OLDER AMERICANS BEHAVIORAL HEALTH
TECHNICAL ASSISTANCE CENTER – WEBINAR#2
Screening and Brief Interventions for Alcohol and Psychoactive Medication Misuse & Abuse

DR. STEVEN BARTELS: The next webinar will be on March 21st and it will focus on suicide prevention. So, set that aside on your calendar. We'll be looking forward to hearing from you then. We will be recording this webinar. So it will be available later as an archive webinar. So that's important to know.

In terms of the question and answer period that will occur after about the one hour or one hour and ten minute presentation, please type in questions into the window that you see here on your computer screen. So it will be much more efficient to read the questions and a moderated question and answer session will occur at the end of the presentation.

So again, we're really delighted to have so many people participating today. And what I want to do is just first introduce the speakers which are both good friends and colleagues who will be presenting today.

First, Dr. Kristen Barry is a leading research scientist with over twenty years of experience in substance use

disorder, intervention development, research and training. She's a technical expert and provides technical assistance on the current SAMHSA/CSAT Older Americans Behavioral Health Technical Assistance Center. She's a research professor in the Department of Psychiatry at the University of Michigan and is a national and international leader in demonstrating and developing substance abuse and use disorder interventions with a particular emphasis on brief psychosocial interventions that address substance misuse in a variety of health care settings.

We're delighted to have Dr. Barry presenting along with her colleague Dr. Fred Blow who is the scientific co-director on the Technical Assistance Center and is an internationally known expert on behavioral health in older adults, with more than thirty years of experience coordinating, conducting and directing research studies and centers. And I'm sure you know his reputation precedes this webinar. And he's documented and studied the efficacy of the SBIRT model as an evidence-based practice for older adults and has done pioneering work in prescription and illicit drug use among older adults.

He has many other roles at the University of Michigan as a professor there doing research in many different areas. But he's I think most widely known as an internationally known expert in older adults and substance use disorders. And it's a pleasure to introduce both of them as colleagues and friends for this first webinar. So Kris and Fred, it's all yours.

DR. FRED BLOW: Thank you so much. Good day, everyone. We're really delighted to be here today to talk about what we think is really an up and coming area that's going to be of great importance as we go forward with the aging of the baby boom generation. And we hope that you'll gain today some new understanding of what is the relevance of alcohol and prescription drug misuse in older adults. And what are some of the techniques that have been shown to be effective in addressing these issues? If you don't already have your phones on mute, we would appreciate if you would do so now simply because it will be less disruptive to the presentation.

So Katie, you're going to forward the slides. If we could go to the next slide, that would be great. So this is just our formal information which she just skipped over. And what I'm going to do today is talk about a broad overview of the problem and give you some key things that we think are important for you to know about. We'll then talk about screening and identification methods and what are some of the ways that we no work in terms of identifying people who may be having problems with alcohol and other drugs. And then Kris is going to take over after I cover those two topics and she is going to give more information about brief motivational interventions, evidence-based practices that have been demonstrated to be very useful for a large range of individuals, including older adults. And then we'll end up with future needs and questions and answers.

Next slide. So we wanted to just show you what we know, a little bit about nationally the percentage of people who use alcohol and other drugs in the later life population older adults. And these are data from SAMHSA. And they are a nationally representative sample. And the numbers actually are increasing now we know over the last several

years. But these are from 2005. And what you can see in this graphic is that it's by race and ethnicity because that's an important element to this. What you can see is that by far the largest number of people in the population are using alcohol in later life, people over the age of sixty-five. Forty-eight percent of non-Hispanic whites report that they consume alcohol, at least a little bit during the course of a month. Thirty percent of non-Hispanic Blacks or African Americans are using. And about 33 percent of Hispanics who are Latino are using alcohol.

The numbers are shifting pretty rapidly as we know that the aging baby boomer population is getting to be now this year sixty-six years old and are starting to really get into the later life period. We know that their use of alcohol in particular is higher than in the current cohort of older individuals. So we expect that the overall use rates will increase.

If you look at the problematic use of alcohol, that is binge alcohol use, drinking four or more drinks on any

drinking day as defined by binge drinking for older people. The rates are getting to be higher and they're higher in minority communities. They're 13, 14 percent among non-whites. But still in the white population of older individuals, about 12 percent report binge alcohol use. It can be a dangerous form of alcohol consumption, placing people at higher risk for a lot of negative health consequences like falls and emergency department use and certainly medication/alcohol interactions.

The number of people who are really the heaviest use is the most problematic use in the population, the current older adult population, is relatively small. You'll see it's three to four percent there. But that is rapidly changing as I say. And I believe it's going to be much greater in the future. And then if you look at the illicit drug use, that is the use of illegal substances, marijuana, cocaine, and other substances, the rates are very low. But we've seen a real spike in the use of marijuana in the older population, probably again being driven by the baby boomers who have a lot more exposure to illegal drugs and have a lot more acceptance of its use, especially marijuana.

I left off the first element of the slide which is cigarette use. And I think it's really important to point out that despite all of the warnings that we've had, despite all of the prevention messages around the dangers of nicotine consumption, especially cigarette use, still a large portion of the population continue to use in later life. And it's a great opportunity for intervention strategies for nicotine dependence also. Much of what we are going to show today about brief intervention were pioneered with smoking cessation programs and can be used very effectively to also influence alcohol use.

So that's kind of a snapshot picture of what we know about older adults currently by race and ethnicity. Again, it's a dynamic system that's changing very rapidly with the aging baby boomer generation.

Next slide. One of the things I like to always point out is that we're really not only talking about alcohol use as the main drug that people use. But we really are also interested in the combined problems of alcohol and

medication misuse. And it's almost 19 percent, almost 20 percent of older Americans have been estimated to be affected by the combined use of alcohol and medications.

