Riding the Comorbidity Roundabout: The Hidden Faces of Addiction in a General Hospital

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Outline

• What is the comorbidity roundabout?
• Defining the problem
• Case example
• Future directions

- Recognition that dual diagnosis extends beyond two co-occurring disorders
- No “typical” client
- Psychosocial issues: crime, unemployment, poor engagement in education
- Compounded by separate treatment systems (addiction/mental health), with divergent philosophies
- Treatment research is sparse

“A traffic roundabout is a useful metaphor for describing the decision-making processes people use when attempting to better cope with their life and circumstances. In order to reach their destination (goal attainment), people with co-morbid mental health and AOD use problems need to take account of their starting location and vehicle characteristics (history, available resources, skills and experiences), local conditions (information and support) and the rules of the road that guide their journey, including how to negotiate detours, change lanes, acknowledge right-of-way rules and show consideration for other drivers (agencies, policies, treatment options, resource restrictions).”
NOTES:  
Roundabout entry points = white side of connecting roads  
Roundabout exit points = grey side of connecting roads  
Clockwise travel on roundabout  
Dashed lines indicate multiple lanes  
Designed for countries which drive on the left-hand side of the road
NO WRONG DOOR

THE COMMITMENT TO MENTAL HEALTH RECOVERY IN SOUTH WESTERN SYDNEY

Source: arafmi.com
In the general hospital

• Screening and assessment typically poor
• Repeat admissions for addictions +/- mental health issues often labeled:
  • “Bed blockers”
  • “Frequent flyers”
  • “Malingers”
• Goal of discharge ASAP
Alfred Hospital HARP

- Geographic catchment – inner Melbourne
- Goal to link to services and prevent “avoidable” hospital admissions
- High prevalence of AOD use led to formulation of CNC position
- Average age 60.1
- 77% alcohol as primary substance
- Largely poor prior engagement with addiction/MH/medical treatment
A case in point

• 74 year old male residing in own home with wife
• Prior employment, now self funded retiree
• Medical history of ischaemic heart disease, CABGs, diabetes and hypertension.
• Also alcohol related fall with traumatic brain injury and long rehab
A case in point

• Long history of wine consumption; grew up on vineyard in Southern Italy

• Consumption of cask wine between 2.5 – 4 litres daily

• Concerning behaviours:
  • Aggression towards wife
  • Wandering from home
  • Disorientation
  • Marked confabulation
  • Inability to tend to ADLs
  • Confronting strangers in the street
A case in point

- General practitioner (doctor) referral to memory clinic
- Memory clinic referral to aged mental health
- Aged mental health referral to aged care assessment
- Aged care assessment referral back to memory clinic
- Memory clinic referral back to aged mental health
- Family referral to crisis team
- Family presentations to Emergency Department
- Absconded from “secure” hospital ward three times
- Referred to HARP service by concerned clinician
General practitioner
Memory clinic
Aged mental health
Aged care assessment
Memory clinic
Aged mental health
Alcohol and other drug treatment service
Crisis team
Emergency department
General hospital, secure ward
A case in point

- On assessment:
  - Wife described history of violence towards her
  - Wife reported poor sleep
  - Wife described dangerous behaviors
  - Feels cornered into buying alcohol to mitigate these behaviors
  - Family report strain, feel situation untenable, supportive of placement
A case in point

- Aged mental health refused admission ("alcohol related...")
- Long process of negotiating admission for medical detox – refused by several rehab/detox facilities due to complexity
- Hand wringing (inability to discharge)
- "Prove it" (more neuropsychological testing)
- "Bed blocker" (push to discharge home)
- "Too hard" (give it a final try with the family)
| General practitioner | Memory clinic | Aged mental health | Aged care assessment | Memory clinic | Aged mental health | Alcohol and other drug treatment service | Crisis team | Emergency department | General hospital, secure ward | Hospital admission risk program | Aged mental health | General hospital, patient attendant | General hospital, secure ward |
A case in point

• Family sourced accommodation
• Ultimately failed due to behaviours
• Referred to aged mental health service
• Hospital admission
• Back on the metaphorical roundabout
General practitioner

Memory clinic

Aged mental health

Aged care assessment

Memory clinic

Aged mental health

Alcohol and other drug treatment service

Crisis team

Emergency department

General hospital, secure ward

Hospital admission risk program

Aged mental health

General hospital, patient attendant

General hospital, secure ward

Failed nursing home placement
What are the issues?

