Shannon will be covering that.

SHANNON: I would like to welcome everybody told to SAMHSA's Older Adult, on medication and misuse and prevention among older adults. My name is Shannon, and I am with the Administration for Community Living, Administration on Living. I am AOA's representative for the Older Adult Behavior Adult Center; the Center has a partnership to provide technical assistance.

A series of Webinars and briefs will be available to the public and that material can be accessed through www.aoa.gov. A series of meetings for State aging and behavioral health leadership will be held to develop strategies to enhance strategies for older adults in states. Today's Webinar will describe the prevalence of alcohol and psychoactive medication misuse and abuse and we will discuss strategy to prevent misuse and abuse. Actions of States and local agencies can take to implement effective programs will be highlighted with a specific focus on the Florida BRITE program. It is a brief intervention for treatment for elder's program which was first Federally-funded prevention project which focused specifically on the older adult population.

Future Webinars in the series include first a partnership of implementation to success seminar in reaching and engaging older adults. Webinar and sustainability in financing and behavior health interventions and also a coming Webinar on family care givers as partners in care and the next Webinar will focus on successful partnership and that will be June 20th, from 2:30 to 4:00 Eastern time and all that are registered for this one will receive registration information for the upcoming Webinar. Now I would like to introduce the speakers for today.

The first speaker will be Dr. Blow. He is the scientific co-director for the Technical Assistance Center (TAC). He is an internationally known expert on behavior adults with more than 30 years' experience in coordinating, conducting and directing research studies in Centers. He has documented the efficacy of screening, brief interventions and referral to treatment as an evidence-based program for elder adults and pioneering application for prescription and illicit drug use among older adults.

He also serves as the Director of the Mental Health Outcome and Transition Section at the Department of Psychiatry. He

has planned and promoted a variety of technical products such as videos for SAMHSA on abuse in older adults.

The second will be Katherine Cameron who is with JBS International. She manages the Webinar series as well as the meetings which I had referenced for from 2009 to 2010 Ms. Cameron directed the SAMHSA-funded Abuse Older Adult Technical Assistance Center, which was designated or designed to increase the number of substance abuse programs within the network specifically adapting the intervention to address alcohol and prescription misuse and brings more than 15 years' of experience, managing research and education and technical assistance to the program. Ms. Cameron was responsible for successfully guiding the society of pharmacist's research and education, foundations, education programs, all of which were intended to improve the health and well-being of older adults. She is a pharmacist and has a master's in Public Health.

The next speaker will be Dr. Kristin Berry with 15 years' experience in substance abuse development and research and training. She provides technical expertise through the older adults, Technical Assistance Center (TAC), and Dr. Berry is a research professor in the Department of

Psychiatry at the University of Michigan, where she holds concurrent positions as the research professor and a research investigator. She has demonstrated expertise in conducting and developing substance abuse interventions. They address substance misuse and a variety of healthcare settings and the final speaker will be Mr. Steven Ferrante who serves on the Florida School of Social Work and is the director of the academy. He is the managing partner of Group Victory LLC, a strategy marketing organization developing consulting firm.

He has dedicated his professional career to working in a human service field in various positions and age groups. For over 20 years' he was employed by the Broward County, Directing Services, specifically those targeted to older adults. With the county he works primarily for the elderly and service division where he began his career as a case manager. And he became the Director with responsibility for oversight of community care, and mental health and supportive services. He has had the opportunity to manage several projects including the Florida BRITE project which he will talk about today. He has represented the agency in the model services locally and state wide and nationally as

a conference presenter and his work has included advocacy and grant writing and implementation and training.

I would like to thank all of the speakers for the participation in the Webinar today. At the end there will be 15 minutes for questions. All questions must be typed into the chat box on the Webinar and also it will be recorded. And the recording and slides will be provided to all who have registered to the Webinar. So now I would like to turn the call over to Dr. Blow.

DR. BLOW: Thank you, Shannon. Hello, everyone. I am going to spend a lot bit of time with you talking about a brief overview of what we know about substance use and misuse in later in life and turn it over to Kathy, the next slide, please.

So, as you can see in this slide, this just gives you an overview of what we know about the prevalence of different use of substances for those over the age of 60. And we want to think about at-risk drinking as one of the areas that is an important area to be focused on. Because if you only focus on people that have the most severe drinking problems, those that might meet criteria for abuse

dependence, you are talking about a smaller portion, something on the order of 2 to 4 percent, but if you think that you know broadly about people who are drinking over recommended, and we will talk about that in a minute and may be placing their health at risk because they are drinking over recommended drinking limits. Then we want to try to think about those as at risk drinkers who might benefit from some brief advice to reduce the consumption because the interactions with alcohol and medications and the interactions with alcohol with chronic illnesses place it at high risk. And it has been estimated that 15 to 20 percent of individuals in primary care settings are the so-called at risk drinkers. And they have been similarly high and they are a target group for intervening with individuals. Often you want to talk about the changing face of drug abuse as we see the baby boomers. Reaching, anywhere from 1 to 5 percent nationally. There are some indication that that is changing fairly rapidly as the baby boomers age because they are more likely to use the illegal drugs especially marijuana. But, right now, the older adult population is relatively modestly involved with illegal illicit drugs. Here is the alcohol abuse/dependence group. It is 5 to 10 percent of the overall population under the

age 60. So over age 60, it is on the order of 2 to 4 percent as said. And most of the individuals who have significant involvement with alcohol with consequences related to their use of alcohol and increased tolerance and some also potential, all withdrawal symptoms.

We now intend the population studies. The rates are lower. So if you take the entire population in the community if you went door-to-door to just assess whether or not people have problems with alcohol and drugs. The rates are relatively lower than in healthcare settings. Healthcare settings are a really good location for identifying people with alcohol and drug issues because they are more likely to attend those. We often will focus our work in a variety of healthcare and other social service settings it is a good place to identify people and the likelihood that they will have more problems is greater. Next slide.

