
Late Life Addictions

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MIRECC

**Mental Illness Research, Education
and Clinical Centers**



Support

- **NIH**
- **Department of Veterans Affairs**
 - **VISN 4 MIRECC**
- **Hazelden Research Foundation**
- **Commonwealth of Pennsylvania**

Overview

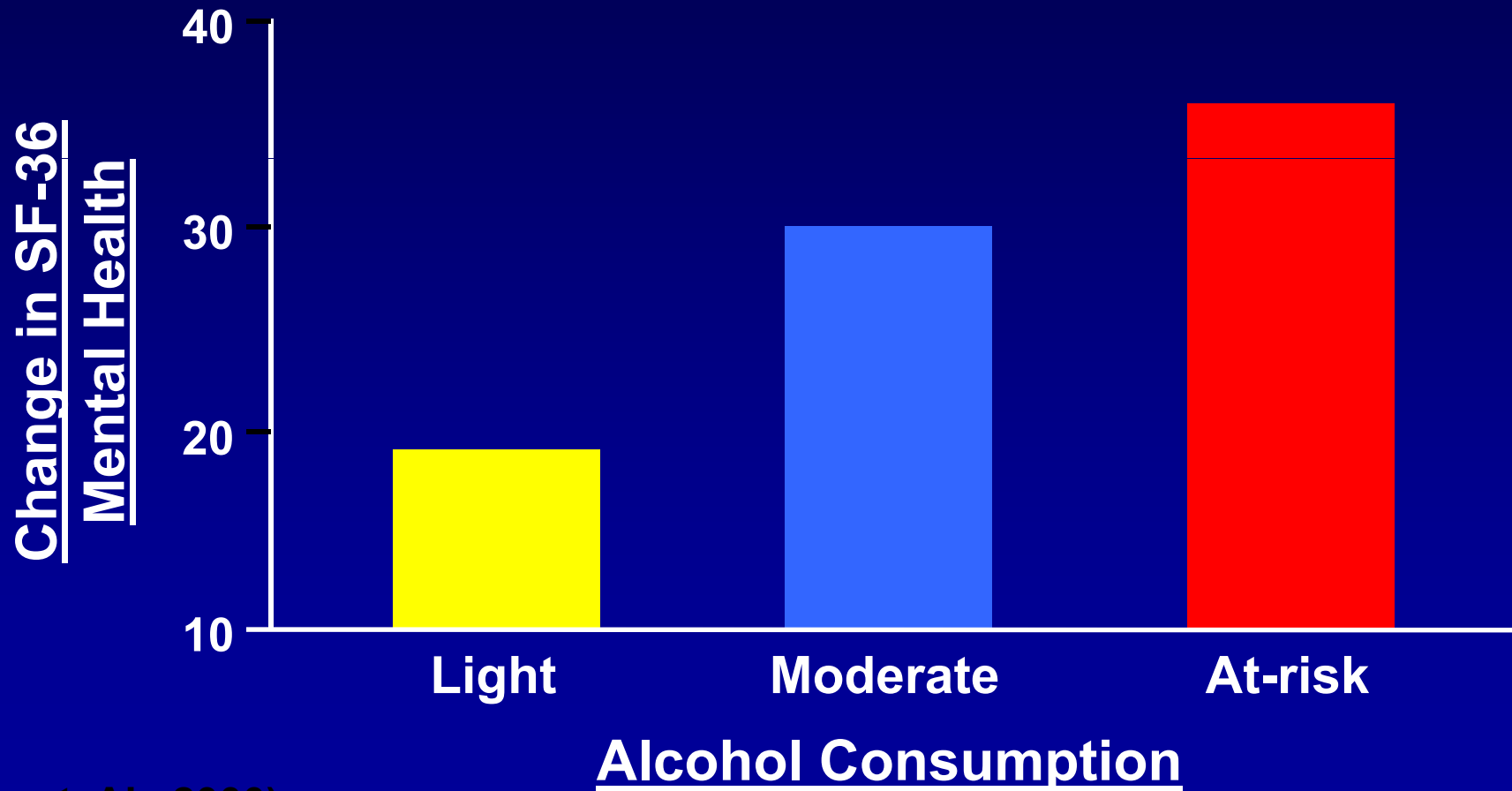
- **It is not all about addiction**
- **What everyone needs to know about treatment**
- **Focus –**
 - **Alcohol and “Addictive” Medications**
 - **Non-addiction treatment settings**



