Substance Abuse and Mental Health Services Administration
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The Substance Abuse Prevention
Older Americans Technical Assistance Center

A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions

Project coordinated by JBS International, Inc. under contract from SAMHSA with the National Council on Aging, a subcontractor.

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Executive Summary

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission is to reduce the impact of substance abuse and mental illness on America's communities. In order to achieve this mission, SAMHSA has identified eight Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. This alcohol and psychoactive medication screening and brief intervention (SBI) manual and implementation project fits squarely within the mission set forth by SAMHSA and supports Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness and Strategic Initiative #4: Health Reform. More information can be found at: http://www.samhsa.gov/about/strategy.aspx.

This manual is designed to be used by a variety of healthcare and social service organizations interested in implementing an early prevention intervention program focused on older adults who are at risk for alcohol and/or psychoactive medication misuse or abuse. The manual content, a guide for implementation of programs to prevent alcohol and psychoactive medication misuse/abuse in older adults, is supported by a large evidence base of SBI clinical trial research results and field-based implementation evaluations.

The content of this guide is divided into two major sections. Section I focuses on all of the information needed by clinicians and supervisors to conduct SBI. Section II guides organizations through determining where and how to embed SBI into their settings. This guide also includes Appendices that include a list of targeted psychoactive medications of concern, prescreening and screening instruments, a list of brochures and pamphlets on safe use of alcohol and medications, a brief intervention workbook, and process evaluation instruments to aid in determining how implementation is working and provide methods to maintain fidelity to the SBI model. Both Sections I and II are needed for organizations to successfully embed and implement SBI within their organizational structures.

The U.S. is now facing the challenge of caring for an increasingly large population of older adults who have significant healthcare needs. As the current cohort of aging Americans transitions from mid- to later life, the emerging research indicates that they are continuing to use alcohol and psychoactive prescription medications at a higher rate than previous generations. Given the demographic changes in the country, the increases in problems related to substance use in older adults that can result in costly negative health outcomes, and the changes in the healthcare system, developing methods for prevention and early intervention for this population is imperative. This evidence-based practice SBI manual gives both organizational leadership and clinicians the tools to successfully meet the prevention and early intervention needs of this rapidly growing population.

Introduction

The new millennium brings the challenge of caring for an increasingly large population of older adults who have significant healthcare needs. The United States Census estimates that the older adult population will grow rapidly between 2010 and 2030 as the baby boomers reach the age of 65. By 2030, there will be about 72.1 million older persons, almost twice their number in 2008. People 65+ represented 12.9 percent of the population in the year 2009 but are expected to grow to be 19.3 percent of the population by 2030 (U.S. Census Bureau, 2008; Administration on Aging, 2010).

As the baby boom cohort transitions from mid- to later life, they are likely to use more alcohol than previous cohorts. They are also more likely to use prescription drugs, in general, and use/misuse psychoactive medications in particular. Misuse of psychoactive prescription medications can have dangerous results.

Additionally, with the size of the baby boomer population and their relatively higher acceptance and use of illicit substances, psychoactive prescription medications, and alcohol, there is a growing concern that as the baby boomers age, there will be a substantial increase in the number of older adults with substance misuse and abuse problems (Korper and Council, 2002; Blow, et al, 2002b). Given these demographic changes and increases in substance use, large increases in problems related to substance use that result in costly negative health outcomes are already being documented (Agency for Healthcare Research and Quality, 2010).

Population changes and the increased need for substance abuse prevention efforts have led to initiatives to address current and anticipated substance use issues for older adults in the U.S. (Center for Disease Control and Prevention, 2009) Recent SAMHSA publications have highlighted the critical importance of optimizing strategies to prevent and intervene early for alcohol/medication misuse in this age group. This SAMHSA project with the focus on prevention of substance abuse in older adulthood fits well into two of SAMHSA's eight Strategic Initiatives: #1, prevention of substance abuse and mental illness; and #4 health reform. (Visit http://www.samhsa.gov/about/strategy.aspx for more information about SAMHSA's eight Strategic Initiatives.)

Manual Purpose and Project Summary

The purpose of this manual is to provide readers with **a guide for implementation of programs to prevent alcohol and psychoactive medication misuse/abuse in older adults**. Specifically, this manual:

- Provides strategies for screening, delivery of prevention materials, early identification of at-risk use, and targeted brief interventions.
- Provides background on this evidence-based practice, screening instruments appropriate for use with older adults, a practical guide to conducting brief interventions, a brief intervention workbook, guidance for embedding and sustaining these techniques in agencies and practices, and evaluation tools to monitor the use of these practices.
- Is intended for use by a variety of healthcare and social service organizations interested in implementing an early prevention intervention program focused on older adults who are at risk for alcohol and/or psychoactive medication misuse or abuse.
- Is a product of the following **SAMHSA Center for Substance Abuse Prevention (CSAP)** demonstration project: Substance Abuse Prevention Older Americans Technical Assistance Center (the Center).

SAMHSA/CSAP funded the translation of science to service project that formed the basis for developing this manual. This project was funded to begin to fill an important void by determining the best ways to

optimize the use of proven screening and brief intervention models in culturally diverse health and social service settings serving older individuals who are at risk for the negative consequences of alcohol and/or psychoactive prescription medication use.

Four sites received funding to implement SBI focused on alcohol and psychoactive prescription drug misuse. The four healthcare/community-based organizations that were selected to participate in the implementation project were: 1) Broward County Elderly and Veterans Services Division in Ft. Lauderdale, Florida; 2) The Council on Alcohol and Drugs Houston in Houston, Texas; 3) Partners in Care Foundation in San Fernando, California; and 4) Rush University Medical Center Older Adult Programs in Chicago, Illinois.

The specific aims of this SAMHSA/CSAP initiative are:

- To determine the extent to which participants' characteristics—specifically gender, age, race/ethnicity, education, perceived risk, and depressive symptoms—correlate with changes in alcohol and/or psychoactive medication misuse/abuse.
- To examine changes in alcohol and/or medication use in at-risk older adults in community settings from baseline to 6-month followup.
- To determine the factors that are associated with successful implementation of SBI programs aimed at reducing alcohol and/or psychoactive medication misuse/abuse in at-risk older adults in community settings.
- To assess the process of implementing SBI for older adults at the following levels:
  - The staff participating in implementing the intervention at project sites
  - The site or organizational level (i.e., evaluation of how the program was implemented, including the lead site and partner organizations)
  - Components/requirements/factors that support sustainability.

The *first phase* of the project included convening an Expert Panel of national experts in substance abuse in later life and social service providers with experience in evidence-based practice implementation. The Expert Panel meeting was convened in March 2010 to provide guidance in developing a structure for pilot project program design, target populations, implementation, evaluation, and data collection. The Expert Panel also discussed key attributes for sites to be selected and participate in the project.

The second phase of this project was providing technical assistance to the four sites to develop strategies for implementation of older adult screening and brief interventions for alcohol and psychoactive prescription medication misuse. Technical assistance activities included Webinars on selected topics related to implementation, onsite training of social service staff to deliver SBI, and development of manualized implementation materials.

