deal of literature on the impact of dual diagnosis on clients, on those close to them and on the community. For example :-

- ◆ Poorer addiction treatment outcomes. (*Todd et al 1998 p 43*)
- ◆ Increased burden on family members. (*Dixon et al 1995 in Mueser et al 2003 p 9*)
- ◆ Propensity to victimization and being taken advantage of. (*Goodman et al 2001 in Mueser et al 2003 p 9*)

## Impact of Dual Diagnosis cont...

- ◆ Tendency towards earlier onset of schizophrenia with increased psychotic symptoms. (Dixon 1999)
- ◆ Worsening psychiatric and health outcomes.  
(Mueser et al 2003 p 9) (Quinton et al 1995 in Keene 2001 p 19) (Dixon 1999)
- ◆ Significant rates of unemployment. (Sestoft et al 1996 in Keene et al 2001)
- ◆ Poor money management. (Dixon 1999)

## Impact of Dual Diagnosis cont...

- ◆ **High rates of non-compliance with treatment.** (Hunt et al 2002) (Dixon 1999) (Keene 2001 p 21)
- ◆ **High rates of homelessness.** (Goldfinger et al 1999 in Mueser et al 2003 p 9) (Todd et al 1998 p 30) (Dixon 1999)
- ◆ **Greater rates of mobility in homelessness when compared to those who are homeless, with mental illness but without substance dependence.** (Marshall et al 1994 in Keene 2001 p17)

## Impact of Dual Diagnosis cont...

- ◆ **High rates of legal encounters.** (Mueser et al 2001 in Mueser et al 2003 p 9) (Sestoft 1996; Hammersley et al 1990 in Keene 2001 p 17)
- ◆ **High rates of violence.** (Dixon 1999)
- ◆ **High suicide rates.** (Bartels et al 1992; Torrey et al 1996 in Mueser et al 2003 p 9)
- ◆ **Cultural variations in diagnosis and response.** (Todd et al 1998 p 31)
- ◆ **Significant problems with engagement.** (Sekerka et al 1999)

## Impact of Dual Diagnosis cont...

- ◆ **Complications with diagnosis** (Kadden & Kranzler 1992 in Keene 2001) that can lead to inappropriate treatment. (Olin JT & Keatinge C 1998)
- ◆ **Greater use of crisis oriented services.** (Dixon L 1999)
- ◆ **Greater service costs.** (Keene J 2001 p 21) (Dixon 1999), Hoff and Rosenbeck (1999)

## Impact of Dual Diagnosis cont...

In summary, “substance abuse in clients with severe mental illness worsens a wide range of outcomes, including psychiatric outcomes, social functioning and health. Mueser et al (2003 p 9)

The effects of severe psychiatric disorders and substance abuse on overall functioning appear to be additive”. Mueser et al (2003 p 9)

“Clinical and social outcomes are less favourable” (Keene 2001 p21)

- ◆ Dual Diagnosis in Adults Aged 55 +

# Research Proposal

- ◆ An exploratory study into drug and alcohol use in a sample of adults aged 55 and older, who have a mental illness.
- ◆ Part of NEXUS strategic response to the 'Dual Diagnosis – Key Directions and Priorities for Service Development' .....
- ◆ Particular under researched dd populations – indigenous and now older adults

# Aims of Exploratory Study

- ◆ Aims to determine the extent of and types of alcohol/drug use in a sample of adults aged 55 and older, who have a mental illness.
- ◆ Aims to understand the functions of their alcohol/drug use currently and historically and their attitudes towards changing it.

# Research Questions

- ◆ What is the extent of and types of alcohol and drug use in a sample of adults with a mental illness aged 55+?
- ◆ What are the differences in extent of and types of alcohol/drug use between younger and older participants?

# Research Questions

- ◆ What are the current functions of their alcohol and drug use?
- ◆ What were the historical functions of their alcohol and drug use?
- ◆ What are their attitudes to changing their alcohol and drug use?

