



**The 'Can Do' Initiative:  
Managing Mental Health and Substance Use in General Practice**

***'Can Do' for Older People  
Training Package***

**Presentations and facilitator's notes  
Case studies and facilitator's trigger questions**

Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for older people at risk of or experiencing mental health and substance use issues.

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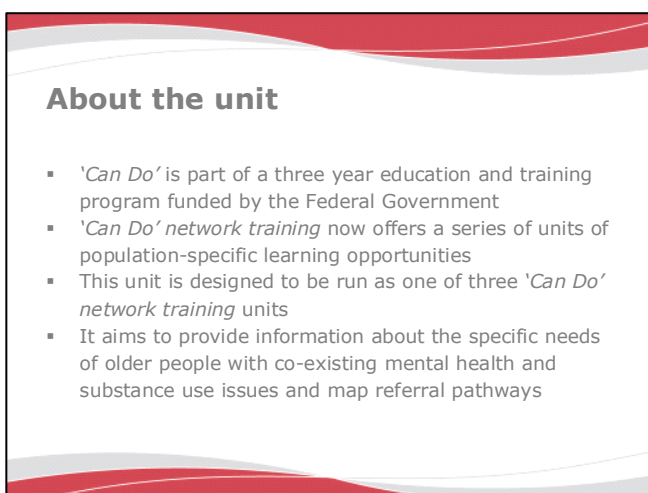
## Slide 1: Title page



This is the title slide. You may use this slide as participants arrive and during the welcome. As the facilitator it is important that you familiarise yourselves with the slides and notes.

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## Slide 2: About the unit



This slide provides an overview of how this unit fits into the 'Can Do' initiative.

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### Key points

- The 'Can Do' initiative is a three year education and training program, funded by the Australian Government Departments of Health and Ageing and Veterans' Affairs. This unit has been developed to provide information about the specific needs of older people who experience co-morbid mental health and substance use issues. A multidisciplinary team focus has been taken, with the aim of involving a range of health and community service providers.
- The unit aims to provide key information related to the topic area, and encourages interactive learning via discussion of the stories of two older people and the opportunity to network and map local service providers.
- It has been developed for a range of professionals and provides the opportunity to increase awareness of local networks and referral pathways.
- The unit is intended to be used alongside other 'Can Do' Network Training units (*Teams of Two* and other population specific units).

## Slide 3: Learning objectives

### Learning objectives

- Increase understanding of the experience of ageing and significance of change in the life of the older person
- Raise awareness of mental health, medication and substance use issues and how they impact on older people
- Increase awareness of risks and protective factors
- Identify local services and networks
- Explore ways of working together
- Understanding the role and needs of families and carers

The overall educational goal of this accredited training program is to provide general practitioners, allied health professionals and other service providers with specific knowledge and skills to work with older people at risk of or experiencing mental health and substance use issues and to improve their health and wellbeing.

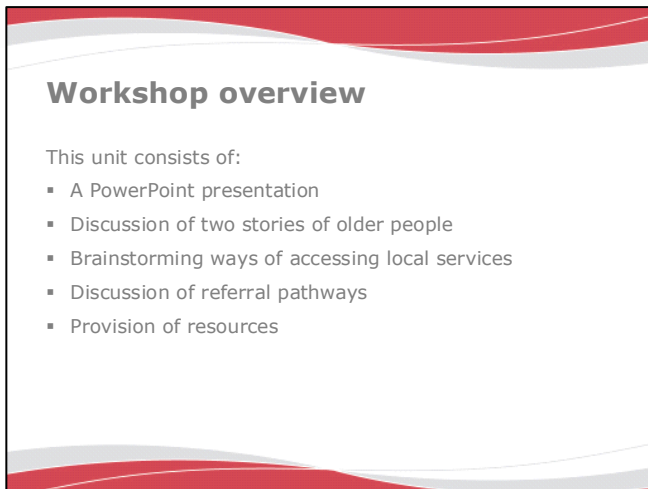
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### Key points

On completion of this program, participants should be able to:

- demonstrate an increased understanding of the experience of ageing and significance of change in the life of the older person
  - demonstrate an increased awareness of mental health, medication and substance use issues and how they impact on older people
  - identify risks and protective factors associated with substance use, taking medications, mental health issues and ageing
  - demonstrate increased confidence in providing support and understanding required by older people with mental health and substance use issues
  - identify health and community services at the local level, particularly those that engage with and provide support to older people
  - demonstrate an increase in ability and confidence among health professionals in developing appropriate pathways of referral and care for older people with mental health and substance use issues and their families and carers.
-

## Slide 4: Workshop overview



**Workshop overview**

This unit consists of:

- A PowerPoint presentation
- Discussion of two stories of older people
- Brainstorming ways of accessing local services
- Discussion of referral pathways
- Provision of resources

This slide provides an overview of the format of this unit. The unit is intended as an *overview* of the main issues when working with this population group.

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### Key points

This unit consists of:

- A brief PowerPoint presentation to provide participants with an overview of relevant background information about older people and substance and mental health issues.
  - Discussion of two older people's stories to provide an opportunity to share knowledge, skills and practical advice on working with this population group.
  - Brainstorming ways of identifying and accessing local services during the discussion of the older peoples' stories and a service mapping exercise – service providers will be given an opportunity to introduce their service in the service mapping exercise.
  - Discussion of referral pathways - details of local agencies and the process of appropriate referral; who is able to refer, what details to include in the referral letter/form.
  - A number of handouts will be provided and a comprehensive list of resources can be found at the end of the unit.
-

## Slide 5: Older people – who are they?

### Older people – who are they?

- Older people are defined as 65+ years
- This is a growing population group
- Early onset ageing (55+ years) is linked to chronic disease, disability or particular life experiences
- Vulnerable groups include ATSI, veterans, homeless, refugees, survivors of abuse, people with longstanding mental illness or substance use
- Longevity in 21<sup>st</sup> century means there are many people who are 85+ years

26.8% of patients visiting GPs are older people (BEACH 2004).

Morbidity and capacity are not always related to age

This slide provides information about the different age groups that it is useful to consider when working with older people and identifies some of the other factors that may influence the way that people age. Older people are a growing population group. The current trend of an ageing population will continue. This is also described in the next slide.

### Key points

- The Beach survey (2004) indicates that older people make up to 26.8% of people visiting general practitioners. Across the whole spectrum of patients, 54% are female, 42.5% hold concession cards, 9.7% are from non English speaking backgrounds, and 1.6% are Aboriginal or Torres Strait Islanders.
- Defining parameters – ageing is not just about 'years', but about overall quality of life including the person's state of health and wellbeing.
- Be mindful of what people *bring* to older age compared to what *develops* in older age.
- Avoid viewing older people from a 'sickness' perspective.
- The 'well' older person has good physical, mental, spiritual and emotional health and an active lifestyle, providing resilience when illness or infirmity arise.
- Those with less resilience include those with long-standing mental illness, a past history of substance use (including alcohol dependence and smoking) and those with chronic illness and an inactive lifestyle (inactive can refer as much to inactive minds as to inactive bodies).
- Some population groups in society are more vulnerable to ill health than others. Vulnerability may include problematic mental health and substance use issues either in the past or currently. These population groups include Indigenous people, veterans, homeless older people and survivors of childhood abuse and/or domestic violence.
- While 65+ may signal an 'older' person, many are much older. 85+ is a fast growing demographic. This can bring with it increasing frailty and complexity of needs.
- Early onset (55+) ageing leads to premature mortality (early death). Causes include:
  - chronic disease and disability: medical, psychiatric, physical and intellectual
  - particular life experience: trauma, long-standing substance use including alcohol , homelessness

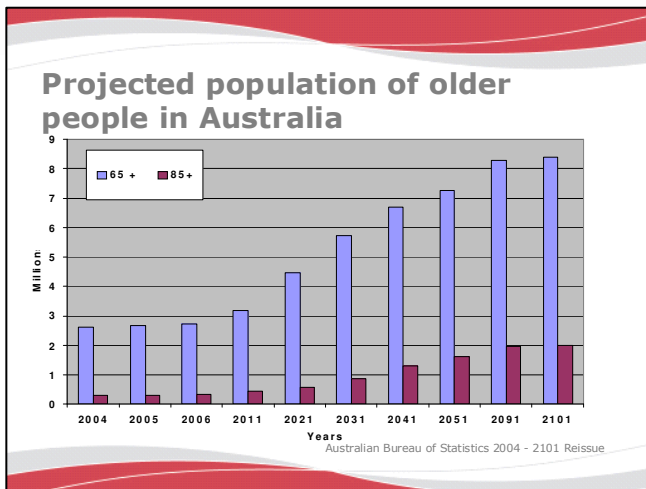
- Consider the fact that people with mental health and substance use issues are living longer and may still be presenting with chronic relapsing comorbid conditions and a range of associated physical problems at 60+

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**References**

Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A. 2004. *BEACH: General Practice activity in Australia 2003-04*. AIHW Cat No GEP 16. Canberra. Australian Institute of Health and Welfare (General Practice Series No 16).