Organization of Manual Content

The manual is designed to provide clinicians and organizations with an implementation guide. It is divided into two major sections. **Section I** is focused on all of the information needed by clinicians and supervisors to conduct SBI. **Section II** is designed for organizations to guide them through the process of determining where and how to embed SBI into their settings. **Appendices** (with a list of targeted psychoactive medications, prescreening and screening instruments, a list of brochures and pamphlets on safe use of alcohol and medications, a brief intervention workbook, and process instruments to aid in determining how implementation is working and in maintaining fidelity to the model) and **References** are included at the end of the manual.

Both Sections I and II are needed for organizations to successfully embed and implement SBI within their organizational structures.

SECTION I:

Alcohol and Psychoactive Medication Screening and Brief Interventions

Background on Substance Misuse and Abuse Among Older Adults

As a growing number of people reach later life, the promotion of healthy lifestyles and disease prevention among older adults is a critical issue. The increase in the number of acute and chronic diseases in later life leads to high utilization of health care among the elderly (e.g., Schneider and Guralnik, 1990; Krop, et al., 1998; Fuchs, 1999). Because of this increased incidence of healthcare problems, older adults are more likely to seek health care on a regular or semiregular basis than are younger adults. Many of these acute and chronic medical and psychiatric diseases are influenced by lifestyle choices and behaviors, such as the consumption of alcohol and the use of psychoactive prescription medications. As a group, those in later life are less likely than younger cohorts to abuse illicit drugs. Drinking problems and psychoactive medication misuse are by far the largest types of substance use problems seen in older adults today. Heavier alcohol use and psychoactive prescription medication use are associated with a number of adverse health effects in this population. In addition, older adults are more vulnerable to the effects of alcohol and, combined with their increased risk of comorbid diseases and their use of prescription and over-the-counter medications, may seek health care for a variety of conditions that are not immediately associated with increased alcohol consumption. These include greater risk for harmful drug interactions, injury, depression, memory problems, liver disease, cardiovascular disease, cognitive changes, and sleep problems (Barry, 1997; Gambert and Katsoyannis, 1995; Welte, 1997).

As the baby boom generation reaches later life, clinicians and researchers are beginning to see even greater alcohol use and larger numbers of individuals who misuse psychoactive prescription medications. Selective prevention strategies, such as brief advice by primary care physicians and other healthcare and social service providers, have proven to be effective in reducing alcohol misuse among older adults (Fleming, et al., 1999; Blow and Barry, 1999; Schonfeld, et al., 2010; Moore, et al., 2011). Screening and brief interventions that focus on lifestyle factors, including the use of alcohol and misuse of psychoactive prescription medications, may be the most appropriate way to maximize health outcomes and minimize healthcare costs among older adults. Therefore, systematic substance use screening and intervention methods are particularly relevant to providing high-quality health care to older adults. Older individuals with at-risk drinking are a special and vulnerable population who require elder-specific screening and intervention procedures focused on the unique issues associated with alcohol use in later life. Preventing alcohol and psychoactive prescription medication misuse/abuse, which is the focus of the Center, can potentially reduce or eliminate negative health and social outcomes among many older adults through prevention and early intervention strategies.

Alcohol Use

The misuse and abuse of alcohol, medications, and illicit drugs in older adults present unique challenges in terms of recognition, interventions, and determination of the most appropriate treatment options. Substance use problems in this age group are often not recognized and, if recognized at all, are generally undertreated. Additionally, there are concerns in the field that the standard diagnostic criteria for abuse/dependence are difficult to apply to older adults, leading to underidentification. Substance misuse/abuse, in particular, among elders is an increasing problem. Older adults with these problems are a special and vulnerable population.

From the standpoint of recognition, older adults are more likely than younger adults to seek services from their primary and specialty care providers which opens the door to greater recognition and treatment for those who drink/use medications at hazardous levels. Health-care providers who work with geriatric patients have a unique opportunity to observe and treat the repercussions of alcohol and medication misuse problems.

Prevalence of alcohol and drug use/misuse/abuse

Over a number of years, community surveys have estimated the prevalence of problem drinking among older adults to range from 1 percent to 16 percent (Adams et al., 1996; Barry, 1997; Fleming, et al., 1999; Menninger, 2002; Moore et al., 1999; Office of Applied Studies, 2004, 2007). These rates vary widely depending on the definitions of older adults, at-risk and problem drinking, alcohol abuse/dependence, and the methodology used in obtaining samples. The National Survey on Drug Use and Health (NSDUH) (2002–2003) found that, for individuals age 50+, 12.2 percent were heavy drinkers, 3.2 percent were binge drinkers, and 1.8 percent used illicit drugs (Huang et al., 2006; Office of Applied Studies, 2007). The 2005–2006 NSDUH showed a significant level of binge drinking among those age 50 to 64 (Blazer and Wu, 2009). They also found that 19 percent of men and 13 percent of women had two or more drinks a day, considered heavy or at-risk drinking. The survey also found binge drinking in those over 65, with 14 percent of men and 3 percent of women engaging in binge drinking.

Estimates of alcohol problems are much higher among health care-seeking populations, because problem drinkers are more likely to seek medical care (Oslin, 2004). Early studies in primary care settings found 10–15 percent of older patients met criteria for at-risk or problem drinking (Callahan and Tierney, 1995; Center for Substance Abuse Treatment, 1999). In a large primary care study of 5,065 patients over age 60, Adams and colleagues (1996) found that 15 percent of the men and 12 percent of the women sampled regularly drank in excess of National Institute of Alcoholism and Alcohol Abuse (NIAAA) limits: more than 7 drinks/week for women and more than 14 drinks/week for men. The guidelines recommend no more than one drink a day for both men and women over 65 (National Institute of Alcholism and Alcohol Abuse, 1995).

As a group, those in later life are less likely than younger cohorts to abuse illicit drugs. Drinking problems and psychoactive medication misuse are by far the largest types of substance use problems seen in older adults today.

These guidelines are consistent with some empirical evidence for risk-free drinking among older adults (Chermack, et al., 1996). Clinicians who are seeing levels of problem drinking and alcohol use disorders in their practices that are lower than those found in the studies cited above may want to begin screening programs. Because patients with a previous history of problems with alcohol or other drugs are at risk for relapse, establishing a history of use can provide important clues for future problems. The health costs of untreated alcohol problems have been well described but may be even greater among the elderly, who are already at increased risk for many health problems.

In terms of meeting criteria for abuse/dependence, two studies in nursing homes reported that 29–49 percent of residents had a lifetime diagnosis of alcohol abuse or dependence, with 10–18 percent reporting active dependence symptoms in the past year (Joseph, et al., 1995; Oslin, et al., 1997). In 2002, over 616,000 adults age 55 and older reported alcohol dependence in the past year: 1.8 percent of those age 55–59, 1.5 percent of those age 60–64, and 0. 5 percent of those age 65 or older (Office of Applied Studies, 2002). Although alcohol and drug/medication dependence are less common in older adults when compared to younger adults, the mental and physical health consequences are serious (Barry and Blow, 2009).