So a little bit more about, let me get this slide up. There we are. The percentages of the past month, cigarettes and alcohol and illicit drug use in older adults. These data are increasing with more current data. Although, we don't have the numbers up yet from SAMHSA. We know that there are increases that are occurring. As you can see from the slide

that alcohol use among non-Hispanic Whites is about half of the individuals in the community are using alcohol, much less likely for non-Hispanic Blacks and Blacks. And Black Americans and Hispanics. I like to point out always that cigarette use remains high in the over age 60 group and we should be thinking about these individuals as a potential for focused interventions and there you can see the rates of binge alcohol use are higher in minority communities than in non-Hispanic Whites and then what I have referred to previously. Next slide.

So, we want to focus on a bit today is also talking about the intersection between alcohol and medication misuse and it is estimated that about 1 in 5 older Americans are affected by the use of alcohol with prescription medications. And this is an important and potentially growing problem, especially with the increase in teens medications the analgesics, especially when mixed with alcohol, it is an area that we want to focus on to intervene and educate them with the dangers of drinking with their prescription medications that are psychoactive. Next slide.

And this just highlights an important study that was conducted around people that were problem drinkers and also had chronic pain. And this is really important to highlight in the study. The drinkers actually reported more severe pain and more disruption of daily activities due to pain and more frequent use of alcohol to manage their pain compared to older, more problem drinkers. And that is the pain was associated with more use of alcohol to manage their pain. And so, and the relationships were strong here among older adults with drinking problems than those without. Although someone has chronic pain and is taking pain medications, we really want to be assessing whether or not they are having problems with alcohol and are using alcohol in an at-risk manner because it places them at much higher risk and the alcohol does not solve the problems that may be related to managing their pain, including break-through pain. So we really should be focusing on these individuals. Next slide.

So what are the recommendations in terms of alcohol consumption? These are from the National Institute on Alcohol Abuse and Alcoholism (NIDA) and from the Center for Disease Control (CDC). And for people over age 60, the

recommended maximum daily consumption is no more than 1 drink a day for both men and women. And that binge drinking if you think about the episodic drinking which is a dangerous pattern of consumption it is defined for a man is no more than 3 drinks in a day and for a woman, no more than 2 drinks on a drinking day. Emphasizing that people should never use alcohol with psychoactive medications and at these rates for older people are half of that for younger individuals. And so the rates that are recommended for younger people are no more than 2 drinks per day and the binge drinking definitions are three or more drinks in a drinking day for–sorry. For younger people, four or more a day and for women, no more than three drinks, on a drinking day. Is a binge episode definition. The idea is that these are lower recommendations than for younger people. And they are fairly modest and then they are aimed at preventing problems, and preventing negative consequences related to alcohol consumption. So the question is, so we are talking about one drink. Next Slide.

And we want to make sure that we are educating people about this concept of standard drinks and it is one of the main components of the drink prevention work that Chris will

talk about in a minute. And that is that different beverage alcohol has roughly the same amount of ethanol, the active ingredient if you measure the alcohol. So one bottle of ordinary American beer, 12 ounces, has roughly the same amount of ethanol than a single shot of distilled spirits that is one and a half ounces of 80 proof vodka, for example. That has roughly the same as five ounces of wine and the same as four ounces of sherry, or the liqueurs.

These are roughly equivalent in ethanol, concentration and are defined as one drink. So just educating an older person about this standard drink idea can be very useful. Because people don't often know that beer and wine have the same amount of alcohol as distilled spirits. The key is that you need to measure your beverage and if you measure this is the daily limit, no more than one of these a day. With that I will turn, it over to Kathy.

KATHY CAMERON: Good afternoon. I am going to go through these slides very quickly in an effort to move on to the discussion of intervention strategies, screening and brief interventions for alcohol and psychoactive medications that Chris Berry and Steve Ferrante will discuss. Recognize that older adults use disproportionate amounts that they treat.

And they are more likely to be prescribed medications long term that can lead to misuse and abuse with medications specifically the psychoactive medications. And we know that about 25 percent, or 1 in 4 older adults use one of these psychoactive medications that have the potential to be misused or abused and that is really the group that are at highest risk for misuse and abuse and those are the ones that we want to try to screen and intervene on to prevent problems. And older adults take these medications because they suffer from conditions like arthritis, chronic headaches and they often have insomnia and anxiety or feelings of nervousness and tension and therefore they are being treated for these conditions with medications like the Opioids, and benzodiazepines for sleep disorders. We have been using the term psychoactive and I think that it would be helpful to have a definition. And simply, a psychoactive medication is a substance that moves from the bloodstream into the brain, and it acts primarily on the central nervous system. Whether it affects neurotransmitters and receptors in the brain. It is changes in the perception of pain, mood, cognition, behavior and consciousness. So, just to give you a sense of the prevalence of medication misuse, there have actually been a

few studies that have specifically examined the prevalence in the nature of misuse in this population and the results have been mixed. But overall, prescription medication misuse represents a small but a growing portion of the older adult population and a few studies are listed on the slide. What we do know is that the psychoactive misuse is a growing problem across the United States among all age groups and you have probably seen articles about this problem in the papers. There has been a lot of news coverage of the use of such things as opioids analgesics. It is the aging of the baby boomers who have different attitudes and experiences with using drugs, including prescription drugs with abuse potential. And one indicator of the growth of this problem is the emergency department visits involving medication misuse and abuse. And since 2004, there have actually been a 121 percent increase in emergency department visits involving medication misuse by older adults defined as those 50 and older. And we are seeing the largest increases in the young and old and that is the baby boomer population.

This slide shows more evidence of the impact of medication misuse. One fifth of emergency departments visits involving

prescription misuse were made by persons 60 and over. And the medications most commonly seen in these emergency department visits are pain relievers, and medications for anxiety and insomnia. And anti-depressants. There are a lot of emergency department visits and many older adults have to be hospitalized as a result of these problems.