## Slide 6: Projected population of older people in Australia



This slide identifies the projected growing population of older people in Australia to 2101

### Key points

- ABS data indicates that the current trend of an ageing population will continue.
- As an increasing proportion of the population enters old age, diseases and disorders that increase in prevalence with ageing will not only become more prevalent but also will form a larger proportion of all morbidity within the community.
- Diseases and disorders that have become more prevalent in the current middle aged population at the end of the twentieth century (for example: anxiety disorders, illicit substance use) may well persist as this cohort ages, leading to greater depth of psychiatric illness and exacerbation of poor physical health in future older generations.
- The changing population of older people may be quite different from the current cohort - be aware of the implications of these changes in relation to services (e.g. they may be better educated, have greater expectations, smaller and less extended families to support them and come from a more diverse range of cultural backgrounds).

### Additional information

#### Population aged 65 and over: projections (ABS 2004/2101)

- This age group will increase rapidly throughout the first half of the reporting period in both numbers and proportion.
- This age group will increase from 2.6 million in 2004 to between 4.5 and 4.6 million in 2021 and to between 7 and 9 million by 2051.
- By 2051, there will be a much greater proportion of people aged 65 and over than in 2004. In 2004 people aged 65 and over made up 13% of the population. This is projected to increase to 26-28% in 2051 and 27-31% in 2101.
- By 2101 it is estimated there will be between 6.9 million and 12.8 million people aged over 65 as compared to 2.5 million in 2004.

#### Population aged 85 and over: projections (ABS 2004/2101)

- This age group is expected to increase dramatically and is expected to experience the highest growth rate of all age groups.

- In 2051 the population is projected to be 1.6 million and 1.7-2 million in 2101 as compared with 295,600 in 2004.
  - In 2004 people aged 85 and over made up 1.5% of the population. This is projected to grow to 2% by 2021, 6-8% by 2051 and 7-10% by 2101.
- 

#### References

Ames D, Ritchie C. 2007. Psychiatric disorders affecting the elderly in Australia. In: G. Meadows, B. Singh and M. Grigg (Eds.) *Mental Health in Australia*. 2nd edition, ISBN: 9780195550771, pp. 450-461.

Australian Bureau of Statistics (2004) *Population Projections 2004-2101*. Cat No. 322.0. Canberra: Commonwealth of Australia.

## Slide 7: Older people –Challenges and stressors



**Older people, challenges and stressors**

Key stressors - can manifest as a range of health and social issues

- Attitudes and values in the community
- Declining physical health and mobility
- Changes to living arrangements and social isolation
- Mental health and substance use – impact on lifestyle and function
- Increasing limitations on service access
- Complexity of navigating the system

*Consider impact of change*

This slide highlights the key areas of health and wellbeing that may present challenges as a person ages. Subsequent slides in this presentation look at these issues in more detail.

### Key points

#### Stressors

- Declining health
  - Increasing frailty
  - Increasingly complex medical conditions leading to many medications and more likely to experience adverse drug effects
  - Decline of cognitive function/decision making capacity
  - Increasing dependency
- Reduced mobility impacts on capacity to:
  - Drive/navigate transport
  - Access services
  - Socialise independently
- Grief, loss and approaching one's own death:
  - Bereavement
  - Sense of self and meaning of life
- Social isolation:
  - Family relationships and social connectedness
  - Isolation from family, loneliness
- Services not meeting needs:
  - Access
  - Involvement of/with multiple services
  - Importance of collaboration and integration of services
  - Values and attitudes
  - No 'one-stop-shop' causing difficulty to navigate between services
- 'Ageism':
  - Values and attitudes
  - Negative media images
  - Challenges to self esteem
- Other changes:

- Change of role: retirement/reduced work hours, child(ren) leaving home, grandparent role, itinerant and/or extended holiday experiences, becoming a carer, from caring to cared for,
  - Economic circumstances
  - Living arrangements.
- 

### **Additional information**

- The health professional needs to take into account the impact that stressors and lifestyle changes play in relation to an older person's health and wellbeing.
  - Where a number of challenges related to these stressors are apparent, the need for services increases.
  - This need for additional services and supports comes at a time in life when the ability to access/navigate them declines.
  - Older people are more likely to be on multiple medications for multiple conditions and be involved with multiple practitioners and services.
- 

### **Reference**

Hamilton-Smith E. 2001. Cultural issues: their impact on the health and care of the ageing person. In Cluning T. *Ageing At Home*. Melbourne. Ausmed Publications.

## Slide 8: How values and attitudes influence health and wellbeing in older people

A rectangular box with a red and white wavy border at the top and bottom. Inside, the title 'How values and attitudes influence health and wellbeing in older people' is followed by the word 'Consider:' and a bulleted list of five points.

**How values and attitudes influence health and wellbeing in older people**

Consider:

- impact of personal, interpersonal and community attitudes as a person ages
- stigma associated with mental health and substance use
- judgemental attitudes about the capabilities of older people
- health professional' attitudes towards older people
- restrictions for the older person in accessing services

The aim of this slide is to prompt and encourage reflection on how values and attitudes influence expectations, decisions and judgments by older people about their health and wellbeing as well as those of service providers who work with them.

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### Key points

- Values and attitudes are:
  - an integral part of how one understands and participates in the world
  - often embedded, hidden or unconscious and not necessarily explicit or stated
  - neither good nor bad, right nor wrong
  - not static but can and do change
  - culturally and generationally influenced.
- The better the 'match' between values and attitudes of providers and patients, the better the outcomes are likely to be. This requires a degree of self awareness and a commitment to reflective practice.
- Values and attitudes may be:
  - personal (the older person's view of themselves)
  - interpersonal (family and friends view of ageing and older people)
  - community (views of the community in which a person ages)
  - societal (the values or otherwise that Australian society places on the roles of and recognition afforded to older people.

**Key message!** *Optimise dignity and independence, be aware of own values and attitudes, allow enough time, listen to the life story*

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### Additional information

- Examples of impact of values and attitudes regarding older people:
  - therapeutic pessimism
  - older people are less likely to be referred for specialist treatment than a younger person for a substance use problem
  - fear of developing dependence on opioids, by both patient and doctor, may lead to under prescribing and under usage of analgesia
  - under recognition of substance use linked to belief that older people don't use drugs

- under reporting of substance use linked to shame and guilt
  - federal/state divide in responsibility for provision of services to older people leading to gaps in services
  - ageism and the media
  - "silly old fool" syndrome versus understanding of mental health problems (community/family opinion)
  - influence setting of future-oriented goals
  - service access criteria may not accommodate early onset ageing
  - "older people don't have sex"
  - end of life issues e.g. is it worth withdrawing from substance use? (especially alcohol).
- 

#### References

Winett T, King A, Altman D. 1989. *Health psychology and public health: an integrative approach*. Elmsford. NY. Pergamon.  
Holt M, Treloar C, McMillan K, Schultz, L, Schultz M, Bath N. 2007. *Barriers and Incentives to treatment for illicit drug users with mental health comorbidities and complex vulnerabilities*. National Drug Strategy Monograph Series 61. Canberra

## Slide 9: Challenges to physical health

### Challenges to physical health

- Chronic diseases (e.g. diabetes, heart disease, arthritis)
- Pain
- Falls
- Continence issues
- Reduced nutrition
- Reduced mobility
- Dementia
- Vision and hearing impairment
- Polypharmacy
- Sleep disturbance

**Reduced ability to access and negotiate services**

This slide outlines some of the physical health issues that older people are likely to experience that may have an impact on their mental health and substance use behaviours.

### Key points

- Older people are more likely to present with one or more of the physical health issues listed in the slide with mental health or substance use problems as secondary issues.
- There is a range of physical health conditions/chronic disease that older people are likely to experience that may impact on mental health and quality of life.
- The state of an older person's physical health may be influenced by their history of substance use and/or mental health problems.
- For those who have been or are alcohol dependent, physical health effects such as liver damage, gastro intestinal disease, cardio vascular impact and alcohol related brain damage need to be excluded or managed.
- Long term smokers may experience reduced lung capacity, shortness of breath and other smoking related illnesses.
- For those who have been or are still injecting drug users, the impact of hepatitis C or other blood borne viruses on general health may be significant.
- Personal need and dependency on others increases as ability to access services decreases.