The importance of context

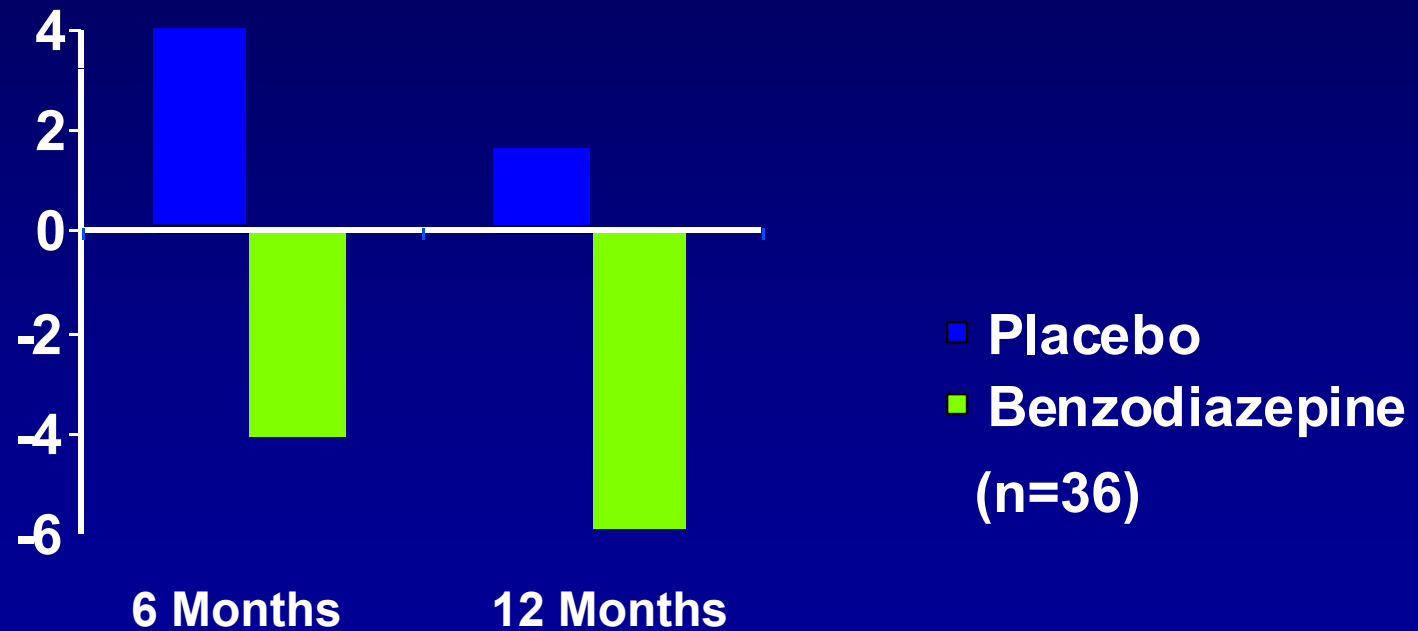
- **Context 1: 80 year old, with poorly responsive major depression, hypertension who drinks 1 glass of wine per night.**
- **Considerations**
 - **Confirm 4-5 oz only**
 - **Impact of moderate alcohol on depression**
 - **Appropriate treatment plan**

Improvement in Mental Health with abstinence and depression treatment



(Oslin et. Al., 2000)