Psychoactive Prescription Medication Misuse

Misuse of psychoactive medications by older adults is perhaps a more challenging issue to identify than alcohol misuse. Despite high rates of medication use among older adults, few studies have specifically examined the prevalence and nature of psychoactive medication misuse and abuse in this population. The existing literature on this topic, while scant, indicates that psychoactive medication misuse affects a small but significant minority of the elderly population (Simoni-Wastila, et.al, 2005). Older adults are at higher risk for inappropriate use of medications than younger groups. Adults aged 65 years and older make up about 13 percent of the population but account for 36 percent of all prescription medication in the United States (Finlayson, 1997; Finlayson, 1998; Cook, 1999). Older adults use more prescriptions and over-the-counter medications than other age groups, and studies show that about a quarter of older adults use psychotherapeutic drugs, with 27 percent of all tranquilizer prescriptions and 38 percent of sedative hypnotic prescriptions written for older adults. A relatively recent study found that 25 percent of older adults use prescription psychoactive medications that have abuse potential (Simoni-Wastila and Yang, 2006). There are over 2 million serious adverse drug reactions yearly with 100,000 deaths per year. Adverse drug reactions are especially prominent among nursing home patients, with 350,000 events each year (Gurwitz et al., 2000; Lazarou, et al., 1998). A survey of social services agencies indicated that medication misuse affects 18–41 percent of the older clients served, depending on the agency (Schonfeld, et al., 2010).

In addition, prescription drug abuse has been the second most common type of substance abuse among older adults for a number of years (after alcohol abuse) (Finlayson and Davis, 1994; Holroyd and Duryee, 1997). Three percent of Veterans Administration geropsychiatric inpatients were diagnosed with dependence or abuse disorders involving prescription drugs (Edgell, et al., 2000); 5 percent of a community-based, high-risk elderly population were referred for prescription drug abuse (Jinks and Raschko, 1990); and 11 percent of patients at an outpatient geriatric psychiatry clinic were diagnosed with benzodiazepine dependence (Holroyd and Duryee, 1997). By 2020, the nonmedical use of psychotherapeutic drugs among older adults is projected to increase from 1.2 percent (911,000) to 2.4 percent (2.7 million) (Colliver, et al., 2006).

Several aspects of prescription misuse and abuse among the elderly differ both quantitatively and qualitatively from those found in younger populations. Misuse and abuse of prescription drugs by older adults is not typically done to "get high" (Blow, et al., 2006). Problematic use by older adults is usually unintentional (Simoni-Wastila and Yang, 2006), and most abused medications are obtained legally.

The psychoactive medications targeted in this manual are opioid medications for the treatment of pain and benzodiazepines used to treat anxiety and insomnia. Opioid analgesics include codeine (Tylenol 3®), oxycodone (OxyContin®), and hydrocodone (e.g., Vicodin®); benzodiazepines include diazepam (Valium®), alprazolam (Xanax®), and triazolam (Halcion®). These two classes of medications are the focus of this project because they are frequently prescribed to older adults, have a high dependence and abuse potential, and interact with alcohol leading to many negative outcomes **(see Appendix 1 for a list of Psychoactive Medications of Concern)**.

What is a psychoactive medication?

A psychoactive drug, psychopharmaceutical, or psychotropic is a chemical substance that crosses the blood–brain barrier and acts primarily upon the central nervous system, where it affects brain function, resulting in changes in perception, pain, mood, consciousness, cognition, and behavior. This includes legal drugs—prescription and over-the-counter medications—illicit drugs, and substances for ritual and spiritual uses.

What are examples of psychoactive medications?

- Central Nervous System Depressants—Antianxiety medications, tranquilizers, sedatives and hypnotics
  - Benzodiazepines
  - Barbiturates
- Opioids and Morphine Derivatives—Analgesics or pain relievers
  - Codeine, morphine, fentanyl, oxycodone, hydrocodone, meperidine

(A full list of medications of concern can be found in Appendix 1.)

Correlates of prescription drug abuse in older adults

There are a number of correlates that have been linked to psychoactive prescription drug misuse/abuse. Female gender (Finlayson and Davis, 1994; Jinks and Raschko, 1990; Simoni-Wastila and Yang, 2006), social isolation (Jinks and Raschko, 1990; Simoni-Wastila and Yang, 2006), and a history of substance abuse or another mental health disorder (Jinks and Raschko, 1990; Simoni-Wastila and Strickler, 2004; Simoni-Wastila and Yang, 2006; Solomon, et al., 1993) are all associated with increased risk of problems related to medications. One study indicates that older adults with prescription drug dependence are even more likely than their younger counterparts to have a dual diagnosis (Solomon, et al., 1993).

Prolonged use of psychotropic medications, especially benzodiazepines, has been associated with depression and cognitive decline (Dealberto, et al., 1997; Hanlon et al., 1998; Hogan, et al., 2003). Benzodiazepine use is also positively correlated with confusion, falls, and hip fractures in the elderly (Leipzig, et al., 1999). Further, the use of opiate analgesics can lead to increased sedation and impairment in vision, attention, and coordination among older patients (Ray, et al., 1993; Solomon, et al., 1993).

In addition to the concerns regarding the misuse of medications alone, combined alcohol and medication misuse has been estimated to affect up to 19 percent of older Americans (National Institute on Alcohol Abuse and Alcoholism, 1998). Substance abuse problems among elderly individuals often occur from misuse of over-the-counter and prescription drugs. Drug misuse can result from the overuse, underuse, or irregular uses of either prescription or over-the-counter drugs. Misuse can relatively easily become abuse (Patterson & Jeste, 1999; Schonfeld, et al, 2010).

> Misuse and abuse of prescription drugs by older adults is not typically done to "get high" (Blow, et al., 2006). Problematic use by older adults is usually unintentional (Simoni-Wastila and Yang, 2006), and most abused medications are obtained legally.

Illicit Drugs

The use of illicit drugs is relatively rare in the current cohort of older adults. The NSDUH (2002–2003) found that, for individuals age 50+, 1.8 percent used illicit drugs (Huang, et al., 2006; Office of Applied Studies, 2007). However, research suggests that the number of illicit drug users (and those with problems related to alcohol) in older adulthood is likely to increase due to the aging of the baby boom generation. Blow and colleagues (2002a) analyzed the National Health and Nutrition Examination Survey (NHANES) data, which suggested that the baby boom cohort, as it continues to age, could maintain a higher level of alcohol consumption than in previous older adult cohorts. Consequently, a larger percentage of future older adults may have alcohol use patterns that place their health at risk.