So, what is medication misuse? We can kind of think of the use of psycho active prescriptions as a continuum that ranges from appropriate use. That is, using a correct medication, dose of a medication, and using it for the intended period of time as prescribed for a legitimate medical problem. And then, the continuum goes through misuse, abuse and dependence. And this slide shows the DSMIV definition of medication and misuse. You may also hear the term non-medical use of prescription medications and sometimes that is used for the misuse of prescription drugs and misuse of prescription drugs. So misuse by the patient would involve taking a higher dose than prescribed. And taking a medication for much longer than prescribed. Taking for purposes other than prescribed. Or using it with alcohol to get the desired effect and there is also misuse for the practitioner. Like continued use of a sleep

disorder medicine. Prescribing for a higher dose than needed for an older adult or failure to monitor or fully explain the use of medications and I think that this happens a lot in pain management.

Medication abuse and dependence is defined on this slide. For the patient it results in declining physical and social function, use in risky situations continued use despite social or personal consequences and a definition for dependence that can result in tolerance or withdrawal because of the physical dependence as a result of using or abusing the medication. Go on. What do we know about who is at risk for medication misuse and abuse? And a couple of studies looking at these factors that increase the risk for medication misuse and abuse and one is female gender. And it might be because females are sometimes more often prescribed these. And social isolation is another risk factor, where older adults may be self-medicating for loneliness or depression. A history of substance abuse or a person of substance abuse are more likely to abuse prescriptions later in life and we know that older adults are more likely to have a dual diagnosis and depression

being a common diagnosis and then medical exposure to medication wise abuse potential.

These are some of the common signs and symptoms of medication misuse and abuse. And as you look at this, you will see that many of these signs and symptoms are common among older adults and are often overlooked or attributed to other problems like dementia or Parkinson's disease. Which makes screening and identifying people who are misusing medications difficult and these are some other signs and symptoms. The loss of appetite, changes of daily living and falls, is common, changes in speech and loss of motivation, family or marital discord. Or drug seeking behavior, such as doctor shopping or requesting refills sooner than should be refilled.

Okay, there are many psychoactive medications that can be misused and abused including prescription and over the counter medications. But the primary psychoactive medications of certain for older adults are two classes that are the central nervous system depressants and those include medication to treat the conditions that I mentioned previously, anxiety, insomnia and those sorts of things and benzodiazepines are the primary class used to treat those

conditions. Barbiturates are not used or prescribed as much as they were in the 70s and 80s. The next class is opioids or morphine; these are very effective in relieving pain. Go on.

So this slide gives a bit more information about benzodiazepine misuse and abuse. We see with it, older adults that may be self-medications, hurts, losses, depression and loneliness. Studies have shown that they have been prescribed more than any other group. Although they are recommended for short-term use they take these for long, long periods of time for anxiety and problems. And as I mentioned they do cause confusion and falls, and it could also cause cognitive impairment in older adults. So this slide with some of the common ones. I have listed both the generic and the brand name and when we send out the PowerPoint slides to everyone, we will have a more complete list of these medications. As well as additional resources on this topic. This is an interesting study on the use among older adults. Remember that these medications are recommended for short-term use only. But are often prescribed for long term use. This shows that those continuing and not continuing daily use of these

medications both reported significant improvements in sleep quality, and depression. And there were no differences between these two groups in rates of improvement. And so it raises concerns about the risk benefit of continuing to prescribe these medications. We know that the study has shown that there is no benefit in continuing the use but certainly there are a lot of risks associated with the long term use of these meds. The next class is the opioids, for the release of pain, sometimes being misused and used to help people sleep, relax and so on. These medications really need to have a dose reduction when they are prescribed because of the changes in absorption and changes in receptor sensitivity. Some of the problems that we see with the use of these medications as a mentioned sedation, and certainly a common one, except the sedation and also increased with fall and risks and here are the examples. As Fred mentioned a huge concern among the alcohol in older adults is the interaction with medications and when the medications interact with alcohol, including those who are most likely to be misused and abused, which Fred said about one and five may be affected by the combined difficulties of alcohol and misuse. And go on. There are a number of mechanisms by which alcohol and medications interact. But

the take home message from this slide is that alcohol in small amounts increases or magnifies the central nervous system of psychoactive medications because alcohol itself is a depressant. So that is why it is really important to screen and educate older adults about the dangers of taking medications with alcohol. So that was a very brief overview. And as I mentioned, we will be sending you some additional resources with more detail on this topic. But I am now going to turn it over to Kristin Berry, and Dr. Berry will talk about prevention strategies to screen for and intervene for those with medication/alcohol misuse problems.

DR. KRISTEN BERRY: Thank you, Kathy. I think that this was a great introduction for taking us to the next step in terms of what we need to be doing to help older adults who are experiencing at-risk or problem use of alcohol and or psychoactive medications in particular. I am going to be spending a little bit talking about the SBIRT model. This includes screening, brief interventions and referral for treatment, where needed. Next slide

We are also going to be starting with talking about the screening portion. Screening is a very important part of

determining what is going on with older adults. And having some standardized screening that we can use makes it much easier to help us figure out what is going on and what we can do to be helpful. Next slide.

The goal of screening and there are two major goals. The first goal is to identify people who are at-risk problem drinkers, people with alcohol dependence, to identify people with psychoactive medication misuse. And so, it is identification. And that is what we are using the screening for. The second part is to determine if there is further assessment and/or some form of treatment needed. And there are a number of treatments that are available for both formal, standardized treatment but there is also brief treatments that are often used and there is a book that was developed out of a whole series of trainings and treatments approaches for brief interventions developed and published by Larry Shoenfield from the University of South Florida and this is on brief treatments and I think that that could be a helpful and useful resource for people. And we will get you all of the list of resources and things at the end of this conference. The rational for screening is that there is a high enough incidence, as we heard from both

Fred and Kathy, there are adverse effects on the quality and the quantity of life. And there are effective treatments that are available. And there are valid and cost-effective screening techniques. Next slide.