Benzodiazepine Discontinuation



Habraken et. Al., 1997

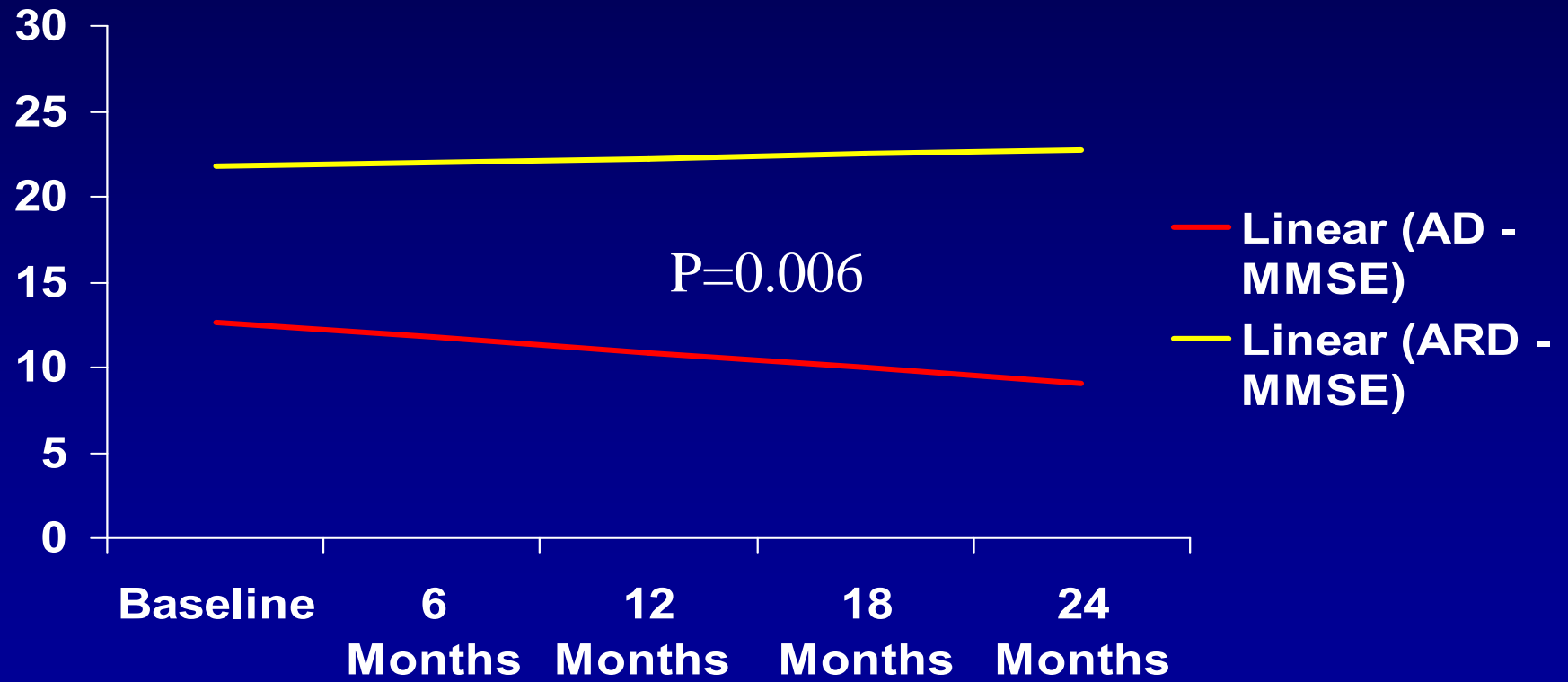
The importance of context

- **Context 2: 73 year old, with early signs of dementia, admitted to a nursing home has a past history of excessive alcohol use.**
- **Considerations**
 - **Prognosis and course of treatment**
 - **Focus of treatment**

Alcohol Related Dementia

- Longitudinal study of nursing home residents with Alcohol related dementia (n=16) or Alzheimer's Disease (n=26).
- Subjects identified from consecutive nursing home admissions (n=212) evaluated for cognition, disability, addiction history
- Subjects followed every 6 months for 2 years.

Disability and cognition



Past History of Addiction

- Many older adults especially those of the “Woodstock” generation will enter late life with a past history of alcohol or drug abuse
- 5 fold increase in late life mental disorders (depression and dementia)
- Treatment of late life depression (3-5 yr outcomes)
 - 88% of those without an alcohol history significantly improved
 - 57% of those with an alcohol history significantly improved

The importance of context

- **Context 3: 68 year old, presents for evaluation of chronic health problems, drinks socially**
- **Considerations**
 - **Appropriate evaluation**
 - **Interpreting the evaluation**

What constitutes a good evaluation?

- **Screening – AUDIT C or TLFB**
- **Full assessment should include**
 - **Quantity and frequency of use**
 - **Urine drug screen**
 - **Biomarkers – MCV, GGT**

Alcohol Screening:

How often did you have a drink containing alcohol in the past year?

- Never (0 points)
If you answered never please the questionnaire is complete
- Monthly or less (1 point)
- Two to four times a month (2 points)
- Two to three times per week (3 points)
- Four or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

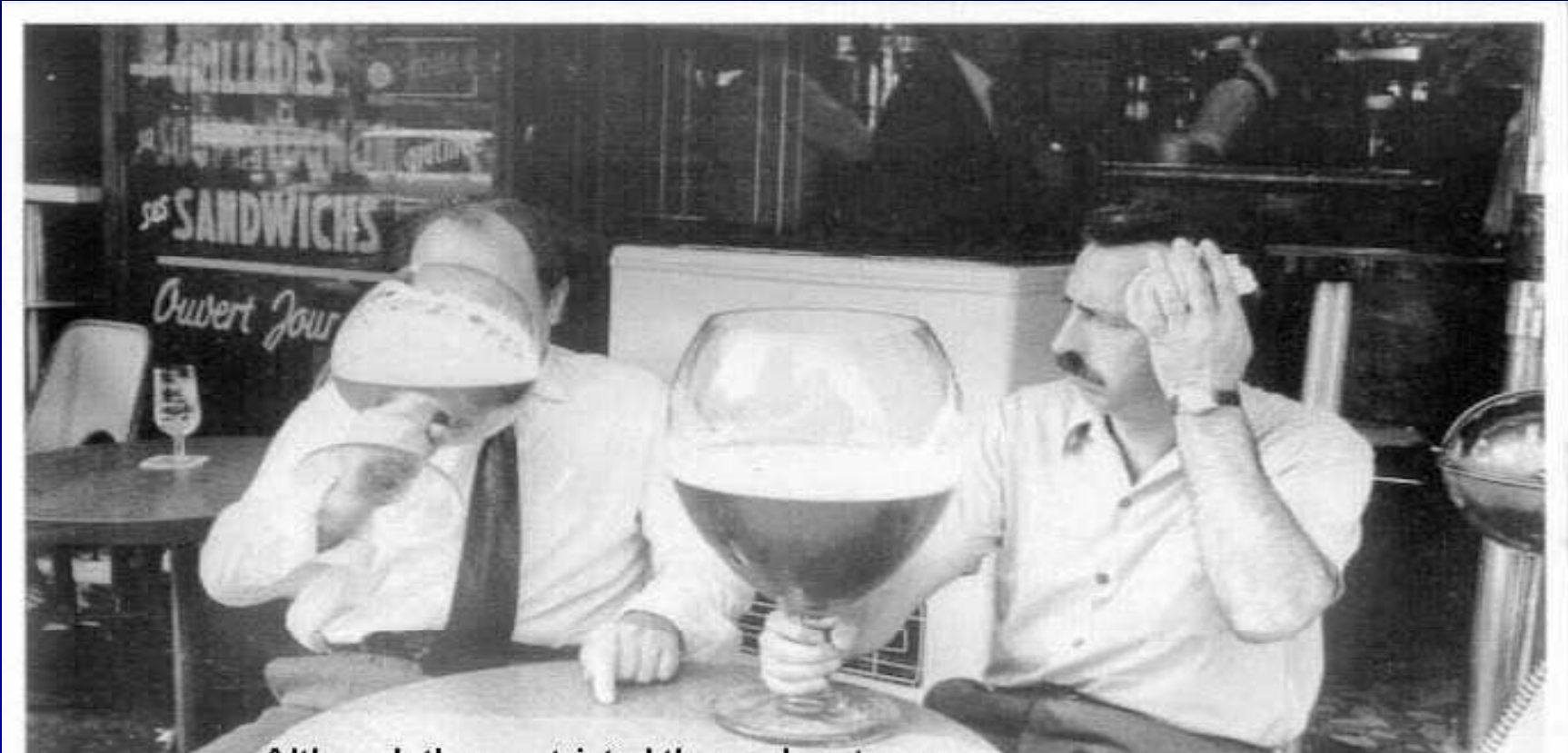
- 1 or 2 (0 points)
- 3 or 4 (1 point)
- 5 or 6 (2 points)
- 7 to 9 (3 points)
- 10 or more (4 points)