Mental and Physical Health Risks Associated with Use/Misuse/Abuse

Drinking at hazardous levels increases the risk of hypertension (Chermack, et al., 1996; National Institute of Alcholism and Alcohol Abuse, 1995) and may increase the risk of breast cancer (Baker, 1985; Rosin and Glatt, 1971) and diabetes (Vestal et al., 1977), among other medical conditions in this population. Hazardous drinking can significantly affect a number

of other conditions in this age group (Fleming and Barry, 1991) including mood disorders and sleep, as well as general health functioning (Blow, et al., 2000). Depression has been linked to relapse in drinking and increased alcohol intake. Blow and colleagues (2000) found negative effects of drinking status on general health, physical functioning, pain, vitality, mental health, emotional role, and social functioning, controlling for race and gender, with low-risk drinkers scoring better than abstainers and better than hazardous drinkers.

Symptoms of harmful drinking are often less visible among older adults because such symptoms may be masked by social, medical, or psychological conditions. Tolerance of ethanol can be reduced by the physiological aging processes (Rosin and Glatt, 1971) and by health conditions common to old age (Baker, 1985). Comparable amounts of alcohol produce higher blood alcohol levels in older adults than in younger persons, and may exacerbate other health problems (Vestal, et al., 1977). Drinking produces higher blood alcohol levels in older adults than in younger persons when comparable amounts of alcohol are drunk, and many problems common among older people, such as chronic illness, poor nutrition, and polypharmacy, may be exacerbated by even small amounts of alcohol (Rosin & Glatt, 1971; Vestal, et al., 1977).

What might be considered light or moderate drinking for individuals in their thirties may have multiple negative health effects in an older person. Therefore, clinicians who treat older patients need to assess alcohol use levels and be aware of health implications of their patients' alcohol use.

Practitioners from a variety of disciplines, including those who provide home health care and extended care, as well as those who manage community-based social programs for the elderly, can play a crucial role in detecting and intervening with alcohol problems in this age group. One of the challenges to all clinicians who work with older adults is meeting these goals within the context of a managed care environment, where providers are expected to deliver quality medical and mental health care across a wide variety of problems with greater time constraints. As more physical and mental health care is delivered within managed health care, the costs of treatment and the effectiveness of interventions for alcohol problems will benefit from new innovative technologies and techniques that require less provider intervention time and are more targeted to each patient's particular set of symptoms and health patterns. Fleming and colleagues (1999) conducted a brief intervention trial to reduce hazardous drinking with older adults, using brief advice in primary care settings. This study showed that older adults can be engaged in brief intervention protocols, the protocols are acceptable

COMMON BENZODIAZEPINES

(brand names in parentheses)

- Alprazolam (Xanax)
- Clorazepate (Tranxene®)
- Diazepam (Valium)
- Estazolam (ProSom®)
- Flurazepam (Dalmane®)
- Lorazepam (Ativan®)
- Oxazepam (Serax®)
- Quazepam (Doral®)
- Temazepam (Restoril®)
- Triazolam (Halcion)

COMMON OPIOID ANALGESICS

(brand names in parentheses)

- Codeine (Tylenol 3, Empirin® with codeine, Fiorinol® with codeine, Robitussin A-C®)
- Oxycodone (OxyContin, Percocet®, Percodan®)
- Hydrocodone (Vicodin, Lortab®, Lorcet®, Tussionex®)
- Morphine (MS Contin®, Roxanol®, Duramorph®, Kadian®, Avinza®)
- Meperidine (Demerol®)
- Hydromorphone (Dilaudid®)
- Fentanyl (Duragesic® transdermal patch)
- Methadone

in this population, and there is a substantial reduction in drinking among the at-risk drinkers receiving the interventions. One procedure found to identify large numbers of heavy drinkers who are likely to be motivated to change is routine health and lifestyle screening in medical settings (Adams, et al., 1996; Skinner, et al., 1981).

What might be considered light or moderate drinking for individuals in their thirties may have multiple negative health effects in an older person.

Definitions Of Substance Use Risk and Recommendations for Older Adults

The terms presented in this manual are derived from both the clinical and research expertise of professionals in the field of addictions. The term ***alcohol use disorders*** includes the clinical problems of alcohol abuse and dependence. However, many older adults have alcohol problems without meeting any standardized criteria for abuse and/or dependence. In order to address the range of alcohol problems in older adults, screening and assessment procedures need to focus on a range of drinking levels. Decisions regarding interventions and treatment may need to be made partly based on level of alcohol/medication use and misuse and partly based on problems manifested, regardless of amount used.

To diagnose alcohol use disorders clinicians look for behavioral factors such as the inability to cut down or stop, social and emotional consequences such as family problems, and physiological symptoms such as insomnia, gastrointestinal pain, liver toxicity, tolerance (over time it takes more of the substance to feel an effect), and withdrawal. A limitation for the alcohol field, particularly in medical settings, is the lack of laboratory tests to make a definitive diagnosis of alcohol abuse or dependence. Liver function and other laboratory tests detect end organ damage but do not detect the primary disorder. Only about 20 percent of people with alcohol abuse or dependence have elevated serum gamma-glutamyl transferase (GGT) (Babor, et al., 1989). Research has indicated a positive relationship between level of drinking (consumption) and severity of alcohol-related problems. This relationship is often true for younger adults but is not as applicable for all older adults with alcohol-related problems. In older adults, problems with alcohol can occur with relatively low levels of use. Screening and intervention efforts should include both an evaluation of medical and psychosocial problems that can be related to alcohol and a determination of consumption levels.

Because of the potential for interactions between alcohol and medications in this age group, the definitions of low-risk, at-risk, problem use, and abuse/dependence should always include an evaluation of medication use (prescription and over-the-counter) along with the use of alcohol. Additionally, it is important to understand the broad range of problematic use of prescription medications that can be found in this population. Culberson and Ziska (2008) provide a breakdown of the various types of medication misuse and abuse that can occur among older adults. Discussion of those definitions is included in the risk categories below.

Low-Risk Use

Alcohol use that does not lead to problems is called ***low-risk use*** (see Case 1) (adapted from Barry and Blow, 2010). Persons in this category can set reasonable limits on alcohol consumption and do not drink when driving a car or boat, operating machinery, or using contraindicated medications. They also do not engage in binge drinking. In this age group, low-risk use of medications could include short-term use of an antianxiety medication for an acute anxiety state during which the physician's prescription is followed and no alcohol is used, or drinking one drink three times/week without the use of any contraindicated medications.

At-Risk Use

At-risk use is use that increases the chances that a person will develop problems and complications related to the use of alcohol. These individuals consume more than 7 drinks/week or drink in risky situations (see Case 2). They do not currently have health problems caused by alcohol, but if this drinking pattern continues, problems may result. There are two types of medication misuse that may fit into at-risk use or problem use (below) depending on severity. The types are misuse by the patient and misuse by the practitioner. Misuse by the patient includes taking more or less medication than prescribed; hoarding or skipping doses of a medication; use of medication for purposes other than those prescribed; and use of the medication in conjunction with alcohol or other contraindicated medications. Misuse by the practitioner includes prescribing medication for an inappropriate indication; prescribing a dosage that is unnecessarily high; or failure to monitor or fully explain the appropriate use of a medication (Culberson and Ziska, 2008).

In older adults, problems with alcohol can occur with relatively low levels of use.