# Measures

- ◆ The ASSIST will be used to collect quantitative data.
- ◆ From those screened, there will be a selection for a semi-structured interview to collect qualitative data.

- ◆ Why research this area?
- ◆ What is the literature telling us?

- ◆ Not much....
- ◆ This is a sorely under researched area...
- ◆ We are all learning....
- ◆ Your experiences in the field are important to developing '***practice*** based evidence'

# Last census

- ◆ 25% of the population are 55+
- ◆ The proportion of the population who are 65+ is set to double

# Alcohol

- ◆ Short term and long term harms for older adults
- ◆ Increased risks of liver damage, stroke, abi, coronary disease, cancers
- ◆ Increased risks of falls
- ◆ Exacerbated by decreased tolerance with age
- ◆ More severe withdrawal symptoms

## Benzodiazepines and other tranquilliser use

- ◆ Can reduce quality of life
- ◆ contributes to incontinence, confusion, lack of mobility, falls, instability

# Social Factors

- ◆ These harms are exacerbated in older people who experience social and cultural isolation, poverty and homelessness.

There is an overall increase in illicit drug use in older adults which is expected to grow owing to the large numbers of older people in society

and larger numbers of drug users who did not stop using drugs in their early to mid thirties.

# Adult Services Age Group

The baby boomers are growing older and “available research evidence suggests that adults who become 65 in 2011 are more likely to have a drug or alcohol problem than adults in the current older population”.

Winick (1992) In Phillips (2001 pgs 898 – 905)

# 2004 National Drug Strategy Household Survey

First Results, show, regarding the **60+** age group, that:

- ◆ 23.3% of males and 11.4% of females consume alcohol on a daily basis.
- ◆ 7.9% of males and 5.2% of females drink alcohol at levels that put them at risk of long term harm.
- ◆ 4.2% of males and 1.6% of females drink alcohol at levels considered risky for short term harm.
- ◆ 4% had used an illicit drug in the 12 months before the survey.
- ◆ When one factors in the possibility that older adults 60+ might understate illicit drug use, 4% is not insignificant.

# NDSHS- 2004

- ◆ Recent use of any illicit drug
- ◆ 14-44 - 22.5%
- ◆ 45+ - 5.9% (not insignificant)
- ◆ Recent use of analgesics for non medical purposes
- ◆ 14-44 – 7%
- ◆ 45+ - 6%
- ◆ Recent use of tranquillisers for non medical purposes
- ◆ 14-44 – 2%
- ◆ 45+ - 2 %

# NDSHS 1991-2004 patterns

- ◆ Overall consumption patterns of alcohol use have remained relatively stable.
- ◆ 75%+ of people aged 14-44 & 45+ consumed alcohol.
- ◆ People aged 45+ more likely to consume alcohol daily. A Main point of difference between the two age groupings.
- ◆ P. Dowling & C Psychogios – VAADA Forum – ‘Older but not Forgotten’ June 2005

# 2004 NDSHS-Alcohol Risk of Harm in the Long Term & Short Term

- ◆ 8% of Australians aged 45+ - 'risky' or 'high risk' of long term harm
- ◆ 20% of 45+ drank at risk of harm in the short term at least once in the past 12 months
- ◆ 6% of people aged 45+ drank at risk of harm on a monthly basis
- ◆ P. Dowling & C Psychogios – VAADA Forum – 'Older but not Forgotten' June 2005

# Alcohol and Other Drug Treatment Services National Minimum Data Set

- ◆ Principal drug and age:
- ◆ 10 – 44 – alcohol 32%, amphetamines 12%, cannabis 25%, heroin 21%, benzodiazepines 2%
- ◆ 45+ - alcohol 75%, amphetamines 2%, cannabis 5% , heroin 6%, benzodiazepines 3%
- ◆ P. Dowling & C Psychogios – VAADA Forum – ‘Older but not Forgotten’ June 2005

## Dual Diagnosis in Older Adults- More Research Needed

USA research “recent evidence indicates that persons 60 years and over experience significant alcohol and substance abuse problems.