How often did you have six or more drinks on one occasion in the past year?

- Never (0 points)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

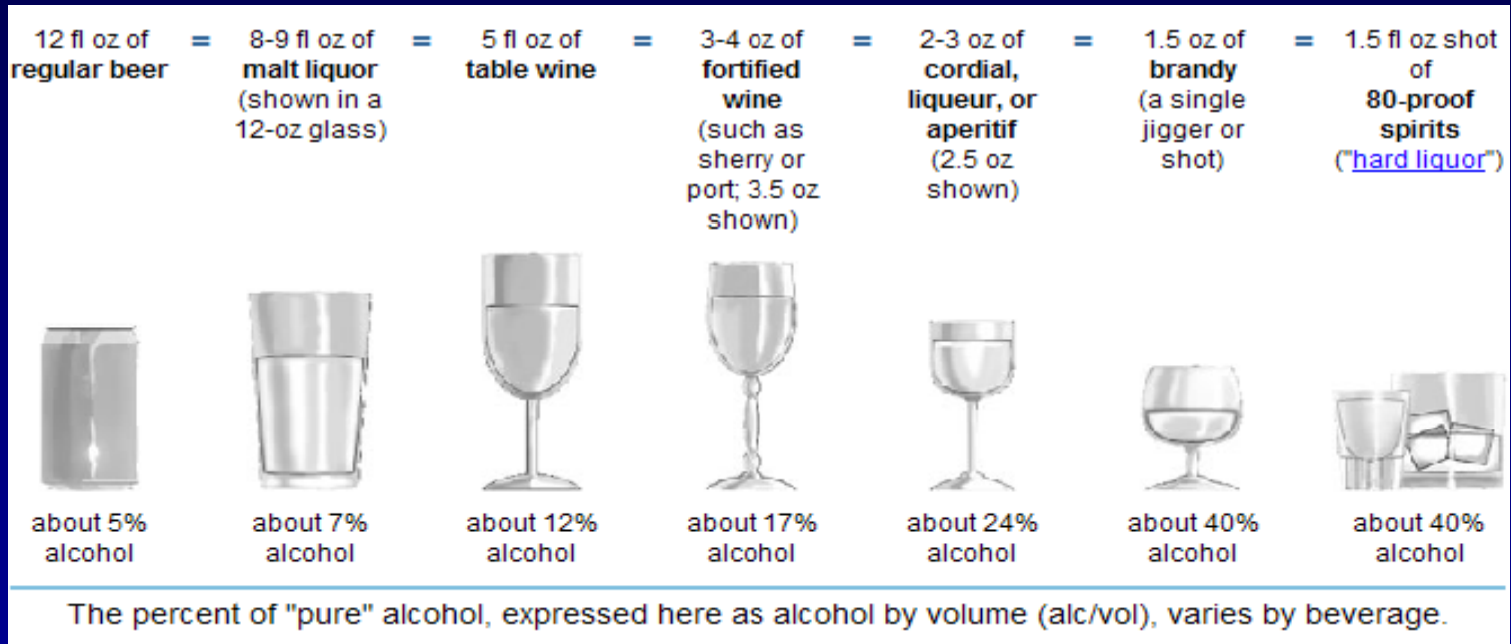
The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). A score of 4 or more is considered positive and suggests the need for further evaluation. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Importance of Standard Drink Sizes



Although they restricted themselves to one drink at lunch time, Howard and Tom still found they were not at their most productive in the afternoons.

What is a Drink?



When should I be concerned?