Problem Use

Problem use refers to a level of use that has already resulted in adverse medical, psychological, or social consequences as in Case 3. Although most problem drinkers consume more than the low-risk limits, some older adults who drink smaller amounts may experience alcohol-related problems. As mentioned above, medication misuse can also fit into the problem use category. Assessment to determine severity is needed.

Alcohol and Other Drug Dependence

Those who use at the level of ***alcohol dependence*** have a medical disorder characterized by loss of

CASE 1:

Mary Howard is a 68-year-old retired teacher who drinks one glass of wine when out to dinner with friends once or twice a week. She takes no psychoactive medications. She has a relatively large social network, exercises by walking in the mall with a friend three times/week, and is active in volunteer work in an adult literacy program. She has no family history of alcoholism and does not take other contraindicated medications. She receives routine health care from a primary care physician and attends a senior center. Ms. Howell would benefit from prevention messages regarding her alcohol use in the context of her overall health and well-being. *"I know that one of your goals is to prevent health problems. Your exercise program looks good. You continue to be active with friends and in the community. You have no family history of alcohol problems, are taking no medication to interfere with alcohol, and have a single glass of wine no more than a few times a week. These are all good things that you have been doing to stay as healthy as you can."*

control, are preoccupied with alcohol, continue to use despite adverse consequences, and suffer physiological symptoms such as tolerance and withdrawal as in Case 4. A wide range of legal and illegal substances can be addictive.

Medication abuse involves medication use that results in diminished physical or social functioning; medication use in risky situations; and continued medication use despite adverse social or personal consequences (Culberson and Ziska, 2008). Dependence includes medication use that results in tolerance or withdrawal symptoms; unsuccessful attempts to stop or control medication use; and preoccupation with attaining or using a medication.

There are recommended levels of alcohol consumption to minimize risky or problematic drinking and to prevent alcohol-related problems. For example, NIAAA (2007) defines moderate alcohol use guidelines for most adult women as no more than 7 drinks per week, or up to 1 standard drink per day. Guidelines for most adult men are no more than 14 drinks per week; no more than 2 drinks/day. Drinking at these levels is generally not associated with health risks (Department 0fHealth and Human Services and Department of Agriculture, 2005). **However, for adults age 60+**, the NIAAA and SAMHSA's Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) on older adults (Center for Substance Abuse Treatment, 1998), recommend that both men and women consume **no more than one standard drink/day (no more than seven standard drinks/week)**.

In addition, older adult women should consume no more than two standard drinks on any drinking day. Three or more drinks on a drinking day is considered binge drinking for older women; binge drinking for older men is no more than three drinks on a drinking day. A standard drink equals 12 grams of alcohol (e.g., 12 ounces of beer; 5 ounces of wine; or 1.5 ounces of 80-proof distilled spirits) (Center for Substance Abuse Treatment, 1998). See Figure 1 for a depiction of standard drinks.

Clearly, some older individuals should not consume alcohol at all, and it is critical that this is part of the recommended drinking limit. Older adults taking certain prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics and benzodiazepines), certain over-the-counter medications, those with medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease), individuals planning to drive a car or engage in other activities requiring alertness and skill, and those who

CASE 2

John Harris is a 64-year-old marketing executive. He works long hours and has few hobbies and interests outside of work. Although the company has a policy that employees retire at 65, he has not planned what he will do. He is slightly overweight, does not exercise except for occasionally playing golf, and drinks 2 drinks/day during the week and 3 or 4 drinks/day on the weekends. He has no diagnosed health problems related to alcohol use, but his wife worries about his drinking and would like him to spend more time in activities with her that do not involve alcohol. He has gone to a therapist at his wife's urging. The message from his therapist could include a statement regarding his use of alcohol and concern about potential problems. *"You indicated that, on average, you drink alcohol every day and drink two drinks at a time during the week and drink more than that on the weekends. You and I have talked about your stresses at work, your wife's concerns about your use of alcohol, and your own worries about retirement. National guidelines recommend that men your age drink no more than [7 drinks/week; no more than 1/day]. I am concerned that your pattern of alcohol use could fit into the at-risk drinking category. How do you see that?"*

are recovering from alcohol dependence, should not drink alcohol.

The most useful alcohol screening instruments include questions on quantity/frequency and binge drinking to ascertain an estimate of the amounts consumed. The Health Screening Survey (Fleming and Barry, 1991) has been validated and used in a number of clinical trials, and the consumption portion of the measure is used in this implementation project **(see Appendix 2 for screening instruments)**.

Alcohol Use Limits for Targeting Interventions

The majority of research studies of both younger and older adults set the limit for entry into studies higher than the NIAAA recommendations for use. This is based on two main factors:

- Most studies that have carefully measured alcohol consumption in older adults found, on average, that older adults who met criteria for at-risk drinking were drinking at levels averaging 12 drinks/week for women and 15 drinks/week for men, with a significant portion drinking at higher levels than that (e.g., men at 21+ drinks/week) (Adams, et al., 2002; Fleming, et al., 1999; Moore, et al., 2011)
- Setting the criteria at 7 drinks/week for adults in this age group means that providers would be intervening with those drinking 8+ drinks/week.

As a cost-effective preventive strategy, providing information for all older adults on guidelines can be useful. This manual provides prevention educational materials for all older adults who complete the prescreening instrument, and is meant to give important information about the unique risks of alcohol and psychoactive

CASE 3

Anna Martin is a 70-year-old widow living alone in a small apartment in a large city. She has developed few interests and outside activities since her husband died 4 years ago. In a routine visit to her primary care clinic, the nurse practitioner asked some questions about her general health and Mrs. Martin reported that she was tired all the time and, because she did not sleep well, she was using over-the-counter sleeping pills. When asked, she said that she generally drinks one glass of wine a day before dinner just as she and her husband did when they were younger. She had been taking prescription medicine for stomach pain for 6 months, but the pain has not improved. The effect of alcohol is exacerbated by age, by the use of some medications for stomach pain like Zantac, and by over-the-counter sleeping pills. Her nurse practitioner discussed with her the potential problems of mixing some medications with alcohol, provided information about the senior center in her neighborhood and the name of a contact person at the center, and suggested she try the center for some activities and stop the use of alcohol, since it could be starting to cause problems that would get worse with time. *"I am concerned about your use of alcohol with the medications for your stomach and the sleeping pills. The stomach medicine you take and the sleeping pills can increase the effect of the alcohol. I'm also concerned that you may not have a lot of options to see other people, and that can be pretty lonely. I'm giving you the number for the senior center in your neighborhood and the name of the person to call at the center. Ideally, I believe it may be best to discontinue both alcohol and the sleeping pills. I know you said that you did not want to do that. So do you think that, for the next month, you could stop using the sleeping pills or stop the use of the alcohol to see how you feel? I'd also like you to try out the senior center. We can revisit what works and what does not work in 1 month. Please call me if you have any problems before I see you in 1 month."* Mrs. Martin felt that she would be able to follow these recommendations. The nurse practitioner made an appointment with her in 1 month to check on progress.