About 150 commonly prescribed medications have significant alcohol interactions with older individuals and have warnings against the use of alcohol with medications. And the drugs that are most problematic are the psychoactive drugs. It's what we focus on a lot in terms of our intervention strategy. So we're really interested in the sleep aids. We're really interested in the anti-anxiety agents. And we're really interested in the pain medication, it's the benzodiazepines and the opioid analgesics. These all have significant alcohol interactions. So small amounts of alcohol can actually interact in a negative way, making the situation worse in terms of potential risk for overdose, for significant negative morbidities related to their combined use.

Next slide. So, we also know that alcohol use can impact functioning in older individuals. And there's some important work that has been done by Alison Moore who's at

UCLA, a colleague of ours looking at instrumental activities of daily living and when do older men and women get into trouble with just basic daily functioning, daily activities. And she found that more than seven drinks per week was associated with impairments in IADLs. And there were also impairments in advanced activities of daily living, something that we're really concerned about if we want to keep seniors in their homes. So, relatively low amounts of alcohol can have an impact on activity. And then if you get to more than three drinks on any given day, this is when we're getting into the binge pattern of consumption. We know that three drinks or more per occasion are associated with lots of impairments also.

So, something to keep in mind as we're trying to talk with individuals about the role of alcohol and their lives and the potential dangers of even moderate consumption of alcohol as people get older.

Next slide. So, we also know that there's a lot of interaction of pain and alcohol misuse. And pain is a common issue that older individuals face. And we also know

that older problem drinkers report a lot more severe pain, a lot more disruption of daily activities due to their pain and much more frequent use of alcohol to manage their pain compared to older non-problem drinkers. And so, when we're starting to look at the issue of pain in older individuals, we want to make sure that we also pay attention to their drinking because that interaction can really place people at high risk. If they're taking pain medication, they could also have a lot more risk for overdose and other problems, unintentionally, by also drinking alcohol.

We also know that more pain is associated with more use of alcohol to manage the pain. So, as people's pain severity increases, we know that there's a lot more alcohol use to manage the pain as well as other medications. And the relationship is strongest among those that might be defined as having drinking problems compared to those without. So pain is another part of the puzzle.

Next slide. Another perspective. Alcohol use can increase caregiver burden. So we think about the whole person and we think about what do older patients deal with in terms of

their families and burden on families and burden on caregivers? And as older individuals increase their alcohol use, we also know it increases the burden of their caregiver. This is an important study that was conducted focusing on geriatric patients undergoing assessment for cognitive problems. And about 18 percent had a current or past alcohol problem, about a third of the men and less than ten percent of the women.

But half of those with current or past problems were actively drinking alcohol. And those patients with a history of problem alcohol use, regardless of whether they were currently users and regardless of their cognitive status, exhibited a lot more behavioral disturbances, agitation, irritability, disinhibition. These are the things that caregivers really are burdened with and have a lot of problems with. And so the issue of alcohol use is an important one in terms of what happens with family loved ones that they're trying to care for. Caregivers of patients with current and past alcohol problems also reported a lot more distress, a lot more caregiver

distress. So it's a combination of things. And even moderate alcohol use can impact caregiver burden.

Next slide. So, alcohol can have a lot of different impacts. And what we really want to try to get to is to figure out, well, how do we deal with people that might be having some higher use of alcohol than we would recommend? Or maybe even people who are starting to have problems with alcohol. Well, there are all kinds of barriers to identification. And I'd like to highlight these because I think they're really important as we start working on a way to identify people. And identification is the first step in conducting targeted brief interventions.

The first is that we have lots of ageist assumptions about what we think an older person who maybe drinking too much or drinking over recommended limits looks like. And we have to be very careful about those ageist assumptions, that if you focus only on those, the most severe problems, the people who are easy to identify because they have a lot of problems related to their alcohol, you're kind of missing the boat. We really need to broaden our

perspective and recognize that those that are maybe lower consumers, but actually people that have a lot of chronic illnesses or taking a lot of medication, maybe at very high risk for problems. And we've got to be careful not to assume that people just won't have problems because they don't look like they're a drinker or look like they're an alcoholic.

So we need to be careful about those ageist assumptions. We also failed to recognize symptoms. The symptoms are subtle. They're complicated. They are a multitude of symptoms that mimic other problems. So it's easy to say, oh, Mrs. Applegate is really having problems related to her memory. When in fact, a lot of that may be related to her use of alcohol. Or Mr. Smith is really depressed. And therefore, of course, he's not going to take care of himself. He's going to look disheveled, et cetera. In fact, those symptoms may be symptoms of his high use of alcohol.

There's a general lack of knowledge about screening, how you screen and one of the most efficient screening

mechanisms, we'll get to that in a minute. But we want to emphasize that we actually know a lot about how to screen for alcohol use and misuse. And we should apply what we know to broad populations of older people.

The attempts of self-diagnosis, that is identifying oneself as having a problem with alcohol or being an at-risk drinker is worse in older individuals, this lack of awareness and lack of self-awareness that they may be having a problem. And again, a lot of the symptoms may be attributed to aging processes of disease when in fact it may be focused on their use of alcohol.

And then finally, many older people don't self-refer or seek treatment. If you think about how younger individuals get into treatment, they get into treatment mainly because of problems with their workplace or their spouse, their families or their criminal justice involvement, drinking driving arrest. Older individuals have challenges in all those areas. They may not work. They may not have a lot of family supports. They may not drive and therefore they'll not get into problems with criminal justice. So

they're a lot less likely to self-refer and to seek treatment. And even though most older people see physicians regularly, many of those who are at-risk don't identify or seek services and don't get referred for treatment.