### Additional information

The following tables provide the leading causes of disability adjusted life years in older Australians. *Leading cause of Disability Adjusted Life Years (DALYs) in 65-74 year olds, by sex. Australia 2003*

Rank	Males	Percent of total	Females	Percent of total
1	Ischemic Heart Disease	15.5	Ischemic Heart Disease	11.4
2	Lung Cancer	7.9	Type 2 Diabetes	6.2
3	Type 2 Diabetes	5.8	Breast Cancer	5.7
4	Prostate Cancer	4.9	Dementia	5.5
5	Adult-onset hearing loss	4.9	Lung Cancer	5.4
6	COPD	4.8	Stroke	5.2
7	Stroke	4.5	COPD	4.8
8	Colorectal Cancer	4.3	Colorectal Cancer	4.1
9	Dementia	3.2	Osteoarthritis	3.3
10	Parkinson's Disease	1.6	Adult-onset hearing loss	3.2

*Leading cause of DALYs in 75 years and older, by sex. Australia 2003*

Rank	Males	Percent of total	Females	Percent of total
1	Ischemic Heart Disease	19.3	Ischemic Heart Disease	18.7
2	Stroke	7.5	Dementia	12.4
3	Dementia	7.3	Stroke	10.5
4	Prostate Cancer	5.4	Type 2 Diabetes	4.1
5	COPD*	5.2	COPD*	3.5
6	Lung Cancer	4.7	Colorectal Cancer	2.6
7	Type 2 Diabetes	3.9	LRTI#	2.4
8	Colorectal Cancer	2.9	Lung Cancer	2.4
9	Adult-onset Hearing Loss	2.4	Breast Cancer	2.4
10	LRTI#	2.2	Falls	2.1

\*COPD (Chronic Obstructive Pulmonary Disease)

#LRTI (Lower Respiratory Tract Infection)

#### References

Australian Institute of Health and Welfare (AIHW) 2002. Older Australia at a glance 2007 (4th edition). AIHW Cat. No. AGE 52. Canberra: AIHW & DOHA.

## Slide 10: Environmental challenges

**Environmental challenges**

As settings and circumstances change:

- independent living options narrow
- the need for care and support increases
- the availability of care and support can be limited (especially in rural areas)
- transitions to supported or residential care must be considered
- institutional care is faced for the first time
- become itinerant, homeless or dependent on hostel care

*Where can I go now?*

### Key points

- The settings and circumstances may change as a person ages, especially where mental health and substance use are present. The older person may:
  - move in with family (this may mean a new location, leaving a familiar environment and friends behind)
  - have family move on and be left alone
  - require residential care.
- Where a person has mental health and substance use issues, the choices narrow about where they live whilst their care needs expand. Coordination of care between services becomes important.
- A small number of older people with mental health and substance use issues are homeless or dependent on nightly admission to hostels and daily living on the street.

### Additional information

- Consider the context and impact of changing living arrangements. For example:
  - Who makes the decision?
  - How much family engagement is there?
  - How much support do housing and social services and health authorities provide?
  - What is the impact of separation from familiar surroundings, friends and family?
  - For the itinerant person who accesses nightly hostel care or sleeps rough, what impact does this have on physical health?
- Consider who is and/or who needs to be involved in the decisions about care and living arrangements.
- Living arrangements don't always reflect morbidity and capacity. Consider that 'home' for older people is a range of settings e.g.
  - *In the community:*
    - Increasing emphasis on living in community from government and consumer groups
    - Staying at home much longer and with greater morbidity and/or needs
    - Role of carers
    - Increasing need for more services for older people in the community
  - *In transition towards moving to residential care*
    - No longer coping at home
  - *In residential care*
    - Spectrum of residential care
    - Residential aged care: increasingly complex and frail
    - Community Residential Units (CRUs) and Special Residential Services (SRSs)

- *Homeless*

- A small number of older people, especially older men, veterans and Indigenous people will have a history of sleeping rough or living in squats or on the street. Many of these will have longstanding mental health and substance use issues. They may choose this lifestyle despite offers of residential care. Hostels provide overnight accommodation and many in urban settings have food provided and link with health services.

NB: Institutional care can include – corrective services, mental health institutions, community group homes, dementia units, hostels.

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**References**

Folsom D, McCahill M, Bartels S, Laurie A, Lindamer L, Ganiats T, Jeste D. 2002. Medical Comorbidity and Receipt of Medical Care by Older Homeless People with Schizophrenia or Depression (Australia) in *Psychiatric Services* 53:1456-1460, November 2002. American Psychiatric Association.  
Howden-Chapman P, Signal L, Crane J. 1999. Housing and Health in Older People: Ageing in Place. *Social Policy Journal of New Zealand*. Otago.

## Slide 11: Mental health and substance use are challenges too

**Mental health and substance use are challenges too**

- Often hidden challenges in older people
- Less likely to present with mental health or substance use as a primary issue
- May have multiple 'co-morbidities' and complex needs
- More likely to have substance use issues related to medications, alcohol and tobacco use than 'illicit' drug use
- Poor mental health and problematic substance use significantly impacts on quality of life
- Where one is present, look for the other

*How's life and who cares?*

This slide encourages participants to think about holistic health and wellbeing and the inter-relationships between key health and social factors in an older person's life where mental health and substance use issues are present. The next few slides cover the inter relationships between the listed aspects of health and older peoples' mental health and substance use

### Key points

- The **key message** of this slide is captured in the question "How's life and who cares?"
- When a health professional thinks about the inter-relationship between the aspects of health and wellbeing described on the slide above, there is a need for a comprehensive assessment, including history taking and assessment of mental health and substance use.
- As part of this assessment it is helpful to understand the context in which the older person leads their life. Ask the following questions:
  - Who are they?
  - What is their life story?
  - Have they or their family ever served in the defence forces?
  - What are their concerns?
  - What is important to them?
  - Where are they living?
  - How are they coping?
  - What social supports are available?
  - How effective are they?

### In relation to substance use note that older people:

- Are less likely than other age groups to present with a mental health or substance use disorder as the *primary* problem.
- May have undiagnosed mental health issues – e.g. depression, anxiety, sleep disorders, substance use.
- May be veterans – and therefore may have a higher incidence of mental health or substance use issues than the general population.
- May be survivors of alcohol and drug use disorders.
- If they are survivors of alcohol and other drug disorders are most likely to be long term tobacco smokers.
- May also have a history of hepatitis C, depression, poverty, chronic lung and health disease and malignancy.

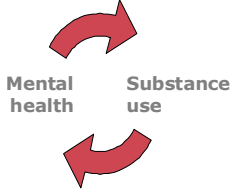
- May be at risk of prescribed medication misuse or dependence especially through use of prescribed benzodiazepines and opioids.
  - Have 'older brains' that are more sensitive to adverse drug effects and neuro-toxic effects
  - May have diminished protective psychosocial factors.
  - Will experience higher risks when withdrawing from substances.
  - Have an increased risk for drug interactions and changes in medication metabolism.
- 

**Reference**

Winstock A. 2007. 'Can Do' Clinical Education: history taking and assessment. AGPN. Canberra. ([www.agpncando.com](http://www.agpncando.com))

## Slide 12: Substance use and mental health – the relationship

### Substance use and mental health - the relationship



Mental health

Substance use

**A relationship of mutual influence**

- Where you identify one, look for the other
- Need for integrated treatment approach

This slide outlines the relationship of mutual influence between mental health and substance use. The principle of identification of one and careful search for the other is an important aspect of history taking and assessment in older people.

### Key points

- There are 3 main medical model hypotheses have been put forward to explain the relationship of mutual influence between mental health and substance use:
  1. Drug use as a way of coping with or managing mental health problems
  2. Drugs potentially leading to mental health problems
  3. Combination of genetic and environmental risk factors
- Any of these three may present in the older person. Remember: mental health and substance use issues are LESS likely to be the primary presenting issue in older people than in the general population.
- The principle of looking for substance use and mental health issues during every occasion of history taking and assessment of older people is vital if these – often co occurring conditions – are to be identified and an integrated approach to prevention, treatment and support developed.

### Additional Information

#### **Dual diagnosis/comorbidity**

Within some sectors 'dual diagnosis' or 'comorbidity' are used to describe a person who is affected by both mental illness and substance use. However, these terms are imprecise. Within this diagnostic category:

- 'Mental illness' encompasses a wide spectrum of diagnoses and severity of conditions
- 'Substance use' encompasses a wide spectrum from use to misuse to harmful use to dependence.
- People in this diagnostic category are part of a complex heterogeneous group - there is no "typical" client.
- Older people are more sensitive to drug and alcohol effects.
- Older people are less likely to present with mental health and substance use issues as primary problems.

"Mental health and substance use problems are associated with increased health care utilisation and significant health care expenditures. Studies have indicated that targeted prevention and early intervention with this population (i.e. older population) can offset substantial costs to consumers, their families, health care organisations, and the government." (SAMHSA, 2008)

*Refer to Handout: Mental Illness Fellowship of Australia Inc (MIFA) Understanding dual diagnosis: mental illness and substance use.*

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**Reference:**

*Substance Abuse and Mental Health among Older Americans: the State of the Knowledge and Future Directions*, Substance abuse and mental health services administration (SAMHSA) Service Technical Center <http://www.samhsa.gov/OlderAdultsTAC/index.aspx>

## Slide 13: Mental health in older people

**Mental health in older people**

- Definition of mental health
- High prevalence disorders – depression, anxiety, sleep disorders
- Co-occurring substance use – don't forget alcohol and tobacco are drugs too
- Dementia – a physical or a mental health issue?
- Recent onset of mental health issues or long term?
- Impact on quality of life and functioning
- Impact on families and carers

This slide provides participants with a definition of mental illness and describes high prevalence mental health disorders in older people. The next few slides describe depression and anxiety and look briefly at the differential diagnosis of delirium, depression and dementia in older people.