FIGURE 1

What's a standard drink?

1 standard drink=

medication use to all older individuals (**see Appendix 3 for a list of brochures and pamphlets on the safe use of alcohol and medications**). As a preventive intervention strategy, however, conservatively setting

CASE 4

Joe Thompson is a 68-year-old retired electrician. He has had chronic abdominal pain and unresolved hypertension for the 10 ten years. He has a history of alcohol problems and had one admission to alcohol treatment 15 years ago. Four years ago, after experiencing withdrawal symptoms during a hospital admission for a work-related injury, he again entered an alcohol treatment program. After 2 years of abstinence, Mr. Thompson began drinking again. He now drinks approximately five beers a day plus some additional liquor once a week. His physician and social worker in the primary care clinic are aware that this is a chronic relapsing disorder and continue to work with Mr. Thompson to help him stabilize his medical conditions and find longer term help for his primary alcohol dependence. *"Mr. Thompson, your high blood pressure and your stomach pains do not seem to have improved. The amount you are drinking can certainly interfere with them getting better and can make other physical and family problems worse. I know you've tried hard to deal with your alcohol problems and you really kept those problems in check for a long time, but now they seem to be getting in the way of your health and well-being again. I know it takes a lot to stay sober and that slips can occur when people are more stressed. I'm worried about your health and would like you to talk to someone from the alcohol program to assess whether or not it is time do get some additional help to prevent further problems. Would you be willing to talk with them if we call and make the appointment together?"*

the limit at a slightly higher level (10 drinks/week for women age 60+ and 14 drinks/week for men age 60+) will reach the majority of older adults who are at-risk drinkers (Fleming, et al., 1999), and will allow providers to intervene with those older adults who could benefit from changing their drinking to optimize their health outcomes. The screening tool used in this implementation project uses this drinking limit (i.e., 10 drinks/week for women age 60+ and 14 drinks/week for men age 60+) **(see Appendix 2 for screening instruments)**.

Psychoactive Prescription Medications

The misuse of psychoactive prescription medications (use in greater quantities or more often than prescribed) with or without the additional use of alcohol is now seen as a growing problem in the U.S. (Agency for Healthcare Research and Quality, 2010). In fact, admission to hospitals for all drug-related conditions grew by 117 percent for individuals age 45–64 (the baby boom cohort) over a recent 10-year period. The rates of hospital admission for all drug-related conditions among those aged 65–84 followed closely, growing by 96 percent. Studies have also found that higher scores on measures of psychoactive prescription misuse have been associated with a history of substance abuse, higher levels of psychosocial distress, and poorer functioning (Adams, 2005; Holmes, et al., 2006).

Psychoactive medication misuse is an important area for prevention and early intervention among older adults. Many medication-related problems are predictable and thus potentially preventable, but the mechanisms underlying the development of medication problems are complex. The use of brief intervention techniques has been shown to produce positive changes in both alcohol and psychoactive medication use and can lead to improved outcomes for vulnerable older adults. The Schonfeld study (2010) found that those older adults who received the brief intervention used less alcohol and contraindicated medications and had improvements in depressive symptomatology.

The National Institute on Drug Abuse (NIDA) Modified ASSIST instrument, developed originally to measure illicit drug use/abuse, has been adapted in the field and is now more widely used to measure psychoactive prescription medication problems (e.g., Schonfeld, et al., 2010). The project that is the basis for this manual uses the NIDA Modified ASSIST **(see Appendix 2 for screening instruments)**.

Evidence For Screening and Brief Interventions

Screening

There is a large body of evidence that screening and motivational brief interventions delivered in a variety of healthcare and social service settings can effectively reduce drinking, particularly for at-risk and problem users. Over the last 20 years, preventive interventions in a variety of medical and social service care settings have proven to be efficacious in reducing alcohol misuse among younger and older adults (Fleming, et al., 1999; Blow and Barry, 1999; Lin, et al., 2010; Moore, et al., 2011). The three major aspects to the provision of brief interventions in healthcare or social service settings are **prescreening, screening, and brief interventions**. In addition to the randomized controlled trials cited above, two notable large-scale effectiveness studies have been conducted to study the implementation of these models in practice: the Primary Care Reserach in Substance Abuse and

Mental Health for the Elderly Study (PRISM-E) (Oslin, et. al., 2006) and the Florida BRITE (Brief Intervention and Treatment for Elders) project (Schonfeld, et al., 2010). These two effectiveness studies demonstrated that, despite the strong evidence of the efficacy of screening and brief intervention approaches, and deliberate attempts at implementing these evidence-based interventions into practice, enormous barriers in implementation continue to exist for the implementation of preventive interventions that work with older adults in real-world settings. These barriers include stigma from the perspective of older adults, difficulty in outreach to older adults, lack of healthcare and other professionals trained in screening and brief interventions, chronic medical conditions that may make it more difficult for providers to recognize the role of alcohol and psychoactive medication misuse in decreases in functioning and quality of life, and few or low reimbursement/funding sources for SBI. These and other barriers and possible solutions are discussed in the second section of this manual.

This science-to-service gap remains despite many excellent efforts to rapidly translate SBI's efficacy and effectiveness into programming for the growing population of older Americans. This need is becoming more acute as the evidence grows regarding the widespread use and misuse of alcohol and psychoactive prescription medications, such as opioid analgesics and benzodiazepines, in this aging population. Therefore, **SAMHSA's implementation project and this manual help service providers determine the best ways to optimize the use of proven SBI protocols in a wide variety of healthcare and social service settings that serve older individuals, many of whom are at-risk for the negative consequences of alcohol and/or psychoactive prescription medication use.**

Prescreening for problem substance use is a critical first step in identifying patients who may need further in-depth screening and those who may be suitable candidates for brief interventions. Prescreening generally identifies at-risk and harmful substance use, while more extensive screening measures the severity of the substance use, problems and consequences associated with use, factors that may be contributing to substance abuse, and other characteristics of the problem. The prescreening and screening process should help determine if a patient's substance use is appropriate for brief intervention or warrants a different approach.

Although prescreening and screening are addressed in further detail elsewhere in this manual, two brief approaches bear mentioning, adapted from *The NIAAA Clinician's Guide to Helping Patients Who Drink Too Much* (National Institute for Alcohol Abuse and Alcoholism, 2005). Simple questions about heavy substance use days can be used during a clinical interview or before a patient is seen, followed up with further questions as indicated.

Prescreening question: Do you drink beer, wine, or other alcoholic beverages?

Followup questions: If yes, how many times in the [past year; past 3 months; past 6 months] have you had 5 or more drinks in a day (for men)/4 or more drinks in a day (for women)?

On average, how many days/week do you drink alcoholic beverages? *If weekly or more:* On a day when you drink alcohol, how many drinks do you have?

Prescreening question: Do you sometimes use illegal drugs? Do you use prescription drugs in a way different than prescribed?

Followup question: If yes, follow up with additional questions regarding which substances, frequency and quantity of use **(see Appendix 2 for Prescreening Instrument)**.