Next slide. So, we wanted to cover briefly what we know about or we recommend about screening in terms of instrumentation. And we will have these screening instruments on our website as part of the Technical Assistance Center. And then you'll be able to access easily. But the idea is that what you want to do is you want to capture alcohol consumption. You want to know about quantity, frequency and binge drinking, drinking heavily on any given day.

One of the efficient ways to do that is to use the first three questions of the AUDIT, the Alcohol Use Disorders Identification Test. That's called the AUDIT-C. It's an efficient way to get at quantity and binge drinking. We recommend basically four questions, the three AUDIT questions. The first question is: do you drink alcohol at

all? You identify people that you don't need to screen further. So, alcohol consumption is an important element.

Another element is related to alcohol consequences. You also want to know whether a person is having any problems related to their consumption. And so, therefore you want to get at consequences. There's a number of validated instruments, including one we developed called MAST-G, the Michigan Alcohol Screening Test - Geriatric version. There's a short version as well as a long version. And it focuses on alcohol consequences. So these go hand-in-hand. I would recommend that you absolutely ask about alcohol consumption frequency and binge drinking. And then if you want more information, you can efficiently ask about alcohol consequences and understand whether someone's having problems.

Another strategy that Kris Barry pioneered awhile back is using something that she developed called the Health Screening survey. It embeds the drinking questions within questions about other health behaviors. This is a way to diffuse the potential reactivity that some people might

experience if you're just isolating the alcohol consumption questions or the consequence questions. And they can be embedded in a variety of health behaviors. That screening instrument is available. She embedded them with nutrition, exercise, smoking and depression questions, but there could be others. So I should speak to you about efficient screening within your settings. You might want to use some of these instruments around consumption and consequences as an adjunct or as an additional piece of information of other screening that you're already doing.

Next slide. So I chaired the panel on substance abuse in older adults that SAMHSA put together, focused on treatment improvement. And we put together a national panel of experts to recommend a variety of things. And one of the things we recommended as part of that Treatment Improvement Protocol was that every person over sixty should be screened for alcohol and prescription drug misuse as part of their regular physical examination.

And we recommended using the so-called "Brown Bag Approach" where all of the medications are brought in for a review

for their current use, whether there's any misuse of medications, medication/medication interactions as well as alcohol/medication interactions, an efficient way to really assess whether someone's at-risk for negative consequences.

You want to screen or rescreen if certain physical symptoms are present or if the older person is undergoing major life transitions. We recommend strongly universal screening. That is regular screening of an entire group of individuals as part of routine practice. I can guarantee that if you focus only on those that you think are having problems, you've really missed the bulk of individuals who might benefit from brief interventions. So we recommend more broad based screening, especially as the baby boomers age because there's lots of evidence that they continue to drink into later adulthood at a much higher rate than younger individuals.

Next slide. So what you want to do is ask direct questions about your concerns. You know, one of the big questions that often comes up in our trainings – Kris and I have experienced this many times – is that, oh, we can't ask

personal questions like alcohol use. Well, you actually can. And it works really well. And there's not often much push back if you preface the questions, linking the questions to your concerns about their medical conditions or their other health concerns, and if you're careful not to use stigmatizing terms.

One of the big things that the current cohort of older people are really worried about is that you're going to figure out that they are a heavy drinker. And you're going to label them an alcoholic, which is often regarded by the current cohort of individuals as a moral weakness. It's one of the worst things you can be. So we want to make sure that we are diffusing that and not in any way indicating or suggesting that someone is going to get labeled with a stigmatizing term.

So if you say what we're interested in at-risk drinking. We want to look at health and health behavior. And we're really concerned about how your use of alcohol may interact with your medications and your health. Then it becomes a

different kind of dialogue and a different discussion entirely.

Next slide. Now I'm going to transition a little bit into motivational brief interventions and intervention methods. And I'm going to give you a little bit of overview and background. And then Kris is going to take over and talk about some of the specifics related to the elements of effective brief interventions, the evidence-based practices.

I like to show this slide because I think it really contextualizes the spectrum of interventions that we ought to have and we do have in our toolkit. As you can see on our left hand dimension, we're talking about prevention/ education, brief advice, brief intervention, brief treatment intervention and formal specialized treatment. And at the top, you can see a whole range of drinkers ranging from the non-drinkers, the abstainers, all the way to the chronic/severe dependent individual.

And what I like to really emphasize with this is that prevention and education work. And it's very effective in potentially avoiding people getting into serious trouble with alcohol. And much of what we think of when we think about screening is an opportunity to provide people with educational materials about what are some of the benefits of alcohol use. But also what are some of the problems? What are some of the negatives or the risks? So, prevention and education are important elements.

Brief Advice is a very limited thing. And it's focused on an often two minute or three minute conversation, often done by a health care provider with an older individual, focused on a little bit of advice about the dangers of their alcohol consumption and the potential for their alcohol use as it might interact with the psychoactive medications or the dangers of their psychoactive medications. And it's very, very targeted, very brief and is a little bit of advice in the context of a health visit.

People say, well, that's not very effective. Why even bother? Well, if you think about it, a two minute

interaction or a three minute interaction actually will get anywhere from ten to fifteen percent of the people to change their behavior. People do respond to brief advice. It's not the best way to do it, but it's not worthless either. So we want to try to make sure that that's not left out. Because sometimes having a healthcare provider reinforce the idea that you're going to have a dialogue with the individual about their medication use and their alcohol use can be very, very productive.