Generally speaking, when we do screening, we like to cover a few kinds of issues. The first issue that we like to cover is how much is being used. It is basically quantity and frequency of use. Both for alcohol and for psychoactive medications. And to the extent that we can determine that for our illicit drugs. In terms of alcohol consumption, we like to use screening tools that include quantity, frequency, and binge drinking. All of which are markers of potential issues that need to be dealt with. We also like to look at alcohol consequences. To see if there are some shorter term and longer term consequences that people are experiencing. One of the screening tools that work quite well for this is called the audit. The alcohol use identification test. This was developed by the World Health Organization (WHO) in the 10-country study. And it has been widely used all over the world in many languages. And the audit is the first three questions of the audit which is

the quantity, and frequency and binge drinking questions. And those are all very good questions that can be used.

The health screening survey is a survey that we developed a number of years ago that included alcohol quantity and frequency and binge drinking, but it also included other health behaviors that included, nutrition, exercise, smoking, depression. So what we are trying to do is what we all want to do when we work with older adults and that is put the alcohol use or the psychoactive medication use in the context of health. By looking at a number of behaviors we can both target the alcohol or the psychoactive medications but we can also be of assistance with other things that are issued for people that they might wish to change. Fred brought up a good point about smoking earlier. That other instrument that we have used and has been adapted for use with psychoactive medications for use and misuse is the assist. This is the instrument developed by the National Institute of Drug Abuse (NIDA). And it was originally developed to deal with illicit drug use. And we and others have adapted this to use with psychoactive medications in particular. Next slide.

Once we have screened -- Next slide, please.

Once we have screened, we need to move to the next step if a person that we are working with screens positive. Fred talked about what the screening positive was in terms of alcohol use. And we have also heard from Kathy a lot about what might be considered positive for psychoactive medications misuse. In terms of brief interventions, I want to talk a little bit. Next slide, please.

About the definition and then talk a little bit about what goes into a brief intervention. Brief interventions are time-limited and so they can be anywhere from five minutes to five brief sessions. And they target a specific health behavior in this instance we are targeting alcohol use and psychoactive medication use. The goals are reduce use, to change the use pattern, to help people who are using both alcohol and psychoactive meds. To help them to cut back on the psychoactive meds and not use alcohol. Because the combination of the two as Kathy mentioned, is deadly. And it is an important issue for us to be dealing with. And we also can facilitate treatment entry. The brief interventions come from a SAMHSA Protocol Number 34 of brief treatments and interventions for substance abuse. There is empirical support for both the screening

techniques and there is empirical support for the effectiveness of the brief interventions with the both younger adult and older adults. There have been over 100 studies done that I ran in the control trials looking at brief interventions to see how they work in different populations. And they have proven to be a very effective method of working with older adults, next, slide, please...

The reason that we are looking at this slide right now, is I want to spend a couple of minutes talking about who we tend to target with brief interventions. Brief interventions often target people who are anywhere in the at-risk and problem use and we do target people in the severe use and the more serious problems to help them get into treatment. But, in the at-risk use in particular, that is a group that we see more older adults than we do, than we see older adults who have abuse or dependence and often we will remember the people that have the most serious problems but if we do universal systematic screening, we find that most older adults fit into the at-risk and or problem use if they are having problems related to alcohol or to psychoactive medication. And so, it is important to

remember that is a group that we also want to target with this. Next slide.

But the thing that we want to avoid and the reason that we have all worked for a long time developing the materials as have many other people, to work with both screening and interventions for older adults for alcohol and for psychoactive meds is we are trying to set up systems so that those aging services networks, and the people providing the services are not over worked. And so we have developed pretty streamline methods to do this. And those methods and all of the materials for that will all be available to all of you. Next slide.

The key components to an alcohol brief intervention are screening, feedback, motivation to change. So we use the motivational interviewing types of techniques for these strategies to change. We often have a behavior contract as part of this where we have an agreement with someone for either how much they are going to cut back. Are they going to stop using even the psychoactive meds or stop using alcohol while they are using some psychoactive meds that have been prescribed for them and follow-up? Generally they will use a workbook. When we have workbooks available for

you, the workbook that will be available for you developed with Larry Shoenfield from the University of South Florida. He has done a great deal of work in older adults and substance use. He was the developer of the expert program for older adults in Florida. And he worked with Dr. Bob Hazlet who did a great deal of trainings for that. So those materials will all be available to you. I am going to now turn this over to Steven Ferrante, who developed the expert program in Broward County and did an excellent job both developing it and a lot of information about how you set up these programs. We have talked about how what the problem is and how you screen for it. But, Steven is going to talk about how you really enact this in your setting. Steven?

STEVEN Ferrante: Thank you, Kris. So thus far the other presenters have talked to you about the prevalence, the complications, screenings and instrument and process and intervention, approaches. And I am going to share with you how in Florida and particularly in Broward County in South Florida how we put all of this together and created a Florida BRITE project and initiated this in our community as well as across the state. And I am going to start really with talking to you about the agency or the context in

which we initiated this project. And Broward County was the community, and the county elderly services where you heard that I spent 20 years was the first agency to implement this program in Florida. And this agency was a county and it is a county governmental agency. And the county was really charged with being the lead provider for older adults and veteran support services. And the agency itself, had case management as its traditional and primary focal point and service. The agency was mainly established to assist older adults with physical and cognitive impairments but over time, the agency realized that it needed to take a more comprehensive approach in addressing the older adult population and built a health continuum of care for that populations that focused on mental health and substance abuse issues. And although, older adults in our community included the veteran population, so the assistance was offered to veterans. We also have found that it makes sense as you look at sustainability of this program to perhaps be offering this to a younger veteran population as well. And the last point that I will make about the agency's philosophy and really what the direction and the agency began to take as the years went on, is much more of a health promotion approach to providing services to older

adults and veterans and specifically because of taking that type of approach, beginning to look at what type of evidence-based interventions and services are available and how does it fit into what the agency is doing and can be easily embedded like the SBIRT model. Next slide, please.