A useful validated screening instrument is the Alcohol Use Disorders Identification Test (AUDIT), which was developed by the World Health Organization (WHO) as a brief screening tool for excessive drinking (Babor, et al., 1989; Fleming, et al., 1991; Schmidt, et al., 1995; Barry and Fleming, 1993; Fiellin, et al., 2000). The AUDIT can also be helpful in developing a framework for brief interventions for individuals drinking at hazardous or harmful levels. The AUDIT

The three major aspects to the provision of brief interventions in healthcare or social service settings are prescreening, screening, and brief interventions.

is well validated in adults under 65 in primary care settings. The AUDIT is a 10-item questionnaire introduced by a section explaining to the respondent that questions about alcohol use in the previous year only are included. The questionnaire is often used as a screener without the clinical examination. The recommended cutoff score for the AUDIT has been 8. A copy of this tool can be found in **Appendix 2** and at: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Documents/Audit.pdf.

Screening opportunities include during routine appointments, when filling out new patient intake forms, before prescribing medications (particularly those that interact with alcohol or other drugs), in emergency departments/urgent care centers, and for patients with health conditions that may be alcohol related, patients with illnesses that are not responding to treatment as expected, and populations of patients who may be more likely to drink heavily.

Brief Interventions

A multitude of published brief intervention studies with younger adults have been conducted in many settings. Over 100 trials of brief intervention techniques have been conducted over the past 25 years for adults under age 60. Early studies in Europe and other countries demonstrated a significant (10- to 20-percent) reduction in drinking for intervention compared to control groups (e.g., Wallace, et al., 1988). A number of meta-analytic studies compare brief intervention clinical trials. For example, Whitlock and colleagues (2004) examined 39 studies; 12 met criteria for inclusion in their review. All of the interventions in these studies included personalized feedback based on the individual's responses to screening questions and untailored (generic) messages to cut down or stop drinking. Meta-analyses of randomized controlled studies have found that these techniques generally reduce drinking in the intervention versus control groups. Across studies, participants reduced their average number of drinks/week by 13–34 percent compared to controls. Most of the trials of brief intervention techniques have been conducted in primary care settings (e.g., Chick et al., 1985; Wallace et al., 1988; Harris and Miller, 1990; Babor and Grant, 1992; Fleming et al., 1997). One of the largest clinical trials conducted in primary care practices is Project TrEAT (Trial for Early Alcohol Treatment). Individuals in the intervention group significantly reduced their use, and had fewer hospital days and emergency department visits compared to controls. The effectiveness of the intervention was still significant after 2 years for Project TrEAT participants (Fleming, et al., 1999).

In addition to these primary care and social service settings, the venue seeing the largest numbers of patients during times that are often called teachable moments (times of crisis) are emergency departments. There have now been a number of successful brief alcohol intervention trials conducted in emergency settings with individuals who are of varying ages and levels of use (see Havard, et al., 2008 for meta-analysis including 13 randomized controlled trials).

Finally, specifically related to the Center's activities, brief interventions have been shown to be effective for older adults in reducing alcohol misuse (Fleming, et al., 1999; Blow and Barry, 1999; Moore, et al., 2011), as well as medication misuse (Schonfeld, et al., 2010). Although there have been fewer studies with older adults, more data are now available that show the effectiveness of screening and brief interventions in this population. Specifically, screening and brief interventions in a variety of healthcare and social service settings have reduced alcohol consumption among older adults, with these reductions sustained over time (up to 12–18 months) (Fleming, et al., 1999; Schonfeld, et al., 2010; Moore, et al., 2011).

From a public health perspective, because so many patients are seen in a variety of health and social services settings, the development of easy-to-use, quickly administered screening and intervention mate-

rials has been critical to advancing the field. In primary care, brief interventions for alcohol misuse have ranged from a few simple, straightforward comments from the clinician to the patient to several short counseling sessions with telephone followup (Center for Substance Abuse Treatment, 1999). Brief comments to a patient with at-risk or problem drinking might include the clinician stating concerns about the patient's drinking, informing the patient that his/her current consumption levels are above recommended limits, and recommending the patient reduce or stop drinking (National Institute on Alcohol Abuse and Alcoholism, 2005).

Adapting the SBIRT Model

A comprehensive model for addressing alcohol and psychoactive prescription misuse in a variety of health-related settings, SBIRT, has been developed. SBIRT consists of **S**creening, **B**rief **I**ntervention, and Referral to **T**reatment. *Screening* quickly assesses the severity of substance use and identifies the appropriate level of intervention. *Brief Intervention* focuses on increasing insight and awareness regarding substance use and motivation for behavioral change. *Referral to Treatment* provides access to specialty substance abuse assessment and care, if needed.

SBIRT for substance use offers opportunities for early detection, focused motivational enhancement, and targeted encouragement to seek needed substance abuse treatment, where appropriate. The majority of older adults who have at-risk use of alcohol and/or psychoactive prescription medication use do not need formal specialized substance abuse treatment. However, many can benefit from prevention messages, screening, and brief interventions. This project is focused on the screening and brief intervention **(SBI)** portion of the model, because many organizations serving older adults can use SBI successfully in these settings. It is anticipated that sites using this model will develop referral sources for older adults who need to be assessed for treatment. These include primary and specialty care providers and formal specialized substance abuse treatment programs, where available.

Practical Guide to Screening and Brief Interventions

Prevention Implementation Protocol

This section gives organizations a picture of how a staff person and older adult would work together to complete alcohol and psychoactive medication screening and brief interventions. Here we present the protocol steps and scenarios for screening and brief interventions and describe the potential use of the outcome and process evaluation instruments to monitor the use and standardization of this evidence-based program (EBP).

Section II will guide organizations through a planning, decision, and implementation process. The guidance spans work with partners, decisions about organizational roles, staff training, and other implementation steps.

Client Process

Prescreen: All older adults complete the prescreen survey. The prescreen quickly identifies older adults who drink alcohol and/or use any of the psychoactive medications targeted for the intervention (e.g., opioid analgesics for pain and benzodiazepines for sleep, anxiety, nerves, agitation) **(see Appendix 2)**.

Educational Materials: All older adults who have a prescreen should receive prevention educational materials on alcohol and psychoactive medications

The majority of older adults who have at-risk use of alcohol and/or psychoactive prescription medication use do not need formal specialized substance abuse treatment. However, many can benefit from prevention messages, screening, and brief interventions.

(see Appendix 3 for examples of brochures and pamphlets on safe use of alcohol and medications).

Screen: If an older adult has a positive prescreen, he/she should then complete the screening questionnaire (either self-administered or staff-administered). Included in Appendix 2 are examples of screeners, including an adapted ASSIST instrument, the Alcohol Use Disorders Identification Test (AUDIT), and the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G). Any of these instruments can be used successfully with older adults. It is important to have a measure of quantity/frequency of use and consequences of use.

Brief Intervention: If an individual screens positive, he/she should be offered a brief intervention. It is most effective to use a workbook to deliver the intervention (see Appendix 4).