Since a combination of alcoholism and depression is likely to increase the relative risk of suicide, it is important to examine the prevalence of dual diagnosis in older adults”. Blixen et al (1997).

# Dual Diagnosis in Older Adults – A Study

“A retrospective chart audit of 101 elders discharged from 3 psychiatric hospitals showed 37.6% had a substance abuse disorder in conjunction with psychiatric disorder and of this

- ◆ 37.6%, 71% abused alcohol and
- ◆ 29% abused alcohol and other substances.
- ◆ 17.7% of the elders with a dual diagnosis made a suicide attempt prior to admission, compared to 3.3% of the nondually diagnosed”.

The researchers advocate that routine screening is therefore necessary.

Blixen et al (1997).

## Dual Diagnosis in Older Adults

- ◆ Also, I suggest that it is important to consider that the rates might be higher, as it is possible that the aforementioned charts were completed with out full cognizance of dual diagnosis.

## Dual Diagnosis in Older Adults

- ◆ Dually diagnosed older adult patients had longer inpatient stays for substance abuse
- ◆ and more out patient substance use related visits than non dually diagnosed elderly patients
- ◆ and more out patient general psychiatric visits than all the contrast groups.
- ◆ Prigerson et al (2001)

- ◆ Should more dual diagnosis patients survive to old age their consumption of some form of mental health care is likely to be high.

- ◆ Prigerson et al (2001)

- ◆ Therefore, we need to plan ahead .....
- ◆ Future service planning is one of the main rationales for exploring this area more fully.....

# Screening

- ◆ The literature indicates that currently, screening for alcohol and drug issues in older adults (with or without dual diagnosis)
- ◆ either lacks sensitivity
- ◆ and/or lacks breadth.

## Screening - Sensitivity...

Research indicates that low level intake can cause problems in older adults

The commonly used CAGE screening (Cut down, Annoyed, Guilty, Eye-opener) is designed to detect heavier use.

# Screening-Sensitivity

Fink found that the Alcohol Related Problems Survey (ARPS) “identified nearly all drinkers detected by the CAGE, SMAST (Shorter Michigan Alcohol Screening Test) and AUDIT (Alcohol Use Disorders Identification Test)

and detected hazardous and harmful drinkers not identified by these measures. Fink et al (2002)

## Screening - Breadth

Secondly, there is the issue of screening for a wider range of drugs.

Alcohol abuse is among the most common of psychiatric disorders in the elderly, surpassed only by anxiety disorders and various forms of dementia.

What remains unknown about this age group is data about the use of illicit and designer drugs such as heroin and ecstasy.

- ◆ Multiple substance use is the norm.
- ◆ Clark, C. et al (2003) Cert. 4 competency – work with clients who are intoxicated

## Wider range of drugs?...

It is important to consider aspects of non-alcohol drug abuse in the elderly

Menninger (2002)

“substance use disorders in the geriatric psychiatry out patient population exist to a significantly greater extent than previously reported”.

Holroyd and Duryee (1997)

# Use of Other Drugs?

We know little about drug use in older people

“There has been far more research into alcohol use and misuse in older people than there has been in drug misuse”

“The reported prevalence and patterns of substance (mis)use among older people are significantly different from those of younger adults”.

## Different Patterns of Use

In contrast to young alcohol abusers, older adults drink smaller amounts at one time, use drugs prescribed by several doctors and share medication with friends (licit and illicit) and are more likely to drink and use drugs at home than in public.

## Different Patterns of Use

Also, what is specific to this age group and unlike younger persons, who often seek out drug and alcohol use for recreational purposes, is that older adults may be seeking therapeutic effect, such as relief from grief and pain.

Colleran (2002) and Van Wormer & Rae Davis (2003) in Shafer (2004 p 6)

# Older Adults and Illicit Substances?

“The use of illicit substances does occur among older people, but the research evidence is equivocal....(but) rates may represent an underestimation”.