Brief Interventions - we're going to spend a fair amount of time on after this. They're usually anywhere from fifteen to twenty minute interventions. They are typically one to five brief sessions. Mostly we focus on one session, brief intervention, sometimes with a booster, sometimes not. And they are targeting specific behaviors. In this case, we're talking about people's use of alcohol and psychoactive medication. But they've been used as I've suggested with smoking, with continued nutrition, with increasing mammogram rates, with all kinds of health behaviors. So these can be used in a lot of different ways and we'll talk more about that in a minute.

The Pre-Treatment Intervention is an often motivational based intervention that is aiming to get the individual to think about going to treatment. Many people are resistant to thinking about formal specialized treatments. And sometimes, using motivational techniques to motivate people over periods of time can actually encourage them to go to treatment.

And then finally, we don't want to forget the utility and the importance of formal specialized treatment. We know that treatment works for this population for older individuals and that's what may work even better than with younger individuals. And that we want to continue to expand our abilities to meet the special needs of older individuals in community settings with specialized substance abuse treatment by educating providers about how to do that, substance abuse providers about how to address the specific needs for older individuals because it can be very, very powerful for individuals to get into specialized treatment. That's kind of the spectrum of interventions and the kinds of things you might want to be thinking about

as an array of services that are needed in community settings so that you can address all of those people that you might identify through screening.

Next slide. We like to show this slide as just a conceptualization of how we typically have thought about alcohol use and alcohol problems. On the one dimension, you can see is alcohol use, ranging from no use to heavy use. On the other dimension, the bottom dimension, is alcohol problems ranging from no problems to severe problems. We typically have organized all of our health care around the people that are the heaviest users and those that have the most severe problems, those that have alcohol or substance abuse or dependence.

This is really the tip of the triangle, the small portion of the overall population. As I suggested earlier for older adults, probably no more than three or four percent and probably less than that for women have the most severe problems. And it is a small portion. It’s an important group because they have a lot of negative health consequences. But if you only focus on that group, you

really miss the major problem that people have in later life. And that is those that we classify as at-risk or problem drinkers or problem users of medications.

And we want to try to identify people earlier to find out if they have risk factors that make their health at-risk, that they're drinking over recommended limits or they're using their medications, their psychoactive medications in an unsafe way. So that we can prevent people from developing full blown serious problems or other health problems related to their use of alcohol or medication. And so we really want to try to broaden the perspective here and to give you more rationale for thinking more broadly than just the dependent individual.

Next slide. It's useful to talk about definitions. Because I think that I've been throwing around a lot of terms so far in the presentation. And I think it's useful to look at the World Health Organization drinking definition. And I think the most common area that people often focus on is this so-called harmful drinking. This is alcohol or medication use that causes complications. And

these are what we typically think of as people with abusive dependence.

But more importantly, we also want to think about hazardous or what Kris and I and others have talked about as at-risk drinking or medication use. And that's the use of substances that increases the risk of complications. That is increasing the likelihood that people will have negative consequences.

And then there's the third group which we call non-hazardous drinking. It's the use of alcohol without any clear risk of complications. This includes the beneficial use which we know that certain beverages of alcohol, particularly wine, red wine, in particular, has some health benefits for selected individuals. And so, we want to make sure that we can also educate people about what is non-hazardous drinking. Some people that have in the past refer to this as social drinking. I don't like that term. It has value connotations. So we stick to non-hazardous drinking as a way to describe it.

So a lot of the action here is in the hazardous drinking or the at-risk drinking group. And we should try to focus on that as a key target for brief intervention.

Next slide. Brief interventions have been around for many years. The early trials for smoking were done in the early ‘70s, landmark studies in Great Britain. And then subsequent work that was done in the U.S. was very good. The first U.S. trial on brief interventions in primary care. And as part of that trial, a specific portion of it was done for older adults. That’s Project GOAL (Guiding Older Adult Lifestyles). Basically, in Wisconsin, primary care clinics screened individuals when they came in for a health visit and identified people who were at-risk drinkers. And then did a physician-based intervention that resulted in reduced consumption at twelve months. About a third, 40 percent of people changed on the basis of this fifteen minute intervention. That was physician focused.

We did a larger trial with Kris’ help in Michigan focused on an elder specific motivational enhancement session. We identified people in primary care with screening measures

and then conducted in-home visits and had social workers and psychologists delivering the intervention. And compared to usual care, no intervention group, it reduced the at-risk drinking at twelve months. Similar rates to the original trial that Kris did.

Since then, there have been several other major projects, randomized trials, of older adults. And similar results have been shown with different bells and whistles. But the idea is that a 15 to 20 minute guided, motivational, brief intervention reduces at-risk drinking in older individuals at a much higher rate than those that received controlled traditions.

The next slide shows some of the current knowledge that we have around this, including that brief interventions can reduce alcohol for at least 12 months. You know, pretty cost effective if you think about it. If you can do a 15 to 20 minute intervention and have it effective over a 12 month period, it’s usually very, very powerful. We know that the motivational enhancement is effective for older adults. We weren’t so sure about that when we started all

of this. But, in fact, you can motivate people and they can be very motivated to change their behavior, is acceptable and can be conducted in a whole range of settings. We've done it in clinics, in emergency departments in hospitals as well as in home and in congregate meal sites and in social service settings, a whole range of settings. And it appears to reduce alcohol-related harm and alcohol-related health care utilization, including emergency department use. And so, we think it's a really important evidence-based practice. The U.S. Preventive Services Taskforce has given these series of interventions a rating of B which is not bad in terms of preventing illness. And I think it's a pretty effective way to think about what you might do in terms of evidence-based practice in community settings.

Next slide. So having said that, that interventions are effective, the big question then is how can they be implemented? And I wanted to just give you a little brief on a project that Steve Bartels and I had a small role in called the PRISM-E study which is the Primary Care Research in Substance Abuse & Mental Health for the Elderly,

supported for SAMHSA and the Department of Veterans Affairs.