### Key points

#### **Mental health and wellbeing**

- The World Health Organization describes mental health as a level of cognitive or emotional wellbeing or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism, mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience.
- WHO states that there is no one "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined.
- The aim of health systems is to promote mental health and wellbeing within an holistic model of health care and support.

#### **Mental illness**

- A mental illness has been defined by the World Health Organization (WHO) as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised medically diagnosable illness or disorder. Those illnesses defined include alcohol use disorders, and drug use disorders, as well as the high prevalence mental health disorders such as anxiety and depression. Experiencing a mental disorder is associated with lower educational attainment, joblessness and poorer physical health.
- High prevalence disorders in older people include depression, anxiety and sleep disturbances.
- Older people may have recent onset or longer term mental health problems.
- Declining mental health has a significant effect on an older person's quality of life and functioning ability.
- Declining mental health in older people impacts on families and carers.
- Mental health issues are often associated with substance use.

- Don't forget alcohol and tobacco are drugs too.
- 

**References:**

California Psychiatric Association. 2007. *Frequently Asked Questions About Psychiatry & Psychiatrists*.

<http://www.calpsych.org/publications/cpa/faqs.html>

Rogers A. & Pilgram D. 2005. *A Sociology of Mental Health and Illness*, Open University Press, 3rd Edition.

WHO. 2001. *World Health Report 2001 - Mental Health: New Understanding, New Hope*. World Health Organization. Geneva

## Slide 14: Depression in older people

**Depression in older people**

- 1 in 5 people experience depression during their lifetime
- Depression in older people is under reported and under recognised
- Depression in older people is often associated with pain
- Better recognition, assessment and management of comorbid pain can improve outcomes of depression (and vice versa)
- Use a stepped approach to treatment using psychological support as a first line
- Effective treatment of both conditions is possible and can lead to reciprocal improvements in the other.

*Look for pain when you see depression and vice versa*

This slide outlines depression in the older person and its association with pain.

### Key points

- Prevalence:
  - Depression affects one in five people in the general Australian population during their lifetime.
  - Major depression probably affects 0.5 to 3% of the community dwelling elderly population. Milder depressions may be comorbid with physical illness or organic mental disorder. This often follows adverse life event such as bereavement and is likely to affect 10-20% of older people.
  - Depression is most common among those living in aged care facilities known as nursing homes and hostels.
  - Depression is especially prevalent in those who suffer chronic illness or disability, especially conditions that produce pain, urinary incontinence or significant activity limitation.
  - Depression in older people is often associated with pain.
  - Remember, for some patients, complete pain relief may never be possible.
- Depression is *under reported* due to:
  - reluctance of the current older age cohort to talk about their feelings
  - cultural factors
  - predominance of symptoms such as loss of appetite, sleep disturbance, forgetfulness and lack of concentration rather than depressed mood
  - acceptance of depressed state as 'normal'.
- Depression is *under recognised* due to:
  - values and attitudes of providers
  - predominance of symptoms such as loss of appetite, sleep disturbance, forgetfulness and lack of concentration rather than depressed mood
  - provider priority placed on management of physical illness rather than mental health.

### Additional information

- Approach
  - Be aware of symptoms/triggers as depressive disorders are common and amenable to treatment. Where there is pain look for depression, where there is depression look for pain.
- Triggers
  - Recent bereavement and anniversaries

- retirement
- functional decline
- going into residential care
- end of life issues.
- Risk indicators
  - social isolation
  - bereavement
  - social disadvantage
  - previous depression.
- Diagnosis
  - The diagnosis of depression in older people may not meet all DSM-IV criteria.
  - Notably, older people within the spectrum of dysphoria may respond to antidepressants and to other interventions that would traditionally be part of the management of clinical depression.

### Care Plan

A typical care plan might include:

- Adjunct treatment modalities - including medication (tricyclic antidepressants and/or analgesics) and psychological support/family therapy.
- Mood and pain monitoring
- Frequent reviews
- Physiotherapy/dietitian referral
- Medication reviews – e.g. Home Medicines Review (HMR), Residential Medicines Management Review (RMMR)
- Management of other comorbid physical/psychological conditions
- A stepped approach to medications with careful dose titration in tandem with response and symptoms.

---

### References

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## Slide 15: Differentiating Delirium – dementia - depression

	<b>Delirium</b>	<b>Dementia</b>	<b>Depression</b>
<b>Onset</b>	Acute	Insidious	Usually insidious
<b>Attention</b>	Impaired	Usually preserved	Impaired by severity usually preserved
<b>Short term memory</b>	Impaired	Impaired	May be impaired – often 'don't know' answers
<b>Fluctuations</b>	A feature	Usually absent	No
<b>Agitation</b>	Usual (but quiet delirium common in elderly)	Varies – not a NEW feature if present	May occur
<b>Mood</b>	Anxious	Usually normal	Depressed
<b>Delusions and hallucinations</b>	Common	Less common	Delusions can occur
<b>Precipitating cause</b>	Always present but may be unapparent	Not usually found	Triggers may occur
<b>Resolution</b>	Always improves (but may not resolve in elderly)	Does not resolve - progresses	Responds to therapy but may recur

M Woodward 2008

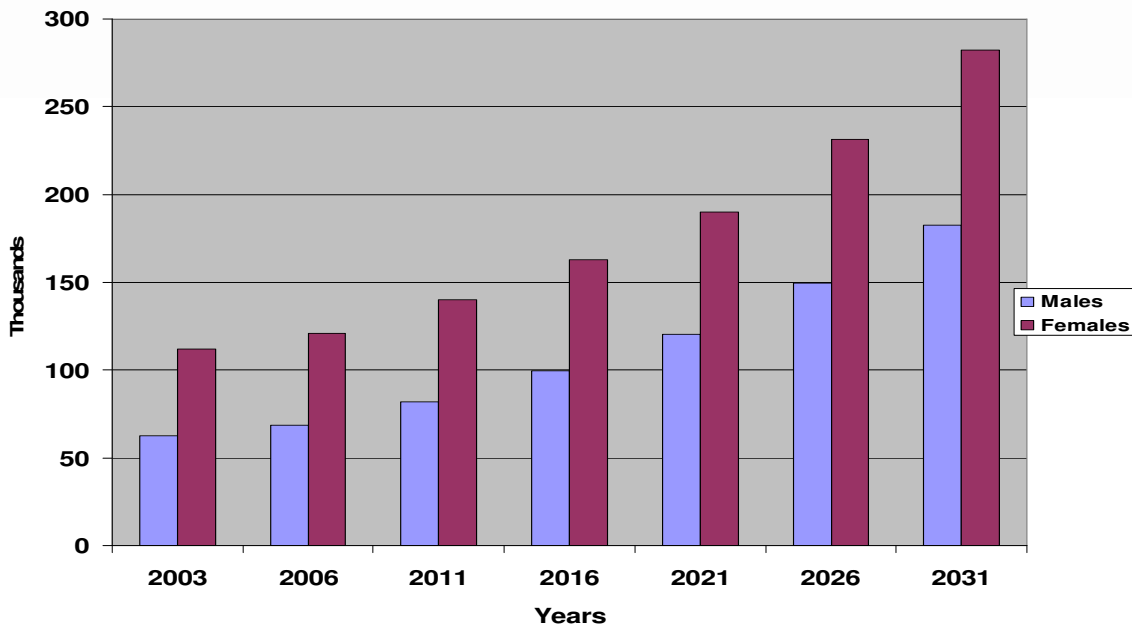
This table shows the differences between delirium (which may be substance induced) dementia (which may be an alternative diagnosis) and depression in older people.

### Key points

- It can be difficult to differentiate between dementia, delirium and depression in older people.
- Dementia is characterised by functional decline
  - *cognitive decline*: confusion, loss of capacity of memory, understanding and judgement.
  - *physical decline*: loss of mobility, poor nutrition
  - *neuropsychiatric behaviours*: wandering, agitation, aggression.
- AIHW data predicts enormous increases in the future for the prevalence of dementia in Australia. Projections are described in the additional notes below.
- Early diagnosis & early drug and behavioural management interventions optimise:
  - level of functioning
  - support and resources for families/carers
- There is lack of consensus about whether dementia is primarily a mental illness or a physical condition. This has significant practical implications for service design, service provision and for patients and families/carers. Common service problems include:
  - services being poorly equipped to meet the needs of patients and their families/carers
  - patients 'bounced' between services
  - gaps in services
  - poor coordination of service provision
  - complex to navigate through services.