So, what brought us to even venture in this direction? And it had to do with challenges the agency was facing in terms of providing services to the older adult population. And we were finding that more and more older adults that were referred to our organization for assistance, actually had substance misuse issues. And not only were we finding that in the referrals we were receiving, but as we began to more closely look at the individuals who we had been traditionally serving, we also began to find that at a minimum there was a risk of substance misuse in our existing population as well. So, in wanting to address the issues in the elders that we served, we looked initially to the local substance abuse service continuum and because we were primarily an aging service provider, and aging was our specialty, we looked to those for whom substance abuse, prevention and treatment was their specialty. And not only did we find that they were not really serving an older

adult's population, but we found that the infrastructure that they were delivering their services were not really conducive to the seniors that we were serving. In fact because practically all of those services were facility based they were not environment settled where adults were actively seeking to engage in. And of no fault to the providers it was not their experience to serve an older adult population. They did not really set up outreach, in-take and even a service continuum that was senior friendly. And in some instances they even felt that bringing seniors into their treatment environment was a risk because they did not really have the capacity to deal with all of the issues that the older adult population was facing. So, as we were looking to then to provide support for us, we turned around and looked at us to say, you know we are not set up for this. And you know, perhaps this is something that we should take on together as a community. And I think that as each of the other presenters described to you, we were finding because there was not adequate support for these issues in our community that the primary care setting was in fact the setting that was providing support even though, again, it was not designed to provide the type of

support that would appropriately address substance, misuse, issues in older adults. Next slide, please.

So as an agency that had a desire to address mental health issues more effectively in the senior population that we were serving, recognizing the increased prevalence, and recognizing the lack of resource in our community and the next step really for us was advocacy. We realized that we needed to engage key stake holders in trying to identify some solution to address this population. We also realized that although this was a community issue, since Florida is a state that has a high prevalence of a 60 plus population and just to give you an idea in Broward County, over 350,000 individuals are over the age of 60. It is approximately 20 percent of the entire population. So the county has been for a long time where the rest of the country is headed as our country continues to age. And so, we felt that we needed to both advocate, locally in our own community as well as to advocate on a state level and find some key folks on a state level that would be interested to work with us. And we recognized that we needed to have that to support the work that we wanted to do in identifying this as a priority area for funding and services. So we

looked at what existing data we had in terms of what was already being collected around these issues in the older adult population and in doing so, recognized where we were falling short and then, attempted to collect additional data to help us support the advocacy that we were going to move forward with. And really our initial approach was for more of an educational standpoint then a strong assertive standpoint that we needed community change. And we brought education to a number of existing committees and forum and sort of began to address it in a very non-threatening way. And we also partnered with a state-wide coalition and helped to create a local chapter of that coalition in our own community so that we could build the momentum and the number of supporters around our issue. Which eventually brought us in front of the decision-makers and funders. And getting that audience took the stance that we wanted to partner with our funders and help to present to them solutions and work in a partnership to come up with what is the best approach? And certainly, sharing a lot of information about models like the SBIRT model. The results of all of this advocacy included our state identifying older adult, mental health and substance abuse as a priority issue. It eventually led to state funding that

targeted older adults substance abuse and it also encouraged the state to apply for a SAMHSA grant for the Florida Brite project the use of the model and to successfully receive that grant. Next slide, please.

Out of all of that effort, grew the Florida BRITE project. And the Florida BRITE project used the SBIRT model as the foundation and screened and provided intervention and support around alcohol misuse and prescription and over the counter misuse elicit including use and depression and including questions related to suicide in the depression portion as well. And of course, the focus of the Florida BRITE project was to provide early identification of at-risk elders for substance misuse in related problems and to also provide interactive response to those issues. Initially, the Florida BRITE project was funded with the state general revenue and that funding created three to four pilots state wide. The first one being in Broward County and which the Federal funding came into the state, that Florida BRITE project was expanded up to 20 sites state-wide and picking really the areas in our state that were heavily populated with older adult and making sure that all regions within the state had some representation

of some kind. Also implementing this project across the state, there was an effort to provide standardized protocol and standardized training or certification for call providers so that everybody was working with the same exact model across the state. Next slide, please?

I want to share with you in our effort in our organization to initiate the Florida BRITE project. The type of staffing that we set up to make this as practical as I had probably can. And we staffed the Florida BRITE project with a program coordinator who was an individual that held at least a master's degree in a related area and in this case it was psychology. And our Florida BRITE counselors were substance abuse counselors with at least a bachelor's level degree in the related area. In the state of Florida we have certification for additions professional and if the individuals that we have hired for the Florida BRITE program did not come as a certified addition professional that was a requirement that they accomplished that within two years of their employment with the organization. We also wanted to ensure that the staff that worked in this project were well-rounded in terms of understanding ages and the developmental stages of aging and factor and

stressors associated with aging as well as to not only understand addition, but understand current mental health issues. So internally as well as through the use of external training resources we helped to insure that the staff had that aging and behavioral health specialization as well. And lastly because Broward County is incredibly ethnically diverse, we wanted to be sure that the project was culturally competent. Not just from the standpoint of understanding how to engage people of different cultures with this type of initiative but also being able to deliver it in the languages that they speak. And because we have a large Hispanic population as well as a fairly long Asian population, we also ensure that we have the ability to deliver the program in Spanish and French Creole. And as you can see probably from this slide, as an organization, we not only took what the standards were for the state but built upon that what was relevant to make this initiative successful for our county and community. Next slide, please?

So, what were the goals state-wide for the Florida BRITE project? And what was obviously important in our community as well? Well, one thing that had traditionally been the

approach is really providers working somewhat independent of one another and the system that was not as integrated or collaborative as it could be. And so certainly initiating this project was an effort, particularly because of its referral component to develop stronger linkages across the providers in our community and also to ensure that what everybody was doing, particularly in the primary care setting was also integrated. And for our organization internally because we had multiple components where we had older adults including the veteran component. We made sure that we embedded it in all aspects of our agency just as we sought to engage the providers in our community to find ways to embed it with what they were doing. Of course the goal here was to identify substance misuse early on before it became a serious risk or a crisis situation for the elder adults and to be responsive to that risk and making sure that the right connections were made for that older adult to avoid at reaching a point of addiction or dependency.