• Poor treatment engagement
• Inefficient delivery
• Inefficient resource utilization
• Expensive
• No care coordination
Poor Treatment Engagement

• Burnout on family
  • At “wits end”
  • Felt there was nowhere to turn
  • Every door was a wrong door
  • ED presentations = only logical choice

• Patient spends much time retelling history

• No real concerted effort to engage in treatment
  • More time spent proving patient does not meet service criteria
  • No active efforts to build rapport
Inefficient Delivery

• Several services involved, often more than once
• Administrative procedures more important than actually guiding patient/family to appropriate treatment
• Rigid service delivery models that do not meet the patient in their setting
• Huge silo effect
Inefficient Resource Utilization

• Multiple presentations to multiple services:
  • Multiple assessments
  • Poor information sharing/use
  • Clinicians doing repetitive paperwork tasks in each silo
  • Time spent “selling” referrals as opposed to actual care of the patient
Expensive

• Clinician hours to conduct assessments:
  • Interviewing patient
  • Interviewing family
  • Collateral
  • Gathering history
  • More paperwork
  • Administrative tasks

• Cost to family – burden of care, carer burnout

• Cost of long hospital admission/s that may have been presented earlier
Poor Care Coordination

• No ownership of patient journey
• No guidance ("Recovery Coaching," Omar Manejwala, IntNSA 2016)
• Poor attempts at enacting change
• Overall reluctance to take ownership of the situation
How do we prevent the hidden faces of addiction?
Screening

• Typically poor
• Found to be 15.5% in an inner Melbourne older adult mental health service (Searby, Maude and McGrath, 2016)
• Prevalence varies in other services
• Early screening may prevent progression to high healthcare utilization
We don’t even ask about their usage, let alone what they want to do about it. So I think as a service we really need to go back to basics and work out, and train us in how to have those conversations with people. I mean I’ve been working in this area for over 20 years, so I feel quite comfortable just having that conversation but I know in my supervision of lots of new grads ... they are still really uncomfortable asking about mental state and risk and suicide, and you know, relationships and drug use. There is lots of stuff we don’t talk about because people are personally uncomfortable.

(Searby, Maude & McGrath, 2017)
Reassessing treatment setting

- The traditional model of patients approaching to refer, or families/other health professionals referring is arguably inefficient and not capturing the target population effectively.
Alcohol Use in an Older Adult Referred to a Consultation-Liaison Psychiatry Service: A Case Report

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Consultation-Liaison Psychiatry Referral made

Collateral from Primary Care Doctor and family obtained: Problematic medication pattern discerned.
ASSIST conducted: History of alcohol use disorder in line with stressors of death of father, role stress as teacher/parent

Bedside assessment by Consultation-Liaison nurse and doctor.

Anxiety and bruxism initially treated with duloxetine 30mg with plan to increase if tolerated.

Bruxism ceased, reports subjective improvement in mood.

Duloxetine increased to 60mg.

Home based assistance increased to allow ongoing independent living with husband.

Monitoring of medication dispensation/dosette system arranged with community pharmacy.

Primary care doctor advised of AOD plan: Support provided at follow up appointments. Ongoing acamprosate and further medication monitoring.

Discharge
Future directions

• Research identifying patient journey
  • Recognize missed points of intervention
  • Attribute cost to multiple encounters
  • Describe the flexibility of addictions nurses as agents of change

• Education in general nurses
  • Dual diagnosis education in Bachelor students
  • Development of novel methods and short screens ("burden of paperwork")
  • Expansion of the SBIRT model
  • Specific postgraduate education for mental health workers/addictions nurses
Thank you

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