### Additional information

Graph of projected number of people with dementia, 2003 to 2031



Source: *Older Australia at a Glance, 4th Edition, 2007, AIHW*

- Almost 175,000 people had dementia in Australia in 2003, and 190,000 in 2006, of whom 64% were female and 81% were aged 75 or older
- Since dementia prevalence is strongly age-related, the number of cases of dementia is expected to increase to almost 465,000 by 2031, as the population grows and ages.
- Dementia may be classified as 'mild' in about 96,000 people (55%); 'moderate' in 52,000 people (30%); and 'severe' in 26,000 (15%).
- Most people with mild dementia are living in households and most people with moderate or severe dementia are in cared accommodation.
- There were about 37,000 new cases of dementia in 2003 of which 23,000 are female and 14,000 male.
- Most of the 'burden of disease' caused by dementia is due to disability rather than premature death, with disability accounting for about three-quarters of the total disease burden in 2003.

#### Reference

Australian Institute of Health and Welfare. 2006. *Dementia in Australia: National data analysis and development. AIHW cat. No. AGE53.* Canberra: AIHW.

Australian Institute of Health and Welfare. 2007. *Older Australia at a Glance, 4th Edition, AIHW cat No AGE 52.* Canberra. AIHW.

## Slide 16: Anxiety in older people

### Anxiety in older people

- Anxiety can stand alone
- Often goes hand in hand with depression and insomnia
- May be associated with dependent benzodiazepine or alcohol use
- Be aware of triggers and risk indicators
- Management includes psycho-education, sleep hygiene, review and management of medication
- Important to differentiate between iatrogenic benzodiazepine dependence and illicit use.

*“a fear response to the imagined”*

This slide anxiety and its management and provides information about anxiety and benzodiazepine use in older people.

### Key points

#### **Anxiety**

- Triggers and risks for anxiety are similar to depression. Many older people experience many fears that may create, or feed, anxiety. Some common fears include fear of:
  - death
  - dementia
  - disability
  - loss of independence
  - going into residential care
  - bereavement and loneliness
  - falling
- In primary care, it is common to find a mixed picture of anxiety, depressive or somatic symptoms.
- There may be a family and or personal history of 'worrying'.
- It is important to exclude a physical cause – e.g. thyrotoxicosis.
- Psycho-education (including cognitive behavioural therapy and counselling) can build self-management strategies and resilience).
- Sleep hygiene should be an essential part of any consultation with this group.

#### **Benzodiazepine dependence**

- Older people may have developed a dependency on benzodiazepines.
- Patients tend to be older females, anxious - with chronic insomnia and worries and poor general health.
- They will usually fall into the 'iatrogenic' group – that is, people who have developed dependence through the legitimate prescription of benzodiazepines by a medical practitioner – usually for anxiety, sleep disorders, agitation associated with a psychiatric disorder or medical conditions such as epilepsy.
- A small number may be or have been illicit users, who have sought out multiple prescribers or who are dependent on other substances or have a psychiatric disorder.

- Common adverse effects from benzodiazepine use in the older person include confusion, fatigue, dry mouth, blurred vision, altered sleep patterns, ataxia and falls, nausea, vomiting and constipation.

*FOR THIS REASON, BENZODIAZEPINES SHOULD BE USED WITH CAUTION IN THE OLDER PERSON WARNINGS ABOUT THE IMPACT OF THEIR USE ON DRIVING SHOULD BE GIVEN*

### **Combination of benzodiazepines and alcohol**

Mixing alcohol with benzodiazepines will increase the sedative effects and increase risk of overdose, especially in older people. Conversely alcohol also slows the absorption rate of benzodiazepines, making them less effective.

---

### **Additional information**

#### **Doctor Shopping**

- Doctor shoppers are people who see 15 or more GPs, have 30 or more consultations or receive 50 or more PBS scripts in any one year.
  - The most common scripts sought were for opioids and benzodiazepines
  - There were 8,179 doctor shoppers in Australia in 2001
  - 20% of these doctor shoppers were aged between 15 and 29 years
  - 58% of these doctor shoppers were aged between 30-49 years
  - There is likely to be only a small number of older people in Australia who 'doctor shop' to obtain benzodiazepines.
  - The cost of Medicare items in 2001 for these patients was between \$17,023,684 and of PBS (about equally opioids and benzodiazepines) was \$15,831,939.
  - A minority of doctors write the majority of prescriptions for doctor shoppers.
  - 77% of these doctors are in capital cities.
- 

#### **References**

- Ashton H. 2005 The diagnosis and management of benzodiazepine dependence *Current Opinions in Psychiatry* May 18(3) pp 249-55.
- Health Insurance Commission. 2001. *Prevalence in Doctor Shopping*. Commonwealth of Australia.
- Schweizer E. Case WG. Rickels K. 1989 Benzodiazepine dependence and withdrawal in elderly patients.
- Ashton H. Golding JF. 1989 Tranquillisers: prevalence, predictors and possible consequences. *British Journal of Addiction*, May 1984 (5) pp541-6.

**Slide 17: Substance use in older people**

**Substance use in older people**

*under reported and  
under recognised*

- What substances are being used?
  - Alcohol, tobacco, prescribed medications, complementary and OTC medications, illicit drugs.
- What is the level of use and in what combinations ?
- What is the pattern of use? – current, historical
- When were medications last reviewed?
- Consider mental health comorbidity

*Consider a medications review (HMR or RMMR)*

This slide provides some key questions about substance use that require consideration when assessing the health of an older person. It is important that these questions are considered for EVERY patient.

**Key points**

- Service providers need to be skilled in eliciting accurate information
  - Be creative – open ended non-judgemental questions, motivational interviewing, talk to family members, use screening tools
- Service providers need to be aware of their own values, attitudes and assumptions.
- Most important questions:
  - *What medications/substances is the person taking and what is the pattern of use?*
  - Ask about **all** substances – this will include prescribed medications, OTCs, natural remedies, alcohol, tobacco and illicit drugs.
  - Do not just accept what they tell you – there is a range of reasons why they may not fully disclose all use:
    - they may not be aware of adverse interactions
    - they may not be aware of associated risks
    - shame, guilt, fear of judgement
    - they may not recognise a complementary medicine is a 'drug'
  - Check your own assumptions.
  - Assess client's knowledge about medications & substances being taken and possible interactions.
  - Accept that you may not know much about some substance use, especially substance use that is specific to particular groups – e.g. kava. Ask the patient about the substance, how they use it and what effects it has for them.

**Additional information**

- Pattern of use:
  - current use – think about ways to reduce harm from use
  - historical use – think about risks and physical damage
  - reiterate that the current cohort of older people (baby boomers) – are more likely than previous generations to have used (a few may still be using) illicit drugs and to have received treatment for their use. They will survive into old age.

- Where pain is present, a small number of older people may use or seek to use cannabis as pain relief.
- 

#### References

Australian Institute for Health & Welfare *National Drug Strategy Household Survey* <http://www.aihw.gov.au/drugs/ndshs07.cfm> 2007  
Winstock A. 2007 *'Can Do' clinical education. History taking and Assessment.* AGPN. Canberra. [www.agpncando.com.au](http://www.agpncando.com.au)

## Slide 18: Why do older people use substances?

### Why do older people use substances?

- Older people use for the **same reasons** as anyone
  - to relieve boredom
  - to enhance mood
  - to socialise
  - as part of lifestyle or habit
  - to cope with stress or sadness
  - to self medicate symptoms of mental illness
- In the individual, consider
  - reason for use
  - access
  - need for change
  - possibility of mental health co-morbidity
  - referral to specialist services

This slide provides a snapshot of some of the reasons why older people may be using substances. It is important to consider whether an older person is dependent on a particular substance and whether this dependence is long term or late onset.

### Key points

- Older people use substances for the same reasons as the rest of the population. This may challenge provider assumptions.
- Older people may be long term dependent substance users (particularly true of alcohol dependence)
- Important to identify late onset dependence – remember this may signal an underlying stressor or illness that has contributed to late onset dependence.

### Additional information

- mental illnesses may manifest differently in older people and impact on substance use: cognitive impairment leading to disinhibition, forgetfulness and impaired judgement
- older people are more likely to have more 'leisure' time to use substances particularly alcohol

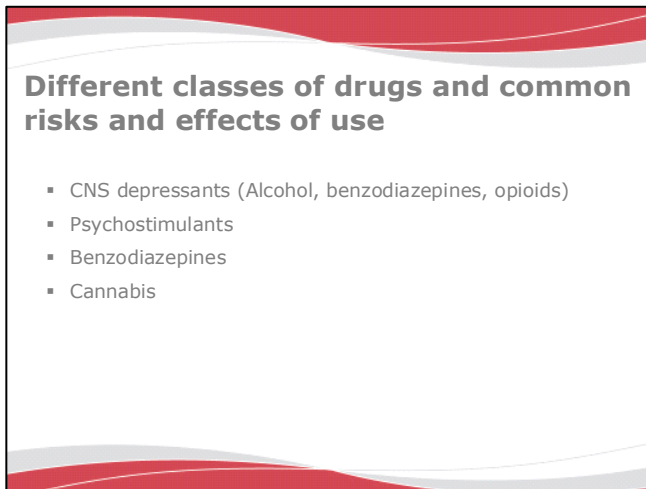
When the pattern of use is considered problematic, consider the person's **readiness for change**, which is determined by a number of factors most significantly the person's perception of the need for change.