Next slide. It was a study that was done to compare two service models for depression and at-risk alcohol use in older adults. And it was the idea of comparing integrated and collaborative care which included identifying people in primary care and then delivering an intervention within the primary care setting in that actual setting, including at-risk alcohol use versus referring people to specialty clinics to get that kind of care. We're going to focus on the at-risk alcohol use today. So that's the most important piece. There were I think ten sites or fourteen sites nationwide. I did all the training with another collaborator for this to deliver the at-risk alcohol use intervention in primary care or in specialty care.

And so the next slide shows you a little bit about some of the results which is that there was a lot greater engagement in care for those that got integrated care. That is co-located within primary care, compared to those that had to go to specialty care. In some cases, the

specialty care was in the same building, but it still was in a different group. Within the integrated care, those receiving care in primary care, 43 percent received at least one brief alcohol intervention. But only nine percent received - in this case, we recommended three brief sessions - only nine percent received three brief interventions, a recommended amount. And that for those that had a comorbid depression or anxiety problem, even fewer people received the intervention. So while the interventions were done, they weren't done all that well. And this was in the best possible circumstances. That is we provided the sites with lots of training, with supports, with resources, to make this happen. And it was very challenging to make it happen.

There were significant reductions in both the frequency and quantity of drinking and binge drinking over six months. And for those that went to specialty care compared to those that had integrated care, there were no differences in the drinking between the models. They did equally well, depending on whether they got integrated care or specialty care.

The big upshot is that there was minimal uptake and implementation of the brief alcohol intervention in both groups. There are huge barriers to making this work. And so I really wanted to emphasize that as you start thinking about implementing I'll call it brief interventions and integrating medication interventions within your settings, don't underestimate the challenges of actually doing the implementation.

Next slide. There's been a lot of work that's been done at SAMHSA and a lot of individual researchers - we have active projects underway here in Michigan also - using this so-called SBIRT model. This is the Screening Brief Interventions and Referral to Treatment model.

Next slide. It's an initiative that focuses on implementing screening brief intervention and referral to treatment in largely medical settings although, it's been broadly construed to other settings. The focus is on the non-dependent substance use, as I suggested, the at-risk use. It emphasizes simple screening followed by one

session of brief intervention, other education and motivational interviewing. The referral to treatment piece is for specialty care, the "deep end" services and other care, as needed. And it is an active referral to those settings. There were competitive five year grants awarded to states, to governors, and their cohorts across 2003, 2006, and 2008. And I think now a little over half the states have received these funds.

Next slide. One state, Florida, received funding to focus on older adults, to do this SBIRT program within the older adult population. And this project was called Florida BRITE Project. It's a state-funded out of some trial work that was done originally. It really provided large scale brief screening and then one brief advice/brief intervention session. But they had flexibility of adding more brief interventions and brief treatments if they wanted to and if the person needed it.

Next slide. So BRITE was offered in a wide range of settings. And we can learn a lot from them, have learned a lot from them, about the kinds of settings that this can be

done in. It expanded from four sites to twenty-one. They were in fifteen counties. They, like everyone else have had a challenge for how do you deal with prescription drug misuse. Part of the problem they had was how to define it. I think we've gotten further along in our understanding of it. And our advocacy, Kris and mine, about focusing on just the psychoactive medications, not the whole world of prescription meds is probably a good way to go. But they still have a lot of challenges. And they were really trying to include all medications which was very, very difficult.

Next slide. They've seen lots of people. They had a lot of challenges in getting the sites up and running. And it's been really successful in a lot of different kinds of settings with different challenges in each of these settings.

Next slide. The sum of the Florida BRITE project is that they were able to demonstrate with large scale limitations that it can work, but that there needs to be a lot of emphasis placed on making sure that people are following

through with identifying people in a systematic way using screening, conducting the brief intervention in again a systematic way and making sure that people are trained to be able to deliver the intervention and not to forget that some people will be identified that are more serious problems that really need to be referred to treatment.

So with that, I'm going to now turn over the session to Kris Barry who's going to spend some time now talking about the actual brief intervention, the evidence-based process.

DR. KRISTEN BARRY: Thank you. I'd like to be able to talk some about the brief intervention session. I do want to say that although there are challenges in setting up first intervention systems in any kind of setting that deals with younger or older adults, there are some very sort of simple reasonable ways that we've come up with over a number of years that I think will be helpful in terms of doing that to make it a little bit easier. And we've found that being systematic is probably the thing that works the best. Anything that we can do that embeds the screening, embeds the interventions, into our usual practices, in a way that

they're just going to get done, makes it much easier. And for many of your sites that you work with, you've been doing other evidence-based practices. And you've experienced a lot of the same issues because of that.

In this next slide, the aspects of an effective brief intervention, they're basically based on the FRAMES model. The FRAMES model was developed quite a long time ago. It includes feedback, responsibility. The person has responsibility for their life and for what they're going to be doing. It has some advice involved in it. There's a menu of options that people choose from. And they help negotiate what's going to happen and what it's going to include. And it includes empathy and some social support for self-efficacy. And that means sort of empowering people to feel that they can do things, make small tweaks in their lives that will help them as they go along.

Most of the brief interventions have been done in a lot of different kinds of settings. And most of the brief interventions use a workbook. And the development of a workbook is an important issue because it gives something

for you to follow as the clinician and for the client to follow along with you. Generally when we use a workbook, we sit next to people and we do it with them. And that works out the best. We've found that that way from a psychological standpoint, people don't always have to be looking at you. You don't always have to be looking at them. You can both be looking at the workbook. And it becomes more of an educational preventive kind of experience.