For some folks who were at higher risk actually getting them into the treatment services in our community that traditionally that they did not have access to and just as

an aside, developing the Florida BRITE project. Also helped our organization to add other substance abuse components that were elder specific to what we did and helped us to build an outpatient continuum of care for older adults so that within our own agency and we could address those treatment issues. Over all you can see what we are trying to do here is decrease the misuse as well as improves the health outcomes for seniors. Next slide please.

So the components of the Florida BRITE project and certainly the standard components in our own organization began really without reach and referral and actually to be successful in this manner, we the agency developed a marketing strategy for this project. And really find a way to make it comfortable with our community and really address it or promoted it as a wellness program than directly as a substance abuse program. We also wanted to create relationships with referring agencies so that in some instances they could serve as an initial screening for risk before actually making a referral and getting other providers in the habit of beginning to look at substance misuse issues in older adults that they had not traditionally looked at. So our engagement was both at the

provider level as well as the elder level. And in terms of making sure that we put ourselves in places where elders were, and found a way to make this project seem like any other traditional service that they could find in that setting. The stages of the project included a pre-screening which was a couple of questions with really the purpose of trying to identify substance misuse risk in the senior. If there was a level of risk identified at the prescreening stage, then a full screening and assessment would be completed and with the tools that Dr. Berry described to you. So that we could get a gauge on the level or intensity of risk that the elder was facing. Based on that intensity of risk and appropriate intervention was provided. Whether it was a brief intervention that was one to five sessions, brief treatment that was up to 16 sessions, or for people that had stronger levels of risk engaging them in outpatient treatment or in-patient treatment in using ancillary services. The book described by Dr. Berry as well which was instrumental in working with our state in terms of training and helping us understand the model. The other thing that was critical to the components of this project was that prior to discharge, we would screen the older adults again to see what the intensity of risk was

certainly with the goal of insuring that it had decreased and there were also follow-up screenings at 30 days, 60 days and 6months. To determine that the elder remained with not a level of risk that they were initially assessed at. Next slide please.

So the areas that we worked in our community to deliver this program really were anywhere that we could find older adults, places that they naturally congregated as well as settings in which they resided. We also recognized as I pointed out before the importance of the primary care setting and also engaged primary health clinics in our community that were visited frequently by the older adults as well as hospital systems in our community. And actually, out stations, some of our counselors in hospital emergency rooms and those counselors eventually not only enter-faced with the seniors even in the hospital room if they were admitted for in-patient stays. So that we could really work with seniors perhaps at the initial points of entry that were traditionally missed and where substance misuse was not being assessed. In our continuum of care, or behavior health as an agency, we developed prevention programming and a prevention curriculum and if elders that we presented

our prevention and health promotion programming to self-identify, we would easily connect them with one of our BRITE counselors as well. We embedded BRITE into our own agency intake and also as I pointed out before, formed collaborative with other organization to help them be an extension of our outreach and referral. And one thing that we found that was important for us in this process was to formalize those relationships with that at a minimum of understanding so that everybody was clear in terms of their roles and responsibility. We had set aside planning for communication, and we sort of set it up in a way to be successful. Next slide, please.

Some of the lessons we learned from the Florida Brite project which is still in existence in our state starting at the client or consumer level, is that part of our job was always to begin where the elder wanted to begin and part of that was assessing not only their risk but their readiness for any change if risk was found. And in some instances this certainly involved staff being persistent and being patient and usually just that patience and consistency in being non-confrontational paid off because the elders were engaged and if the elders had any

resistance to understand what it fulfills to address that need to minimize their fears. As I pointed out before, we really try to offer this programming in a way that naturally occurred like any other aging service that they were used to. And we found that a way to typically engage the older adult population was to motivate them based on what they cared about. Typically they cared about their health. They cared about their finances and cared about their autonomy and the things that they valued like the family and the significant relationships in their life. And we approached this project allowing the elder to be really the decision-maker and the lead in what we did in trying to take more of a facilitation role in forming a partnership with the older adult to deliver the services and because this project was one that looked at things comprehensively and looked at co-occurring issues, we approached our services in that manner, as well. Next slide, please.

Part of the Florida BRITE project in terms of the workbook is to help older adults perhaps redevelop or strengthen the self-management skills that they have to develop protective factor and decrease their risk. And we learned very early on how successful this approach was. And particularly in

following up on them in screens after discharge from Florida BRITE and finding the high percentage who remained to be at-risk. Another thing that was obviously a success for us and we believe was strongly connected to how well the program worked was not trying to implement this project independently as an organization and just offering it and operating it independently but forming the relationships with other entities to connect this across our aging service continuum in our area. This approach is obviously a prevention-first approach. And it is one that seeks to provide services before they reach a crisis state and before more intensive intervention is required. And certainly, although we were following these standardized models, we had to individualize particularly our engagement and sometimes our follow up with seniors; we served because each older adult was certainly unique in their own way. Next slide, please.