- It is generally accepted that people will not change until they identify a need for change. A useful model to understand people's readiness for change is **Prochaska and DiClemente's Stages of Change Model**. They describe six stages. People may move back and forth between stages
  1. *Pre-Contemplation* - not currently considering change: "Ignorance is bliss"
  2. *Contemplation* - ambivalent about change: "Sitting on the fence", not considering change within the next month
  3. *Preparation* - some trialling of change, attempting to change: "Testing the waters", planning to act within 1 month
  4. *Action* - practicing new behaviour for 3-6 months
  5. *Maintenance* - continued commitment to sustaining new behaviour, 6 months - 5 years
  6. *Relapse* - resumption of old behaviours: "fall from grace"

### References

Prochaska J, Di Clemente C. 1986. Towards a comprehensive model of change. In Miller W, Heather N. (eds) *Treating addictive behaviours: processes of change*. NY. Plenum Press.

## Slide 19: Different classes of drugs and common risks and effects of use



**Different classes of drugs and common risks and effects of use**

- CNS depressants (Alcohol, benzodiazepines, opioids)
- Psychostimulants
- Benzodiazepines
- Cannabis

This slide outlines the different classes of drugs and highlights some of the risks and side effects associated with substance use in older people. Remember these are *in addition* to the challenges and stressors that face older people that have been described in previous slides. Adverse effects from substance use can confound and/or compound physical problems, environmental issues and mental health concerns.

### Key points

- **Use of CNS depressants** in older people may include **opioids, benzodiazepines and alcohol**
- These substances are particularly problematic if used in combination and can result in:
  - respiratory overdose, aspiration, coma
  - withdrawal specific syndromes
  - cardio-respiratory problems: arrhythmias, pulmonary oedema, pulmonary emboli, cardiomyopathy.
  - renal complications: rhabdomyolysis, membranous nephropathy
- Neurological effects can include peripheral neuropathy, local nerve damage, myopathy.
- In older people opioid use is generally prescribed medication for pain control. A very small number of older people may be long term illicit opioid users.
- **Benzodiazepines:** rarely cause fatal overdose in isolation but the risk is significantly increased in older people, especially if they are taking other medications. In combination with opioids and/or alcohol, benzodiazepines can be very dangerous in overdose.
- **Psychostimulant** use in older people, as for other age groups can lead to cardiac arrhythmias, cardiomyopathy, aneurysm, MI, pulmonary hypertension. Metabolic effects can include hyperthermia, dehydration, aortic dissection. CNS effects can include choreoathetoid movements or seizures.
- **Cannabis** use may produce adverse effects such as nausea, vomiting or anxiety which are usually self-limiting. Older people may be long term cannabis users or may be using cannabis to control pain. Management is supportive, requiring reassurance and occasionally symptomatic relief. If pain is the underlying issue, thorough assessment and appropriate pain management is required.

**Additional information**

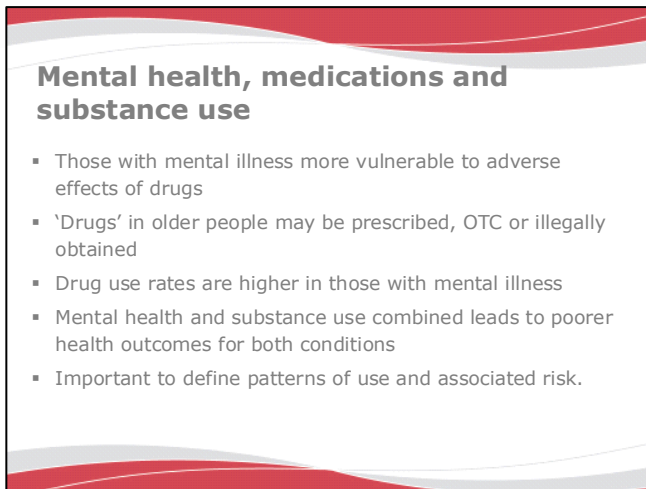
If participants would like more detail on clinical effects of substances, refer them to 'Can Do' clinical education package at [www.agpncando.com](http://www.agpncando.com)

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**Reference**

Degenhardt L, Lynskey M, Hall W. 2003. *Drug Trends in Australia*. National Drug and Alcohol Research Centre. UNSW.

## Slide 20: Older people: mental health, medications and substance use



**Mental health, medications and substance use**

- Those with mental illness more vulnerable to adverse effects of drugs
- 'Drugs' in older people may be prescribed, OTC or illegally obtained
- Drug use rates are higher in those with mental illness
- Mental health and substance use combined leads to poorer health outcomes for both conditions
- Important to define patterns of use and associated risk.

This slide outlines a number of connections between mental health, medications and substance use in older people.

---

### Key points:

- With mental health and substance use, always assume that if one is present the other may also be present.
- Remember that while only a small number of older people will be long-term illicit drug users, many will be long-term tobacco smokers and many will consume over the recommended limits of alcohol.
- There is significant under-recognition of substance use by health professionals because
  - older people are less likely to disclose and are more likely to use "indoors".
  - health professionals' values & attitudes influence inquiry, screening and diagnosis – 'low degree of suspicion'
- When it is recognised, treatment and management approach may be less straightforward than in younger age groups
- Families and carers can provide important verification of patterns of use and also important support for the older person.
- Those patients in this particular life stage are more likely to experience grief and loss/anxiety and depression.
- Expected increase in numbers of older people (baby boomers) who are:
  - likely to have mental health and substance use issues
  - with dementia

### Additional information:

- Substance use disorders more likely to present as a secondary problem in this age group
  - Check for a history of substance use and dependence.
  - If an older person has a history of illicit drug use, then they may also have a history of hepatitis C or other blood borne viruses, depression, poverty, chronic disease, poor nutrition, poor relationships/isolation and crime.
  - Important to differentiate between overuse of prescribed medication and illicit use of prescribed medication especially benzodiazepines and opioids.
  - Remember that older brains are more 'drug' sensitive and that protective psychosocial factors diminish.
-

## Slide 21: Alcohol use in older people

**Alcohol...**

- is the major substance use problem among older people
- is under reported and under recognised
- seen as understandable in context of poor health and changing life circumstances

*more likely to drink "indoors"*

- Approach: aim for **harm minimisation**
  - know recommended safe levels of use
  - ask about use, use screening tools
  - consider implications of current use
  - consider implications of long term use
  - consider individual's need for change

This slide covers some key aspects of alcohol use by older people and suggests some simple screening tools to use to identify levels and patterns of drinking.

### Key points

- Alcohol use
  - is under reported and under recognized in older people
  - is the major substance use problem among older people
- Prevalence data - **60+** age group (AIHS 2004)
  - 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
  - The prevalence of hazardous drinking in older people (65+) according to current NHMRC guidelines is 16.6% of patients seen by GPs (2006).

### Ask about use

- The limited research indicates that alcohol use in older people is under recognised by health professionals. This suggests that providers need to raise their clinical index of suspicion for harmful levels of alcohol use in this age group.
- Ask about drinking history and alcohol related problems
- Check if there have been previous treatments
- Ask about the circumstances surrounding relapse
- Check family history of alcohol use
- Conduct a risk assessment
- Where patients have both mental health and substance use disorders a risk assessment **MUST** be conducted that explores past predictors of violence as well as current assessment of risk.

### Long term use

Where older people have been drinking at harmful and hazardous levels for a long time, look for the following:

- Alcohol Related Brain Disease: frontal lobe encephalopathy, Wernicke's encephalopathy, Korsikoff's syndrome.
- Other alcohol related disease e.g. alcoholic liver disease.

- Consider their physical health and nutritional status.

---

## Additional information

### Approach

- *At the time of developing this resource the NHMRC guidelines for responsible alcohol consumption were under review. The NHMRC is seeking a new guideline that moves away from recommend levels of drinking and description of harmful and hazardous level to a single standard that promotes low risk drinking.*
- *CHECK latest information at [www.alcohol.gov.au](http://www.alcohol.gov.au) for the latest information about responsible consumption of alcohol.*

### Screening for alcohol use

There are a range of screening tools are available.

#### CAGE.

The CAGE questionnaire is good for heavy/dependent drinkers, but tends to miss many of those with less severe alcohol use disorders:

1. **C:** Have you ever felt you should **C**ut down on your drinking?
2. **A:** Have people **A**nnoyed you by criticising your drinking?
3. **G:** Have you ever felt bad or **G**uilty about your drinking?
4. **E:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

#### AUDIT

- Because CAGE may miss those who are drinking at risky levels it is useful to use AUDIT as well as CAGE.
- The AUDIT tool (Alcohol Use Disorders Identification Test) is a ten item, self-complete screening tool for dependent and hazardous drinking. It can be used to assist in the delivery of brief intervention.
- The AUDIT tool is a quick and reliable instrument for measuring alcohol use and related problems, It is particularly useful for primary health care settings and can be integrated into routine history taking and followed up by the general practitioner or the practice nurse.