DR. KRIS BARRY: The next slide is on confrontation versus motivational interviewing. And in brief interventions, we really take a motivational approach. And this is an important approach. It's slightly different in tone and content from traditional substance abuse treatment. But I would say, having worked with substance abuse treatment centers now, both Fred and I have over a number of years, they're changing their approach also. And so we're seeing more places are taking kind of a motivational approach to working with people. What the motivational approach basically does is it de-emphasizes labels. It emphasizes

personal choice and responsibility. It elicits concern. It shows some evidence for what's been going on.

And one thing that we do is we roll with resistance. And I'm going to take you through the steps of a brief intervention and then talk a little bit about what we do and how we do that. And we meet resistance with reflection. We don't argue with people as part of this. And we don't insist that they accept a particular way of thinking about their issues or what they want to be dealing with. And the goals and the strategies are negotiated. And that's probably one of the keys to this all is people do have some choices obviously in what they're going to do. And if you're negotiating with them in sort of an upfront way, I think you might be surprised to know how well that works because knowing that we have choices often helps us all to make better choices.

Next slide. The settings for brief interventions we've done already. They've been done in lots and lots of kinds of settings.

The next slide is the steps of a brief alcohol intervention. I'm going to go through these each individually. But the first thing we do is identify future goals. We summarize health habits which is why we have questionnaires that we give people in screenings. We talk about standard drinks. We talk about the types of drinkers and/or people who are using psychoactive medications. We make sure that in our brief interventions, we include psychoactive medications, So that we are asking some questions about that. One of the most dangerous combinations that people can be taking at any age, but certainly in later life, is a combination of psychoactive medications like the opioid analgesics, benzodiazepine, the prescription medications for pain, sleep and anxiety and to drink in addition to that.

I think probably one of the things, we all just saw this last week, was Whitney Houston's death which was an untimely death. And we don't know exactly what the cause was. But there's certainly been history that it could have been a combination of alcohol and prescription medications. And we see this all too often. And as people age, I think

you all know that our bodies change. And when our bodies change, we don't metabolize alcohol as easily or as well. We don't clear them as well. So even the problems that we see earlier in life could really be enhanced later on.

So part of this is also looking at reasons to cut down, looking at an agreement that could either be abstinence, not using any alcohol. Or it could be what we might call control drinking or non-risk drinking. And we look at risky situations and some alternatives as part of it.

Next slide. So the first thing we do in the workbook is we identify future goals. Now, why would we do that? Why would we take the time to do it? Well, the reason we take the time to do that is that we really want to know what's important to a particular person. When you look at yourself, when you look at your clients, you know the different things motivate each of us. And so what we're really trying to do is come up with what's important for people and develop some discrepancy in what they're doing, their use of psychoactive meds and/or alcohol, and how that might impinge on their ability to reach their goal. For

many older adults, one of the keys is that they want to stay as independent as they can. So that's an important thing to be thinking about.

Next slide. We then have a summary of health habits. As part of the workbook, there's a place to put in how people answer the questionnaires that we give them. So we have a little bit of information going in. So we're able to give them some feedback, sometimes on their physical and mental health functioning, sometimes on some of their health habits, nutrition issues, tobacco use. Usually what we do is we go through the various things we've asked and say it looks like you haven't been smoking cigarettes. It looks as if you've not been exercising much. That you haven't gained or lost weight. Things have stayed kind of steady with that. And it looks as if you've been drinking at this level. And it looks as if you've you've been taking some medication for pain.

Then what we would say is, "are there any other health habits or behaviors that you'd like some health with?" We say that because everybody will pick something other than

alcohol or the psychoactive prescription meds. So we give them a chance to pick that and to tell them, well, you know, we can help. We have programs that we can refer you to for that. But today what I want to focus on is the either alcohol, psychoactive meds or both.

Next slide. So we then talk about standard drinks and types of older drinkers. We use a pie chart for that and kind of show people where they fit. Because I think it's important for people to have a sense of what level of alcohol consumption they have and how it compares to other people in their age group.

Most people who are using more alcohol than is probably healthy for them often either have friends, relatives, children, other people who are also using more alcohol. And they may have been using this same amount of alcohol all their life. And so from the time they were an early adult, they drank two to three drinks a day every day. Well, now they’re seventy and two to three drinks a day has a much bigger impact on them than it might have had when

they were forty. So I think that's an important thing to keep in mind. So this helps people.

Now, the next slide we look at what standard drinks are. And we talk to people about standard drinks. And the important thing about standard drinks is all of these drink types that are listed here have equivalent amounts of alcohol in them. In the U.S., it’s basically about twelve grams of alcohol. Which means that a twelve ounce beer ... and that’s not a big, big beer. It’s a twelve ounce beer ... is equal to one and a half ounces of liquor which is whiskey, gin, vodka, et cetera ... and that isn’t always a full shot glass ... is equal to five ounces of wine. And if you notice on that wine glass, that’s not a full glass of wine.

So if you’re out someplace and they pour you a glass of wine that goes all the way up to the top of the wine glass, that might be two drinks. It’s equal to a small glass of sherry. And we find that this is still for the older adults now, this is one of the drinks of choice for older women. And that may change with the baby boom cohort, but

right now that's what we're seeing. And it is equal to a small glass, about four ounces of a liqueur, which we see a lot less people using that. But where we really see what people use are the beers, the wines, and some sherry for some older women at this point. And these are all in looking at drinks per day.

And what I think I should talk a little bit about the standard drinks and what a drink per day would be. For older adults, the recommendation for how many drinks per day if you're not using psychoactive medication is one drink a day, one standard drink a day for men. And a little bit less than that for women. It's listed as one standard drink, but the recommendation is usually a little bit less than that.