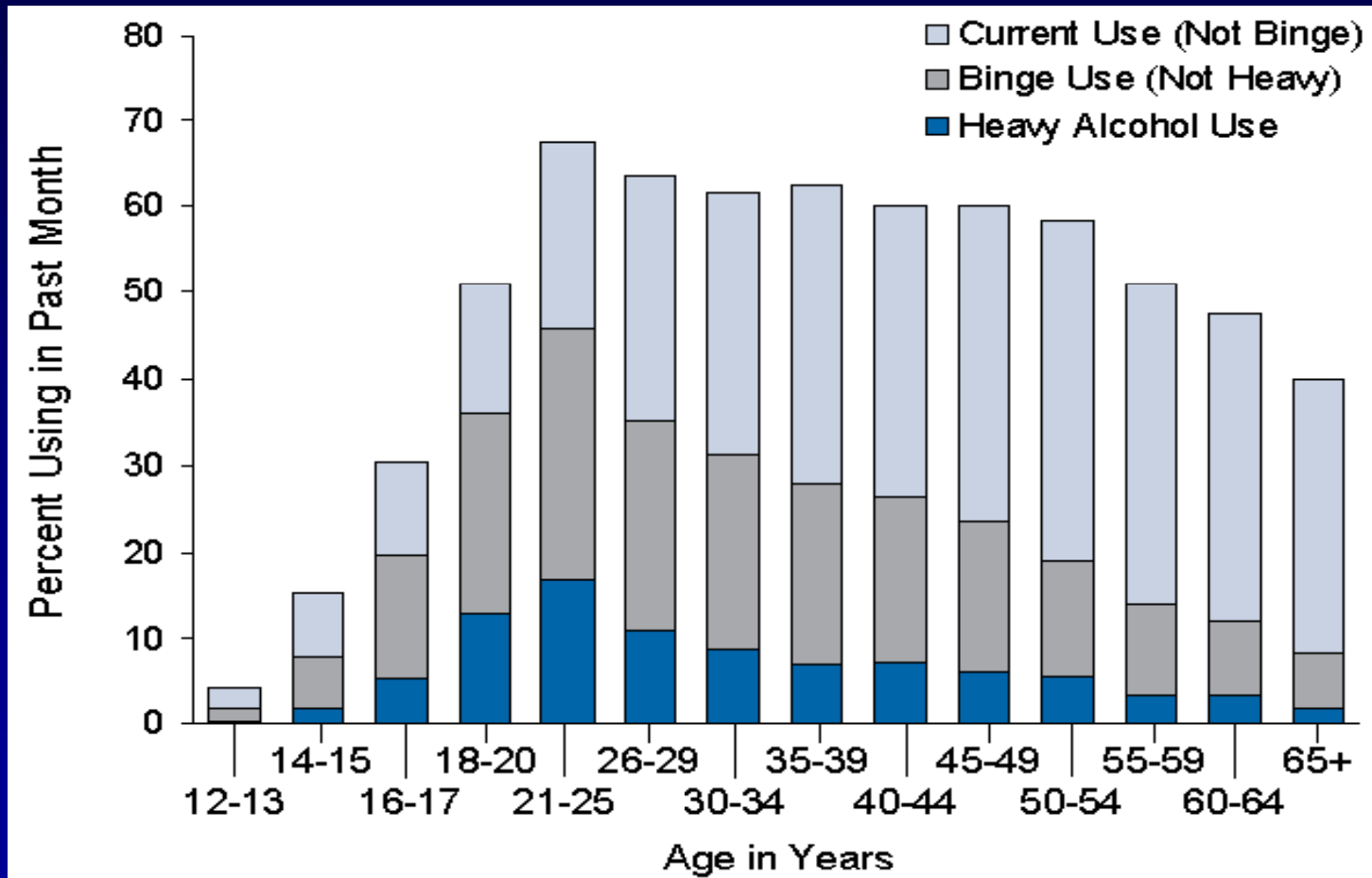
Public Health

- Drinking no more than an average of 1/1.5/2 drinks/day
- No binge drinking (4 or more drinks in one day)
- No drinking while taking certain medications or in patients with certain illnesses

Addiction

- Loss of control

Alcohol use across the lifespan



Medications (opioids, benzodiazepines, etc)