#### Withdrawal from alcohol

- Withdrawal in the older person requires careful management, especially for those with high level of current use of alcohol.
- Transition into settings such as hospitals, nursing homes or other institutional care may mean the older person has to withdraw from their usual pattern of alcohol use.
- Non compliance may be an issue – the patient may discharge themselves from hospital or care setting prematurely because they haven't been able to have a drink.
- Check if there is a need for a supervised withdrawal program. If you are not sure, then seek the advice of an alcohol and drug specialist.

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#### References

- World Health Organization. 1993. *Alcohol Use Disorders Identification Test (AUDIT)* WHO. Geneva.
- Ewing J. 1990. *CAGE Questionnaire*. University of Carolina.
- National Health and Medical Research Council. *2001 Responsible Consumption of Alcohol Guidelines (UNDER REVIEW)* Australian Government Department of Health and Ageing. Canberra.
- Wallace P, Haines A. 1985. The use of the questionnaire in general practice to increase the recognition of patients with excessive alcohol use. *BMJ* 1985; 290 pp 1949-53.

## Slide 22: Pain, depression and medication in older people

**Pain, depression and medication in older people**

- Older adults use a high number of prescription and over-the-counter medications
- There is increased risk for inappropriate use of medications
- Younger substance users may be using opioids illicitly
- Older people more typically overuse or inappropriately mix prescribed and OTC drugs
- Opioids are commonly used by older people as pain control
- Older people are more sensitive to medication
- Many drugs impact on cognition

***Be vigilant in prescribing and monitoring medications***

This slide provides some brief information about the use of medication, especially opioids for pain and depression in older people. Opioid drugs are often over-prescribed and/or overused and may be mixed with over the counter medications and alcohol as well.

### Key points

- The combination of substance use, pain and mental illness is not only one of the most prevalent but also the most complex and challenging of all comorbidities.
- Pain and depression are common conditions in older people, typically managed in primary care.
- Pain and depression are more complex in presentation, less detectable and more resistant to treatment than other co-occurring disorders.
- People with these comorbidities also have higher rates of disability and reduced psychosocial functioning.
- The existence of pain and depression is associated with lower recognition, poorer treatment responses and worse outcomes.
- Better recognition, thorough assessment and management of comorbid pain may improve the outcomes of depression (and vice versa).
- Look for one when you see the other.
- Use a stepped approach to treatment that uses psychological support as first line and Tricyclic Antidepressants (TCAs) where indicated.
- Accept that many older people may increase function and quality of life with good treatment but *remain with some pain*.
- Opioids are effective and can be used safely in chronic pain.
- Note however that long term therapeutic use can be associated with a number of changes : endocrine, immune and analgesics.

### Additional information

#### When to use opioids

Opioids should NOT be denied in those who have:

- Chronic pain
- Been unsuccessful with alternative therapies
- Been investigated to exclude treatable pathologies
- Had psychiatric conditions assessed and effectively treated

- Processes put in place to minimise the risk of abuse, dependence diversion and doctor shopping.

### **Issues specific to older people**

- There is high prevalence of anxiety, sleep disturbance and chronic pain which lead to high levels of prescribed opioids (and benzodiazepines). These medications are open to misuse – wittingly or unwittingly.
- Drug toxicity must be considered in any older person with impaired cognition
- Metabolism of medications changes significantly with age, especially >80-85.
- This contributes to increased risk of adverse drug effects, falls & impaired cognition.

### **Appropriate prescribing**

- Take a thorough history and assess mental health and substance use and pain
- Remember that where there is pain there may be depression and vice versa
- Consider psychological interventions
- Observe QUM principles
- Ensure right medication and right dose
- Monitor adherence
- Review and plan for cessation
- Consider withdrawal process
- Assess risk/benefit
- Do regular medication reviews (HMR/RMMR)
- Consider financial cost
- Deal with ethical and emotional issues

Seek expert advice from alcohol and drug specialists and mental health services where necessary.

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### **References**

*Substance Abuse and Mental Health Among Older Americans: The State of the Knowledge and Future Directions*, Substance abuse and mental health services administration (SAMHSA) Service Technical Center <http://www.samhsa.gov/OlderAdultsTAC/index.aspx>

## Slide 23: Polypharmacy and drug interactions

### Polypharmacy and drug interactions

- Older people are at high risk of polypharmacy
- Medications can react with each other & with illicit drugs
  - always suspect drug interaction when new symptoms present
  - only way to identify drug interaction is to find out what person is actually taking
    - pharmacist, HMR/RMMR/'paper bag' review
- Need for rigorous review of drugs and de-prescribing

***Polypharmacy increases risk of drug interactions AND older people are at high risk of polypharmacy***

This slide discusses some important points about multiple use of medications in older people and the problems that may arise. This is also a good opportunity to introduce the topic of home medicine review as part of care planning.

### Key points

- Older people are at high risk of polypharmacy (4 or more drugs/day).
- There is a link between drug interactions, polypharmacy and adverse drug events.
- This slide links to previous slide – key issue is around appropriate prescribing.
- Polypharmacy
  - increases risk of adverse drug effects through drug interactions and errors including increasing risk of delirium/impaired cognition
  - carries cost and burden to older person of managing numerous medications
- Importance of communication between providers
- Value of same pharmacist

*NB: Think about some of the aids that are available to reduce confusion over medication and to ensure medication regimes are adhered to – e.g. Drug administration aids like blister packs and pill boxes.*

## Slide 24: Getting it right

### Getting it right

- Value the older person and their life story
- Take mental health and substance use histories for all older people
- Where there is a mental health issue there may be a substance use issue and vice versa
- Treating one can significantly improve the other
- Don't forget alcohol and tobacco are drugs too
- Look for opportunities for psychological interventions
- Monitor and review medication frequently
- Work in partnership with other health and social services
- Include the family and carers and look after them too

This slide summarises some of the key opportunities that arise when an older person presents with both mental health and substance use issues as part of their health profile.

---

### Key points

- Value the older person's dignity and their life story
  - Acknowledge the challenges and stressors associated with ageing
  - Think 'mental health' and 'harm reduction'- keep the focus on wellbeing
  - Include mental health and substance use assessment for all older people
  - Remember that alcohol and tobacco are drugs too
  - Don't exclude the possibility of a history or even current use of drugs that have been obtained or used illicitly.
  - Where depression, anxiety or pain present, check for substance use and vice versa.
  - Treating one can significantly improve the other
  - Seek support through a range of services – general practice, psychology services, Aged Care Assessment Teams, Medication Management Reviews (HMRs, RMMRs), alcohol and drug and mental health specialists
  - Work with the family and/or carers where possible
-

## Slide 26: Story vignettes and case discussion – part A

**Story vignette A - Diane**

**Discussion points**

1. What are the important issues for Diane?
2. If Diane were telling you her story how could you and your service help?
3. What are the risks and what assessments might you make?
4. How would you *prioritise* the risks that Diane presents with?
5. Does Diane's age (75+) make a difference to her management?
6. What interventions might be useful at this consultation?
7. What other longer term strategies could be considered and how would you ensure effective follow up?
8. What support could other local health and community services offer at this point and how would you access them?

Diane

*"Lately I've got so much pain and I can't seem to get on top of it. It's the arthritis. It's like as soon as I hit 75, my body just said to itself: 'that's it Diane, you've had a good run but you're old now.' I hate to think of myself like this.*

*It's not like me to stay in bed. You know, I've always been a morning person and when you live by yourself, you can't lie around. If you don't get things done, no one else will. But now it takes me ages just getting up and some days, I can't even think about walking the dogs. I've got the breathlessness too, that's been worse but I think that's probably because of the smoking and I know I should give that up. But the main thing is the back pain.*

*The pain killers don't work like they did. I've got a few sorts. I went around to the other Medical Centre last time because you were very busy and I was given something else. New, he said. So I take that too and also some herbal things. My daughter, you know she lives in the US now, she's been sending me some tablets that apparently her mother-in-law swears by.*

*So I'm rattling but it's all making me very dopey. And I'm worried all the time. I worry about having a fall when I'm out with the dogs and I worry about driving the car. But if I don't drive, what's going to happen to me?"*

---

### Points for Discussion

1. What are the important issues for Diane?
  2. If Diane were telling you her story how could you and your service help?
  3. What are the risks and what assessments might you make?
  4. How would you prioritise the risks that Diane presents with?
  5. Does Diane's age (75+) make a difference to her management?
  6. What interventions might be useful at this consultation?
  7. What other longer term strategies could be considered and how would you ensure effective follow up?
  8. What support could other local health and community services offer at this point and how would you access them?
-

### **Story vignette – feedback session**

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further explanation of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.
- Reflect and if necessary rephrase the participant's comment to link its relevance to the topic.
- Be sure to allow the different aspects of care on offer from the various service providers in the room to be described. Encourage them to think about how these fit together.