Binge drinking for women over sixty is considered three drinks or more on a drinking occasion. For men, it is four drinks or more on a drinking occasion. So this is less than for younger adults. And the reason for that is I was talking about how our bodies change as we get older.

So then on the next slide, we go through reasons to cut down or quit. And we have people identify some positive and negative aspects to their alcohol use, to their medication use. Because we really want to figure out what are the barriers to making changes? And then we can work with them on the benefits of changing. It assists people in trying to ... it's called tipping the decisional balance. They get to weigh the options a little bit. Not everybody will decide to change their drinking or their psychoactive medication use right away. But do they have a workbook that they take home with them? We don't keep it. They have it. And it gives them something that they can think about. And we often find that people have to think about things for a little while and then they make changes. Because the nice thing with older adults is this is a group who really wants to function well and wants to function as well as they can. And we have found this across a lot of different populations.

So the next slide, the next part of the brief intervention, is the drinking agreement or the psychoactive medication agreement in the plan. We then do a short negotiation

about what would be a reasonable amount to be using. If this is a person who's not using psychoactive medication, I might start by saying, well, you know, I think it might be reasonable to have maybe no more than one drink a day, no more than three days a week. What do you think?

And the reason we give people an opportunity to say what they think is it's okay if they say, oh, come on. I'm not going to do that. I don't want to do that. And I say, well, okay. What do you think would work for you that would be within the guidelines? Well, I could try drinking one drink a day. Okay. And remember we talked about the standard drinks. What do you usually drink your glass of wine in? And we ask what kind of glass they drink it in. Because if it's a tumbler, that's not a glass of wine from a standard drink standpoint. So we want to make sure that we've covered that. And we give them some options.

And sometimes people will ask me, well, do you really think I should do it? Do you think it will help? And we talk about some of the issues they've been facing. And in general, most people are facing some physical health

changes. They may be facing some social changes. They may be lonesome. They may not be getting out. They may have lost a partner. And so we try and think of some other things that they can do and ways for them to find some fulfillment.

And by giving people choices, it does increase their sense of responsibility. So then in the first session or if we have people come back at another point. And sometimes I'll have people come back depending on the situation. Usually, we do these interventions as a standalone, one time, anywhere from fifteen minutes to half an hour intervention. But also, I'm willing to have people come back if they want to. So what we do is we give them drinking diary cards which we'll talk about in a minute. And we suggest that they fill those out and medication diary cards. They can fill out, put down if they have a bad day just be as honest and accurate as they can be because that's how we're going to figure out what to do.

And so if we decide that it would be good if they came back, when they come back we might discuss risky situations

then. What were the situations that triggered something to happen? It might be that some days some visit with their wives and the kids. And the kids fight. The wives don't like each other. My sons like to watch the game, but then they drink beer. And I wind up drinking more beer than I was thinking I was going to because they all make me nervous. Those are not unusual scenarios. And we've heard many, many times of scenarios. So we help opportunity think about what are some ways to handle that a little bit differently? How might you want to do this differently?

So that's some of what we do. We train people. Fred and I train people to do brief interventions. We've trained people all over the country to do this. We certainly are more than willing to help any of you with anything you need in setting up how you would do brief interventions, how you would do screenings. And we're available for that as part of the technical assistance. So please do not hesitate to ask us.

The next slide is on fidelity. And it's important that we really follow the way to do this. Because this has been

tested actually fairly extensively. The older adult intervention has been tested in about five or six big trials now. The younger adults intervention which is a very similar brief intervention has been tested in over 100 trials. And I think 95 percent of the trials have come out with positive results. So, brief interventions work. But as Fred mentioned earlier, getting them in place has actually been the difficult part.

So we try to follow some of the four elements. Sometimes we prescreen. So that we ask a few questions and we've taken care of all the people that we don't have to ask any more questions until we do a little bit more of a screen. We do a brief intervention. We fill out an intervener exit form so that we know what parts we did and what the person decided to do. We give the person the workbook. We will refer people to treatment or other services if they need it. We'll just follow up if they need it. And so that's kind of how we do this.

Next slide. We think that embedding screening and brief interventions is very important. It helps organizations

offer screenings and brief interventions on a routine basis. We tend to try to embed prescreens in an initial intake registration. It can be done at health fairs, in emergency departments, primary care.

We screen if people have a positive prescreen. And these can be pretty easily done. People can fill out the questionnaires themselves often. I know people originally when we say that have said to us, well, older adults aren't going to be able to fill this out. Well, we've screened probably about 20,000 older adults now over a number of studies. So we know they can. And that's really the good news. There are some people who can't and who can't speak quite well enough. But they can get some help in filling it out from somebody on the staff. So brief intervention, if you have a positive full screen, then having a short brief intervention with a workbook, it makes it very easy to do it.

Next slide. So the practical summary for all of this is we want to assess for consumption and consequences. We consider people's goals. Do we want them to cut down? Do

we want them to quit using? If it's psychoactive medication, do we want them to go and see their physician and talk to them about the psychoactive medications and see if there's some other things that they can use that will help them? We use a motivational enhancement approach.

Next slide. We want to end this by talking just briefly about resources available to you. On the website for the technical assistance center that this is part of, you will see the Alcohol Use Disorders Identification Test, the Short Michigan Alcohol Screening Test-Geriatric Version that Fred developed, and a Brief Intervention Workbook. We will have a manual on there for how to implement things and how to work with it. NIAAA has guidelines that guide. And SAMHSA, the *Get Connected* toolkit which has been a very effective and important toolkit that SAMHSA developed with NCOA, National Council on Aging, that really helps people think about how to embed services for older adults into their system.

So I think at this point, we'd be happy to take questions. Our contact information is on the last slide. Please feel

free to let us know what you need or let the Technical Assistance Center know what you need and we'd be happy to help you.