So in terms of what we learned on a community-level as well as a funding-level, is that initially when we started out a lot of folks in the community, particularly aging service providers were of the mindset, how does this apply to me? How does this apply to our clients? We don't have a

substance abuse problem here in our senior center or public housing. Our older adults are not misusing substances. So again trying to approach this from a wellness standpoint as well as having the discussion with them about what we are ultimately their goals and what types of outcomes they wanted for the seniors that they worked with and how this type of initiative really reinforced that was seeking the same thing. Eventually, that approach made this project a resource to the community and a sought after resource because it certainly filled the gap. And that really, you know, was part of learning the importance of collaboration. A lot of communication was required not only giving, providers, and seniors incentives to engage in this initiative, but giving them a lot of feedback about what the outcomes were and what the results were, that there was an return on the investment and a value added so to speak on the investment that was being made in this project. And particularly, in the areas where we had staff and emergency rooms or hospital settings, working with the hospital to look at people who did not return any more that prior were individuals frequently coming into the emergency room and you know, what was the cost benefit of that? Certainly because when I initially started talking about approaching

this from an advocacy standpoint where nothing existed partnering with others on a state-wide level and a local level to creates champions and approach it as a coalition and a community again and not as a single provider within an agenda. And that coalition approach was also one that involved, you know, let's talk not just about the problems that we are seeing or the community complications or health, or public health factors. Let's talk about this from a solution approach. Next slide, please?

So, right now, the Florida BRITE project, several SAMHSA money has come to an end. And the state is still investing general revenue but as the federal money, that grant became to an end, the state has been working with providers to look at other forms of reimbursement so that the project can sustain. The state has home and community based Medicaid waiver for older adult and it looks at what the services pay for and how does the Florida BRITE program fit into for the assessment and the counseling that is being paid for out of the waivers. The state is looking at Medicare codes and what can be done in terms of reimbursement particularly where this project is being offered in partnership with hospitals. Looking at are there

seniors that are being served that can actually on a sliding scale contribute to the interventions that they are receiving? What in our—in terms of older Americans, act money that those services match or parallel the Florida BRITE project. What grants and foundations are interested in this project? Our united way became very interested in this project which was part of our sustainability plan, particularly around the medication misuse piece. Agencies across our state including the agency in Broward County and looking at the universities for internship placement to help with staffing and continued evaluation what is going on. We have an active council on compulsive gambling that looks at addiction and does brief screening and how does that fit into this model?

And where we have embedded it how does it make sense and not cost too much more to continue. Next slide please.

The last thing that I wanted to point out is that there are other evidence-based interventions that we used in our organization that are good partner interventions to the SBIRT intervention. One being the chronic pain management disease self-management program. Out of Stanford University. And there may be seniors in this program around

or discussion around medication that it is appropriate as they complete that program to follow up with the Florida BRITE screening. And then the depression management program Healthy Ideas which is typically embedded in the case management as well as the pearls and impact which is often embedded in conjunction with primary care. A lot of these models also do well to be connected with aging services in general. And turn it over now to Dr. Blow to wrap things up.

(UNIDENTIFIED SPEAKER): Thank you, Fred and I will wrap this up. We really thank you Steven for your really good information for the field. Thank you all I think that what we want to spent a couple of minutes is telling you that there are a lot of resources available to you that help you embed screening brief intervention refers for treatment into other services that are provided and provide for a relatively seamless way to do this. The take-home messages from I think what we have talked about today are that screenings for alcohol and drug use and misuse and abuse, in the context of health issues, is probably one of the best ways to do this. Brief interventions are effective both the research and brief interventions and then the

projects that have been implementation of real world settings have all found that it works well. And it can work very effectively and efficiently. Brief interventions that are important to remember are one of a spectrum of approaches to reduce or stop use or problems with use. And this can be put in the context of a number of other things that we do all the way from prevention and primary prevention all the way through formal specialized treatments.

I will add that older adults can benefit from this non-judge mental approach that focuses on what we know to be evidence-based process and so we have a lot of materials, including manual and screening instruments, workbooks, evaluation as to what is available. And those will be different aspects of them will be available on the Website that will be given to you. We also have done a lot of training in screening interventions and on how to implement the program and those materials and those trainings are also available and I think that those are—I think that you can learn to do them and to set up within a variety of settings and that really, I think are the ultimate goal is to try to improve the care for older individuals and to try

to do things that will make a difference in people's lives around these brief interventions. So we believe that these approaches are really very effective and really can make a difference. With that, I am going to turn it over to Kathy and we will come up, if you all have questions, we will move into some questions.

And here --.

Great. And excuse me, but, these are all available on the www.samhsa.gov Website and I would encourage you to go that because there are so many great materials on that Website. Sorry Kathy.

KATHY CAMERON: That is okay. We will also be providing a list of resources include many of those that were mentioned during the webinar today when you are sent the PowerPoint presentation for this webinar so that will be available within two weeks we will be sending out the PowerPoint. To everyone who registered for this Webinar.

Okay, we are now going to take questions and we do have a few questions that have been submitted via the chat box, if you have questions, feel free to type them into the chat box and we have some time right now to address those

questions. Fred and Kris, one of the questions that we did get is can you provide the definitions of binge drinking again?

DR. BLOW/DR.BERRY: Sure. So for an older person a binge drinking episode is for a man, three or more drinks on a drinking day. And for a woman, it is two or more drinks on a drinking day.

DR. BLOW/DR. BERRY: Yes? The concern with binge drinking in part is as we get older we metabolize alcohol and medications differently than when we were younger, that is why the binge drinking levels are lower for older adults than younger adults.

They are modest and so people need to be educated about just going over the limits just a little bit, are much greater for an older person. So we really want to target safer consumption. So that is one of the areas that we really emphasize in our interventions.

(UNIDENTIFIED SPEAKER): Great, thank you.

(UNIDENTIFIED SPEAKER): Okay the next question may be directed to Steven, the question is I get calls every day from first-responders who find older alcoholics living in their

homes under horrible conditions. And adult's protective services deem them to have the capacity to consent. How do we convince them to accept services?

STEVEN: We obviously have had a number of the same scenarios in our community as well. The first thing that one of the entities that we strongly collaborated with is all of our services but of course the Florida BRITE project was it is all; protective service and we made a memo of understanding. And to be assured that individuals in at-risk situations got connected with our agency for follow up.