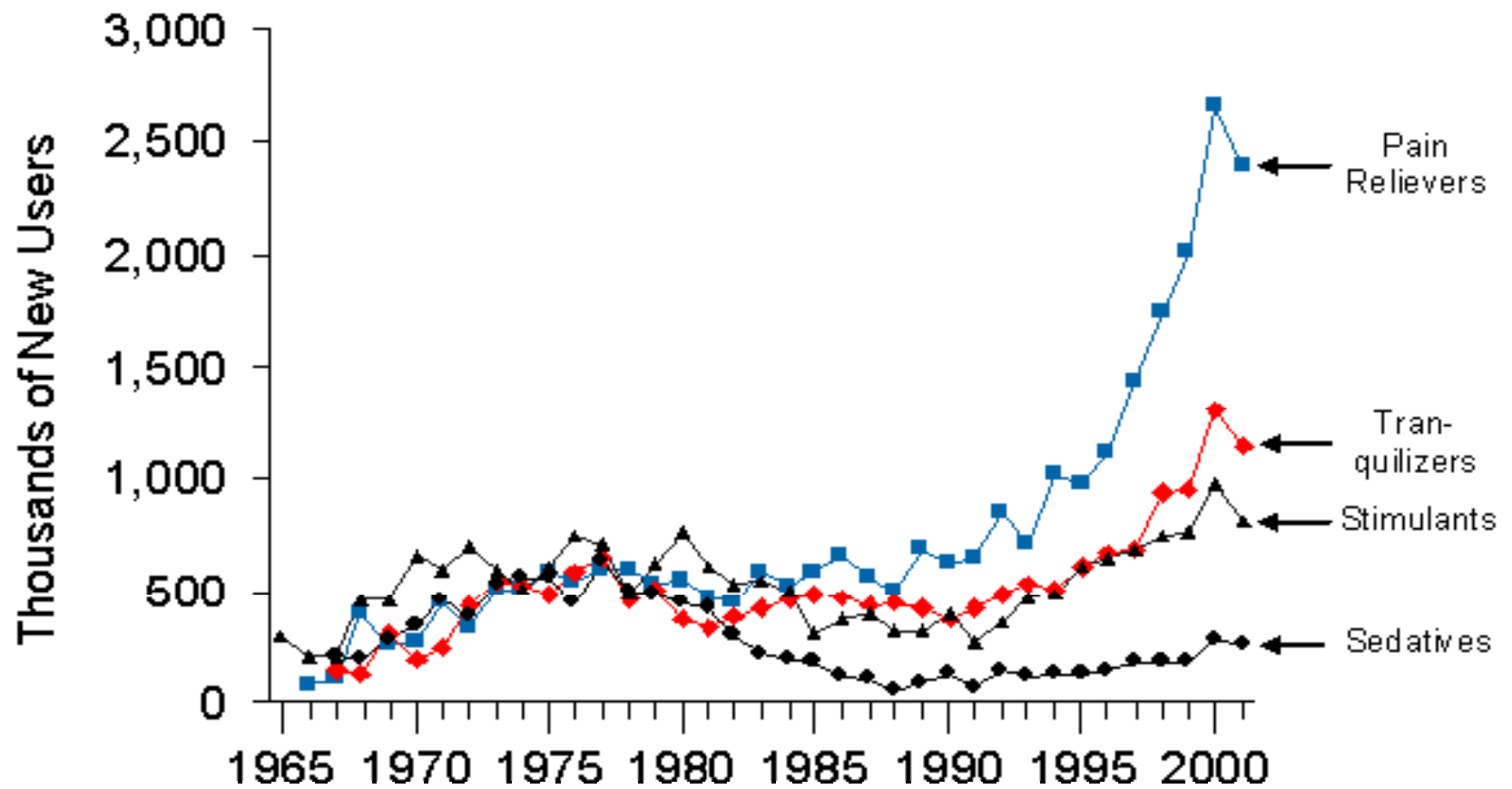
Public Health

- Use with no therapeutic effect
- Use in combination with certain other medications or in patients with certain illnesses

Addiction

- Loss of control

Number of new non-medical users of therapeutics



Relevance to Aging

- **Past history of addiction – impacts treatment choice, prognosis for other disorders**
- **Light to Moderate use impacts other psychiatric illness and is a target for intervention**
- **Addiction does occur in older adults and is often overlooked**

What are my treatment options?

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- **Past addiction**
- **Light to excessive**
- **Addiction**

Past Addiction

- Relapse prevention – avoid unnecessary medications, cross tolerant medications
- ?Aggressive management

Light to Excessive Use

- **Education and advice**
- **Use of motivational interviewing or brief interventions**

Brief Advice and Brief interventions

- Brief advice
 - Express concern
 - Make relevant
- Brief Interventions
 - Time-limited (20 minutes in 1-3 brief sessions)
 - Workbook driven

Brief Interventions

- Can decrease alcohol use for 12 months
- The effect size is similar for men and women
- No difference in effect by age
- Can lead to decreased use of emergency rooms, clinic visits, etc.

Key Components of Alcohol Brief Interventions

- **Identification**
- **Feedback**
- **Motivation to change**
- **Strategies for change**
- **Behavioral contract**
- **Follow-up**

Treating Addiction

Drug Free Housing

Pharmacotherapy

Residential Treatment

CBT

Motivational Enhancement

12 step Facilitation

Telephone Aftercare

Intensive Outpatient

Supported Employment

AA / Peer Support

Addiction

Things to Avoid

- Refer to peer support only
- Simple referral
- Treat concurrent disorder alone
- Abstinence as the only acceptable outcome

Things to Learn

- Brief intervention and refer
- CBT or other evidenced based psychotherapy
- Pharmacotherapy
- Patients may have different goals than you
- Toxicity is often dose dependent. Strive for the lowest dose possible.

Simple vs Brief Intervention Referral

	Attended 1 st Appointment
Motivational Session	70%
Control Group	32%

$p = .006$

Zanjani F, Oslin D (2005). Telephone Based Referral-Care Management. Grant Supported by Philadelphia Veteran's Affairs: Mental Illness Research Education and Clinical Center (MIRECC)

12 Step Attrition 1 month

	Elderly Subjects	Middle Aged
Attend AA	81.2	91.1
Have a sponsor	54.6	64.7
Attend Aftercare	31.2	56.4

Treating Depression and Alcohol Dependence

- Current depressive syndrome
- Current alcohol dependence
- Age 55 and over
- 10 sessions of BRENDA – supportive therapy focused on both alcohol use and depression
- All subjects receive sertraline 100 mg
- Outcomes at 3 months

Effect of not addressing alcohol to remission

	No Relapse	Relapse	p
Depression Remitted	63.3	32.0	0.011
HDRS – end of trial	8.8 (6.7)	12.7 (8.2)	0.013