DR. FRED BLOW: Well, thank you very much. We really appreciate you all being on here today. And we'll now open it up to questions. I think Kathy, you're going to coordinate that?

KATHY CAMERON: Yes. And Fred and Kris, I thought that was a really excellent presentation, very comprehensive on the topic of screening and brief interventions. And we had one question. Katie, if you can bring that up, towards the beginning of the presentation, that you've partially addressed, but you may want to talk a little bit more about it. And the question is:

Question: What information exists regarding drug use over the lifespan and the impact of that on current ADLs and pain management? Is there anything we should be aware of in terms of integrating a person's past substance abuse, even if they are no longer using today?

DR. FRED BLOW: You know, I think that one of the things that I would say is that it's important to understand context of individuals and if they had a previous history of illegal

use. So, for example, if they use illegal prescription drugs that were obtained illegally previously, that is to get high, you'd really want to make sure that you have a good understanding of that because they may be at higher risk for developing serious problems in later life. So previous exposure, previous problems, can relate to later life.

Whether that relates in terms of risk for diminishing IADLs, et cetera, that they've used previously, but are currently not using, we don't know anything about that. But we do know that many had a lot of exposure to the illegal use of substances, both prescription meds and illegal drugs. And that probably is a risk factor for potentially using them later on.

DR. KRIS BARRY: The other thing I would say is with older adults, often when I'm talking with an older adults and if one of the questions I'm asking them is if they drink any alcohol and they say, no, I don't, I often will ask is there a reason that you don't? Because it's not unusual. Now, there are a lot of people who don't drink alcohol because they are older because they're not feeling as well

and they don’t have a good taste for it. Or they never drink much, et cetera. But what you’re really looking for is somebody who says, well, I used to have a problem. Because some of what you can do is what Fred talks about on the slide where brief interventions fit in the spectrum of intervention is you can do prevention. And you can encourage prevention. And I think that's also a really important issue with that group.

I think it will probably be another half a generation before we have really good information on sort of long-term looking at people who used drugs fairly seriously when they were younger and what affect that’s really going to have on their IADLs and ADLs later on. We hear things anecdotally but I don't think we have a good research sense on that yet.

KATHY CAMERON: Okay, thank you. While we’re waiting for more questions, I just wanted to let everyone know that this webinar will be available. We are archiving it. We’ll have the PowerPoint as well as the recording available. And we will it out to the participants. It will also be posted on a number of websites, including the

Administration on Aging, National Council on Aging, the National Association of State Mental Health Program Director and the National Association of States United for for Aging and Disability. So, it will be available. Okay. So the next question that we have is:

Question: What about clients that are drinking two to three drinks, wine or beer an evening? Might there be concerns about detoxing and the medical complications that can cause?

DR. FRED BLOW: There are no tried and true guidelines. But based on consensus opinion of several of us in the field, we've come upon the general consensus that one doesn't need to worry about detox unless people are drinking large amounts of alcohol and stopped drinking cold turkey to go from high amounts to low amounts. So the question is, well, what's the high amount? And what we've come up with is just a ballpark, if people are drinking, this is based on clinical judgment and consensus with several people that I've worked with and talked with over the years, we're thinking about 28 drinks per week, which is four drinks or

more per day. Then you really should be worried about detox.

Now, the reality is most people detox on their own because they cut down on their own. And they end up having lower risk because of that. If someone tapers their consumption over time, there's virtually no risk for detox complications like seizures. So we want to be vigilant that if someone is a high consumer, we don't want to advised them to stop cold turkey, but rather to cut down and taper their use. Or they may need formal treatment depending on their levels of consumption. But in general, I would say that's only at the very high levels. I don't think you need to worry much about two or three drinks a day.

DR. KRIS BARRY: The other thing is part of the brief intervention, there's a question that we ask the clients in the intervention that asks them if when they've had any days when they're not using, when they woke up did they feel shaky? And we ask some questions like that. And what we're really looking for is withdrawal and potential for withdrawal. So that's an important thing to, you know,

it's always good to ask some of that. And there are some acceptable ways to ask that, that don't put people off and that helps them to give really accurate answers. And we've got some of those that are available to people also.

DR. FRED BLOW: Yes, it's embedded in the workbook.

KATHY CAMERON: Speaking of the workbook, we will send that out with the webinar link to the participants on the webinar. You both mentioned that several times and it's the tool that really everyone needs to use to do brief interventions. So we will include that with the webinar.

DR. FRED BLOW: We recognize the webinar is really insufficient to be able to learn how to do these interventions and we typically do day long trainings for people or more, depending on what the needs are for staff. So this I hope will at least get you better oriented about what we're talking about and about the specific elements of an evidence based practice and a brief intervention. But we don't expect you to be able to go into a clinic tomorrow and be able to conduct one. So we're hoping we gave you enough resource to be able to learn more about it and then you might want more training.

KATHY CAMERON: Thank you. Another question we have is:

Question: Can we repeat the suicide prevention webinar date?

Kathy Cameron: The next webinar that we will be conducting is going to be on March 21st and the topic is “Suicide Prevention”. And it will take place at 2:00 p.m. Eastern time. And all of you who are participating in this webinar, you’ll get the notice for our next webinar, the one on March 21st. Okay. Another question that just came in is:

Question: Is the workbook available in other languages?

DR. FRED BLOW: Well, we have it in Spanish and that’s it. We’ve used it in the past also in a project we did in California with Mandarin speakers and with Russian speaker and had some translation of them. But we really were less convinced that those are as well translated as they potentially should be. But Spanish, yes.

KATHY: Okay, thank you. Okay. Well, we don’t have any other questions.

(END OF TRANSCRIPT)