It took us a couple of visits for the elder to just become comfortable with us without even starting any level of screening and assessment. Just sort of building a relationship with the elder. And when that trust was gained and then being able to begin to screen and assess their situation more formally and more comprehensively and because we have invested the time to build the relationship begin to, you know, work with them on some interventions to improve their situations. The other thing that I will point out is I talked about areas that motivate older adults and we frequently started with those things that were important

to them as opposed to with discussions around, you know, problem and risk. It required us to be perhaps a little more flexible and take a little more time than you might traditionally take. But it typically paid off in helping to absolve a lot of the risk that perhaps that elder had been going on for some time.

(UNIDENTIFIED SPEAKER): Great, Thank you. Another question is how are the baby boomers, the young, old, reacting to this program? And are they receptive to the program's benefits?

(UNIDENTIFIED SPEAKER): I would just say that they are absolutely receptive. That most of the work that was originally done with brief interventions and Chris could speak very well to this because she did the first us trial on the interventions were younger people, people under the age of 60. And the people are very responsive to these kinds of approaches. Because they are one of those—they are non-judgmental and they work really well with people of all ages. Do you want to comment?

DR. BERRY: Yes. And the baby boom generation, in again has more experience with seeking assistance for things that they consider a problem and want some help with. They have

more experience with therapy. And with getting additional help for any other things that they may want. And that is slightly different than the older generation that we have at this point. That people who would really do the elders at this stage are people who grow up on a different era. They grew up in a time where being self-sufficient was important and Fred do you want to speak a little bit more to that?

DR. BLOW: well, I think that, yeah. I think that we really are in a major change process in terms of the baby boomers coming to get into later life with their—the oldest of them right now are 66 this year and they have a lot of attitude and beliefs around all kinds of things and also, they are more receptive to help advice and also demand more treatment in the much more assertive way and so there is a major change that will be happening in the next decade. But we don't want to forget that there are a lot of older individuals that still need services that are older than that. And that, even though they are feel more stigma associated with these things, they really end up also needing services so we want to be sure that we focus on those also that is why the non-judge-mental approach is so

important. That age group that we found that it actually works well with all age groups. Thank you.

(UNIDENTIFIED SPEAKER): The next question is do both light and regular beers have the same amount of alcohol?

(UNIDENTIFIED SPEAKER): No. Is the short answer. The alcohol has around 4 percent alcohol, usually between three and a half and five. And light beer usually has less than 3 percent.

(UNIDENTIFIED SPEAKER): Okay. Thank you. Someone has been going out with friends or families for 20 years once a week, and has two portions of alcohol during that time. Are they still considered a binge drinker if they reach age 60 and continue this behavior?

(UNIDENTIFIED SPEAKER): Not if they have two drinks. Two standard drinks. If they are drinking more than that, they may actually become what could be considered a binge drinker. But I think that the important issue in this is that because of the metabolism changes as we get old and her we clear alcohol less well. Drinking two or three drinkers a day when we are young, and if we continue the pattern of drink any couple of drinks a day as we get

older, we may find that it actually does have more of an effect on us as we get older. And so it is important to give people the information about that so that they understand that the risks are different at a young age.

(UNIDENTIFIED SPEAKER): Also I will add to that and the risk changes too if the person is prescribed the psychoactive medication that I talked about where they should avoid the alcohol if they are taking the medications that I talked about.

(UNIDENTIFIED SPEAKER): That is an excellent point.

(UNIDENTIFIED SPEAKER): Okay. The next question which probably will be our last question. What are your thoughts of the DSM expansion proposal to recognize addictive symptoms the list is expected to recognize symptoms for drug and alcohol addiction? That is more symptoms will be recognized and fewer symptoms will be required to establish a diagnosis.

(UNIDENTIFIED SPEAKER): I think that it is going to change things pretty substantially in terms of our thinking about the need for interventions for a wider range of individuals. We now have a large tool kit of approaches including this approach of being address the wide-range of

individuals that may need interventions and so I think that our previous focus in treatment, which is specialized substance abuse treatment will change to a broader, public health approach, which I think is a spirit of what we are trying to do with the SBIRT evidence based practices. And that is going to move our thinking about who might benefit from changes in behavior in a much broader way than we have in the past.

(UNIDENTIFIED SPEAKER): In addition, one of the things that motivational approaches do is they don't tend to provide labels to people. And in particular, when we are working with people, we don't work with them in terms of abuse or dependence or being, "alcoholic" we work with them more as people who are experiencing some difficulties with that particular issue. And it seems to be an approach that in older adults, certainly is more accepted and allows for some feelings that they can be in charge of some of the things in making changes and making feel that they have some strengths to help them do that.

(UNIDENTIFIED SPEAKER): Okay. Thank you. And lastly, one minute left. To address the question of relapse. What has been your experience in working with older adults in SBIRT? Do

they relapse at the same rate or different rates of younger populations?

(UNIDENTIFIED SPEAKER): could --

(UNIDENTIFIED SPEAKER): Go ahead.

(UNIDENTIFIED SPEAKER): And because we have the out-patient treatment program for older adults as well, and actually, our program was being compared to other substance abuse initiatives with other age groups in our community. And we actually had the lowest relapse rate of any of the programs because we found that although it might be a challenge to initially engage the senior in the service, they stayed involved and engaged in their treatment and didn't drop out at the same rates that other populations didn't. Because of that they typically successfully completed treatment and because it focuses around the services and building a support network, you have a lot of relapse prevention being done as part of your intervention. So it seems like a lower relapse rate than a younger population was our experience.

(UNIDENTIFIED SPEAKER): Great. Thank you. And that was the last question. And I just wanted to point out one thing, Steven, you mentioned that you used older American act dollars to

support SBIRT in Broward county and I wanted everyone to be aware on the administration and aging website they have now added Florida BRITE as one of the evidence-based programs to implement using title 3 d funding. I was not sure if everyone was aware of that in the aging network.

(UNIDENTIFIED SPEAKER): Okay. Thank you everyone. We look forward to your participation in our next webinar which will be on June 20th from 2:30 to 4:00. And the topic will be partnerships. Keys to successful implementations of evidence-based programming.

EVERYONE: Thank you.

(END OF TRANSCRIPT)