Pharmacotherapy for Addiction

- Alcohol dependence
 - Naltrexone
 - Acamprosate
 - Antabuse
- Opioids
 - Buprenorphine
 - Methadone
- Cocaine
 - ?
- Nicotine
 - Nicotine replacement
 - Bupropion
 - Varenicline
- Antidepressants
- Mood Stabilizers
- Antipsychotics
- Benzodiazepines
- Sleep enhancers
- Cognitive Enhancers
- Stimulants
- Serotonergic agents

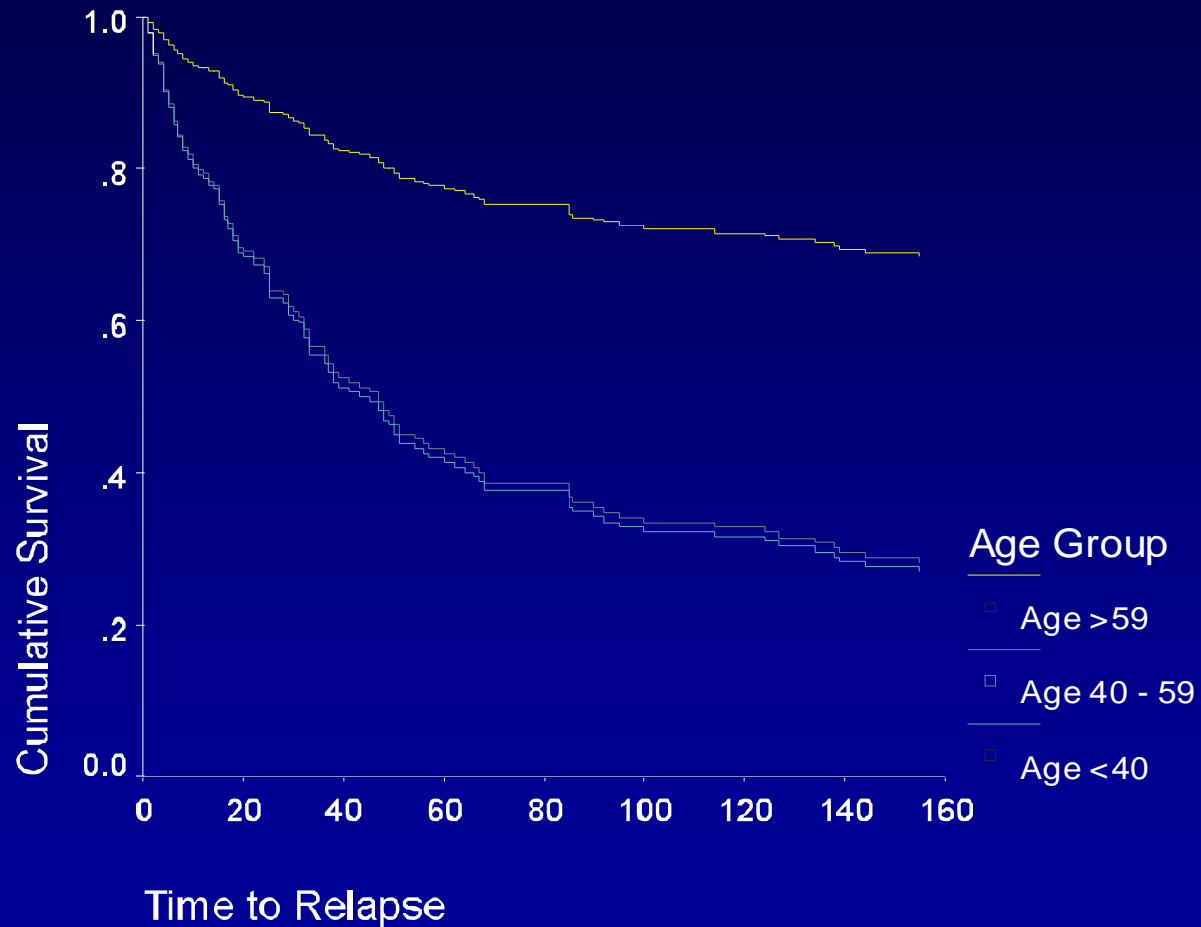
Naltrexone

- **FDA approved for the treatment of alcohol dependence**
- **Functions as an opioid receptor antagonist (mu >> delta or kappa)**
- **Meta-analysis favors use**

Naltrexone Should Be Used for Patients With:

- **Prior treatment failure**
- **Presence of craving, stimulation, or reward**
- **High level of interest in biomedical therapies**
- **Low level of interest in traditional psychosocial therapies or settings**
- **Cognitive impairment**
- **In most alcohol-dependent patients**
- **Consider depot formulation for added adherence**

Outcomes in Older vs younger adults



Oslin DW, et al. American Journal of Geriatric Psychiatry
10: 740-747, 2002.