In Phillips (2001 pgs 898 – 905)

# Rationale

“Drug and alcohol misuse in older people is a complex, multi factorial and not fully understood phenomenon....

....targeted research into the epidemiology, motivations and circumstances in which alcohol and substance misuse occur in older people needs to be prioritized”.

Phillips (2001 p 903).

# Working with Older Adults

- ◆ Screen for a wide range of substances, not just alcohol and benzodiazepines.
- ◆ Assess for motivations for/functions of drug use.
- ◆ Assess for stage of change regarding each drug.
- ◆ Low level intake can cause problems.

# How to Screen?

- ◆ How is of utmost importance.
- ◆ Essential to screen in a manner that **engages**, aims to find out and reduces any chance of defensiveness.
- ◆ Drug/alcohol use can be sensitive issues.
- ◆ Screen as a routine and explain it this way so people don't feel singled out.
- ◆ Without **engagement**, the next steps are going to be very difficult.

# When to Screen?

- ◆ Reasonably soon BUT
- ◆ Take into account mental state and more general 'timing'.

# Screening and then what?

- ◆ Screening can indicate the need for a more comprehensive assessment.
- ◆ Should screening be by passed?
- ◆ If reasonable to expect substance use, go directly to comprehensive assessment and integrated treatment planning?
- ◆ Screening essentially is to pick up exceptions – so widely screen in the 65+?

# Screening and then what?

- ◆ What are the interventions following a screen and assessment that indicates problematic substance use?
- ◆ We must have the steps in place in our services.
- ◆ Key directions – dual diagnosis capable VDDIAG – developing specifics.
- ◆ Talk within your services...Access VDDI resources and support .....

- ◆ As in the directions document – creating effective partnerships between services with living MOUs
- ◆ The Integrated treatment Planning Proforma – appendix of the VDDI screening and assessment guidelines
- ◆ QAs – how are clients experiencing services?

- ◆ A.S.S.I.S.T. and associated brief intervention.
- ◆ Brief introduction....

- ◆ Research themes to date.....
- ◆ Early days.....

## Research themes to date under 65s

- ◆ Only 2 screens and interviews for under 65 (58 and 62)
- ◆ 1 previous use of cannabis and amphetamines. Current alcohol and benzodiazepines. With no current intention to change
- ◆ 1 current use of cannabis, alcohol and benzodiazepines. With no current intention to change.
- ◆ Social reasons referred to

# Themes to date over 65s

- ◆ 16 screen and interviews
- ◆ Alcohol and benzodiazepines predominately
- ◆ 'What ever the doctor prescribes'
- ◆ Guilt and shame regarding alcohol use
- ◆ Not wanting to identify mental illness-begin with 'physical conditions' 'stress' 'breathing problems'
- ◆ If non drinkers-refer to traumatic experiences of 'drunks' when they were younger 'I saw too many of them'

## Themes to Date - 65+

- ◆ Late commencement (30s-50s) of smoking and drinking usually in context of new relationship.
- ◆ Smoking commenced in psychiatric hospitals.
- ◆ With women 'big responsibilities' when they were younger 'let down by other people' 'nasty parents' 'always looking after people' 'always had to be in control'

# Themes 65+

- ◆ Insomnia and nerves commonly referred to as reasons for alcohol/drug use.
- ◆ Wanting 'oblivion' 'crutch' 'numbing' 'feeling so bad...wanting to die' 'desperate loneliness' 'pain relief' 'society was changing so fast...felt so behind and lonely'
- ◆ Less common reference to socialising with alcohol - 'shameful' to be seen drinking in hotels'
- ◆ Those that 'gave up' referred to 'just stopped one day' 'just decided' 'the will'

# Themes 65+

- ◆ Not knowing why
- ◆ 1 previous use of cannabis
- ◆ 1 previously prescribed LSD for BPD  
(because dr prescribed-never used out of this context)
- ◆ 1 previous use of 'chloroform' 'dry cleaning sprays'