### **Facilitator's notes**

- Discuss Diane's story – what other history would participants need to obtain to get a full picture?
- There are a number of issues presented in this vignette – encourage participants to identify and prioritise the risks that Diane faces and to develop short and longer term strategies to assist him.
- Make sure participants discuss the mix of medications that Diane is using and that they consider the use of a home medicine review within the context of care planning.
- How would participants deal with Diane's shortness of breath and her tobacco smoking?
- Encourage participants to discuss safety issues, especially Diane's current living arrangements and the fact she is driving on a mix of medications.
- Isolation seems to be an issue here. Discuss.
- Make it clear that Diane's situation cannot be sorted out in one consultation –he needs longer term support.
- Discuss the risks and effects of alcohol use on Diane's mental health?
- Consider the range of local services that may be able to support Diane?

### **Note:**

Be mindful of potential conflict. Participants may focus on service deficiencies, vent their frustrations or recount negative experiences. Contain the discussion by:

- acknowledging the difficulty/frustration
- identifying the problem or issue
- problem solving as a group (if time permits).
- If time doesn't permit, offer an alternative e.g. agree to meet about later or pass the issue on to relevant people.

Above all, maintain a sense of humour and encourage participants to do so as well!

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## Slide 27: Story vignettes and case discussion – part B

**Story vignette B - Ted**

**Discussion points**

1. What are the important issues here for Ted?
2. If Ted were telling you his story how could you and your service help?
3. What are the risks and what assessments might you make?
4. How would you *prioritise* the risks that Ted presents with?
5. How would you go about estimating Ted's current and lifetime alcohol consumption and its consequences?
6. What interventions might be useful at this consultation?
7. Could you involve his family? How?
8. What other longer term strategies could be considered and how would you ensure effective follow up?
9. What support could other local health and community services offer at this point and how would you access them?

### Ted – 72years

*I can't talk to that other young doctor any more. She doesn't listen. I don't know. I don't seem to have much luck with women full stop. The wife went off years ago and my daughter's not much help – always telling me I've forgotten something, nagging me to clean up my place, have a decent meal and to stop the drinking and calling me a silly old fool. Last time I tried cooking, I left the stove on and nearly burned the place down. Safer not to cook these days I'd say. I know she can't be bothered any more - she just wants to put me away in a home. I think she thinks it'll be like it was with my Mum – she had Alzheimer's you see. I don't know why I bother really – not much to look forward to in life these days except the drink and most of my mates seem to have been put away in nursing homes or popped off. Only good bit of my day is driving down to the pub for a beer or two.*

*But I don't feel so good today, don't even feel like a drink. I've got this reflux pain back again and I've had another fall – my ribs hurt when I breathe. And I'm getting dizzy a lot – perhaps it's my blood pressure again? Can you fix it?*

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### Points for Discussion

1. What are the important issues here for Ted?
  2. If Ted were telling you his story how could you and your service help?
  3. What are the risks and what assessments might you make?
  4. How would you prioritise the risks that Ted presents with?
  5. How would you go about estimating Ted's current and lifetime alcohol consumption and its consequences?
  6. What interventions might be useful at this consultation?
  7. Could you involve his family? How?
  8. What other longer term strategies could be considered and how would you ensure effective follow up?
  9. What support could other local health and community services offer at this point and how would you access them?
-

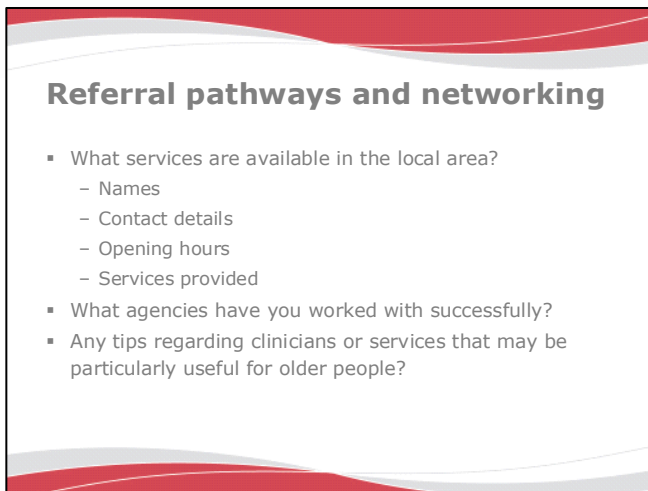
### **Story vignette – feedback session**

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further explanation of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.
- Reflect and if necessary rephrase the participant's comment to link its relevance to the topic.
- Be sure to allow the different aspects of care on offer from the various service providers in the room to be described. Encourage them to think about how these fit together.

### **Facilitator's notes**

- Discuss Ted's story – what other history would participants need to obtain to get a full picture?
  - There are a number of issues presented in this vignette – encourage participants to identify and prioritise the risks that Ted faces and to develop short and longer term strategies to assist him.
  - What assessment tools could you use for Ted's alcohol use? Refer back to AUDIT, CAGE and other psychological assessment tools.
  - Discuss participants' duty of care to Ted in relation to his drinking, his mental health and his lifestyle.
  - Ask participants whether depression could be affecting his memory loss. How would participants distinguish between early Alzheimer's and depression?
  - Consider other assessments for Ted e.g. from the Aged Care Assessment Team (ACAT)
  - Discuss additional supports that could be offered to Ted in his home – or does he need to consider residential care?
  - Encourage participants to discuss safety issues, especially Ted's current living arrangements and the fact he is driving to the pub and back daily.
  - Discuss the risks and effects of alcohol use on Ted's mental health?
  - Consider the range of local services that may be able to support Ted?
  - What would you do if Ted said he didn't need any assessment, home visits or help?
-

## Slide 28: Referral pathways and networking



**Referral pathways and networking**

- What services are available in the local area?
  - Names
  - Contact details
  - Opening hours
  - Services provided
- What agencies have you worked with successfully?
- Any tips regarding clinicians or services that may be particularly useful for older people?

### Service mapping exercise:

Participants are provided with a service mapping template which they should complete and bring with them to the training session. If they have not, ask them to spend a few minutes completing the template.

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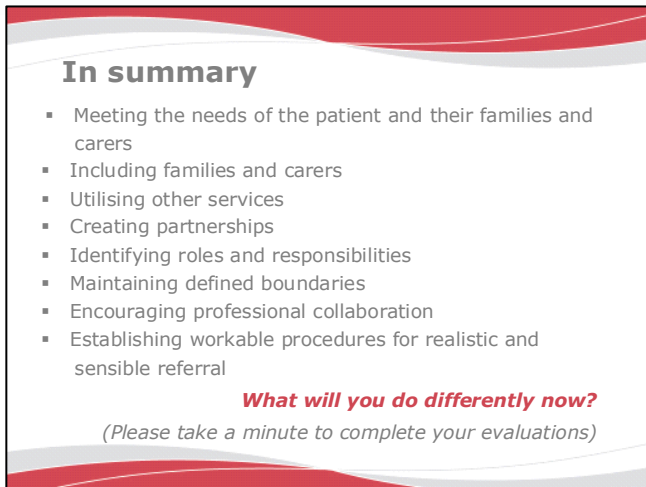
### Key points

- Participants share information about their services based on the areas outlined in the slide.
  - Map key services on the white board or ask the coordinator to scribe information.
  - Be as precise as possible and include contact phone numbers and key information.
  - Where possible, include other agencies and services such as non Government Organisations and community or Council programs.
  - Ask participants for consent to circulate the information provided to all participants.
  - Following the workshop, ensure the coordinator circulates a copy of this information to all participants.
- 

### Additional information

- Revisit the two stories discussed and 'map' the services identified so that participants are aware of the service location, referral procedures, opening hours, contact numbers, and other relevant information.
  - Appoint someone to note the details of local service providers on the whiteboard. If possible, ensure all attendees receive a copy.
-

## Slide 29: In summary



**In summary**

- Meeting the needs of the patient and their families and carers
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Maintaining defined boundaries
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

**What will you do differently now?**

*(Please take a minute to complete your evaluations)*

An opportunity is now provided for the audience to address any questions to the facilitators and conclude the discussion of this topic.

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### Key points

- This unit aimed to:
    - increase participant awareness of the mental health and substance use issues relevant to older people
    - increase participant understanding of why older people may use substances
    - identify the physical, psychological and social risks to older people associated with mental health and substance use
    - improve participant knowledge of strategies to address these risks, and resources available to assist.
  - Ask each participant to say one or two words on what they thought about the unit
  - Ask the question: *What will you do differently?* (as a result of knowledge and information received at the training sessions).
  - Ask participants to complete the post test evaluation.
  - Hand out information packs.
-