Treating Addiction Outside of Specialty Care

- **Compare**
 - **VA Usual Care for Substance Treatment**
 - **Treatment provided using an alcohol care management program**

Participants

- **Inclusion:**
 - ≥ 18 years of age
 - Alcohol Dependence
- **Exclusion**
 - No current drug use (except Marijuana)
 - No current hallucinations, manic episode, or major cognitive impairment.
 - Not currently engaged in addiction treatment
 - No current use of opioid medications

Study Participants

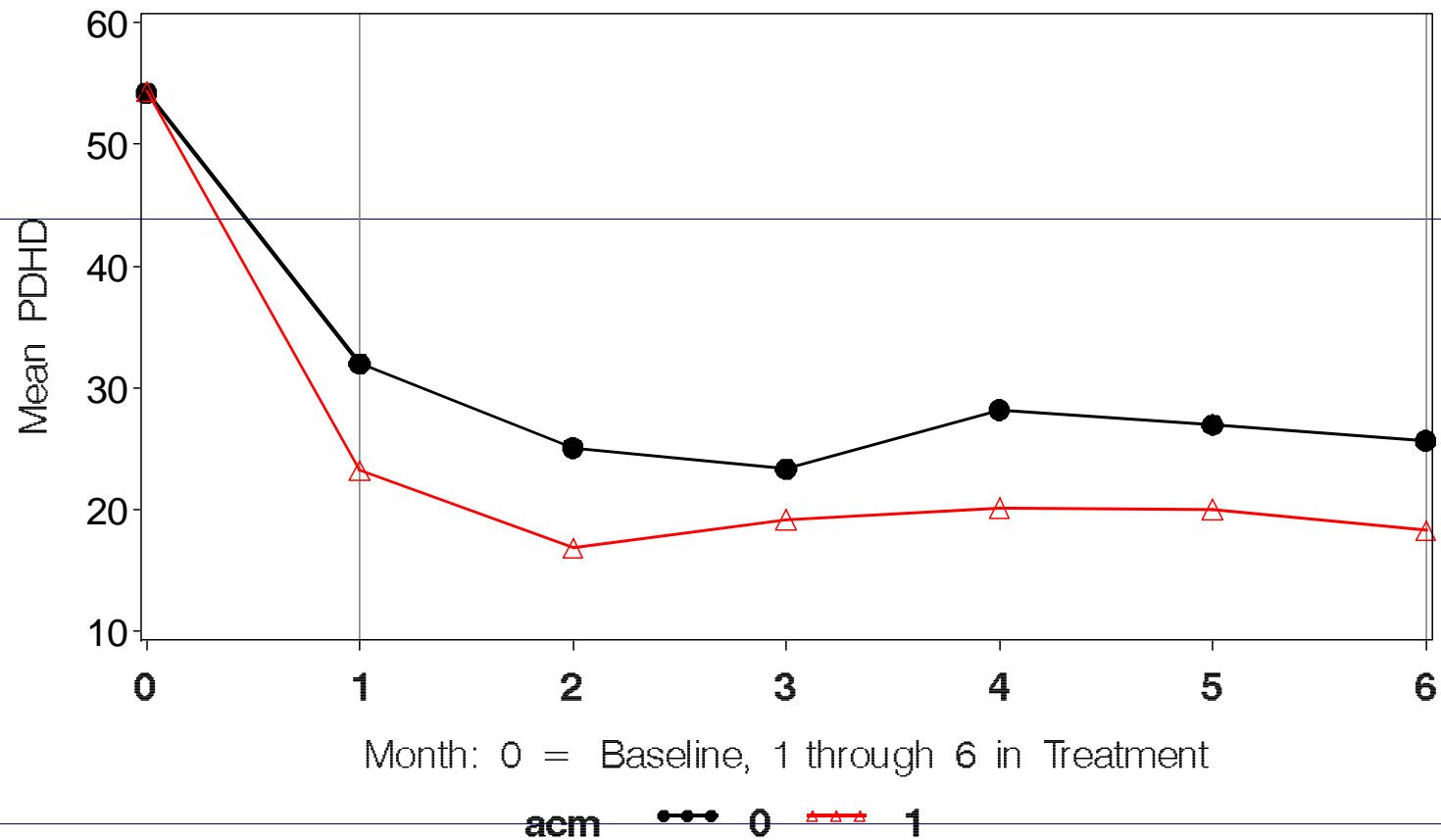
- **N = 163**
- **Age**
 - 21-83 years; mean age = 56 years
- **97% male**
- **42% White/Caucasian**
- **30% married**

Care Management Arm

- Behavioral Health Specialist meets with patient for 16 sessions over 6 months
- Collaborates with provider to:
 - Increase motivation to abstain
 - Be supportive and optimistic
 - Naltrexone
 - Encourage AA attendance
 - Provide education (health risks and detrimental outcomes)

Drinking Outcomes

Group means of Percent Days Heavy Drinking for Baseline and Tx Months



SSRI's and other serotonergic agents

- **By all accounts serotonin is important in addictions**
- **Very common clinical practice**
- **Results from treatment trials**
 - **Some say yes, most say no**
- **Efficacy for older adults with depression is questionable**

Bottom Line

- **Addiction treatment is not one size fits all. There are many options—use them.**
- **You play an important role in treatment outcome if you are not an addiction provider**
- **Compliance with treatment is important. The next contact is the most important part of the session.**
- **Treatment is not a “carve out” available only in select settings.**
- **While abstinence is often the goal, it is not the only goal.**