Staff conducting the brief interventions could also complete a short Intervener Exit Form (see Appendix 5) at the end of each brief intervention. The exit form is designed to elicit if all parts of the standardized brief intervention are completed to assist the organization in maintaining high fidelity to this EBP.

Six-Month Followup: Six months after the delivery of an initial brief intervention, sites may choose to ask an older adult to complete the followup survey (which includes questions similar to the screening questionnaire) (see Appendix 6). This survey mirrors the screening questionnaire and can help service providers and organizations determine if clients are doing well, have changed their alcohol and/or psychoactive medication use, or need additional assistance with their alcohol and/or psychoactive medication use.

Table 1 below summarizes the outcome and process evaluation instruments that can be used as part of implementation, the timing of completion of these instruments, and who would complete each instrument.

Table 1: Survey Details

Instrument	When/Where Completed	Completed By
Participant Outcome Instruments		
Prescreen	Universal prescreening is recommended for all older adults seen in healthcare and community-based senior service settings	Staff trained in prescreening and delivery of prevention materials or self-administered by older adults.
Screen	All older adults who prescreen positive should receive a screening questionnaire.	Staff trained in screening or self-administered by older adults.
Six-Month Followup	All older adults who receive a brief intervention should be followed at 6 months to determine progress.	Staff conducting the brief intervention
Process Evaluation Instruments		
Intervener Exit Form	At the end of each brief intervention, this form should be completed to monitor intervention fidelity.	Staff conducting the brief intervention
Initial Staff Survey	At the beginning of the project	All staff who conduct the screening and brief interventions
Staff Satisfaction Survey	Every 6–12 months	All staff who conduct screening and brief intervention

Brief Prevention Interventions: Process and Use of Workbook

Brief motivational interventions are designed to lessen the potential harm of continued at-risk use of alcohol and psychoactive prescription medications. Specific goals will vary by individual characteristics and context.

Components and Steps of Brief Interventions

The key elements that have been identified as crucial for effective brief interventions make up the FRAMES model (Center for Substance Abuse Treatment, 1999; Barry, Oslin & Blow, 2001):

F*eedback* is given to the individual about risk.

R*esponsibility* for change is placed with the individual receiving the intervention.

A*dvice* for changing behavior is given by the clinician.

M*enu* of alternative options for change is offered.

E*mpathic* and motivational style is used by the intervener.

S*elf-efficacy* or empowerment is promoted.

Brief intervention protocols often use a workbook containing the nine steps listed below. Workbooks provide opportunities for the client and intervener to discuss cues to use, reasons for the level of use, reasons to cut down or quit, a negotiated agreement for next steps, and daily diary cards for self-monitoring. Using a workbook to conduct a brief intervention should take from 20 to 30 minutes, on average. Providers can be easily trained to administer the intervention protocol through role-playing and general skills training techniques in educational programs. The approach follows principles of motivational interviewing.

The brief intervention protocol in the workbook (**Appendix 4**) includes the following components:

1. ***Identification of future goals*** *for health, work, school, activities, hobbies, relationships, and financial stability.* This step gives the service staff member and the client information on what the older adult is interested in achieving and can help to target goals for the intervention.

It is important to go through these goals because doing so establishes a context for thinking about the role of drinking and/or psychoactive prescription medication use in their lives. This part of the intervention establishes rapport and begins to focus the individual's attention on a future orientation. This helps to set the context for the brief intervention and generally provides increased motivation for the individual to change. **Appendix 4** includes two versions of the workbook: Version A is for brief interventions for alcohol only and Version B is for brief interventions for alcohol and/or psychoactive medications.

Key Points to Consider:

- It is important to elicit from the patient the goals that are most important, not to cover all areas. For example, some patients may not have goals for their financial situation but will choose goals related to their physical health or living situation. If the older adult responds with stating he/she has no goals, give some examples such as maintaining current health/independence, improving a chronic health problem, or maintaining contact with family or friends.

Dialogue Example:

"Can you share with me some of your goals for the next three months regarding your physical and emotional health, your activities and hobbies, your relationships and social life, and your financial situation and other parts of your life? Any particular goals that are important right now?"

2. ***Summary of health habits.*** Customized feedback on screening questions relating to drinking and/or drug use patterns and other health habits (may also include smoking, nutrition, tobacco use, seat belt use, safe sex, etc.). This health behaviors information can come from screening questionnaires or from the patient during this session.

Key Points to Consider:

- Summarize information on health behaviors other than alcohol and psychoactive medications first.
- After reviewing the alcohol and psychoactive medication sections of the health habits portion of the workbook, ask the older adult if there any health behaviors with which he/she would like help. Generally, individuals will not indicate alcohol or psychoactive medication use as a targeted health behavior. This gives the service staff the opportunity to move the older adult toward a discussion of alcohol/psychoactive medications.

Dialogue Examples:

"You indicated that, on average, you drink alcohol almost every day and drink one to two drinks at a time. You also mentioned that you are using medicine from the doctor for sleep but that you have been having trouble sleeping anyway and have sometimes taken more than the doctor recommended."

"I'm pleased that you are interested in exercise and nutrition. That's great! These are important areas. I can set up a time for you to talk with the nutritionist [or other]. Right now, I'd like to spend a little more time talking with you about your use of alcohol and the medications for sleep."

3. ***Discussion of standard drinks*** (use the workbook page with pictures of standard drink equivalents).

Key Points to Consider:

- All of the beverages containing alcohol listed in the workbook are roughly equivalent in alcohol content (e.g., 12 oz. of beer or ale = 1.5 oz. of distilled spirits = 4–5 oz. of wine = 4 oz. of sherry or liqueur)
- When pouring wine or liquors, measuring is important.
- Alcohol is alcohol. Some patients may think that they do not use alcohol because they "only drink beer or wine." Some view "hard" and "soft" alcoholic beverages as different in their effects.
- Review standard drinks briefly. Avoid disputes about picky details regarding the alcohol content of specific beverages.

Dialogue Example:

"I never used to know this myself but I learned that these beverages (12 oz. of beer or ale; 1.5 oz. of liquor; 4-5 oz. of wine; 4 oz. of sherry or liqueur) all contain the same amount of alcohol" (refer to the picture in the workbook).

4. ***Discussion of the norms for alcohol/psychoactive medication use in the population****, and where the older adult's use fits into the population norms for his/her age group.* This introduces drinking guidelines (women under 65: no more than 1 drink/day; men under 65: nor more than 2 drinks/day; women and men 65 and over: no more than 1 drink/day or 7 drinks/week), the idea that the client's misuse of alcohol or misuse of psychoactive prescription medications can be related to his/her physical and emotional health, and that it can pose a risk for more health-related problems.

It is important to avoid creating additional resistance. It is very important to "roll with the individual's resistance" or reluctance to further examine his/her use in an empathetic manner. This discussion focuses on the equivalence of alcohol content across various beverage types. This concept provides the context for a discussion of sensible drinking limits the use of alcohol while using psychoactive medications.

Key Points to Consider:

- Review the graph of how much other people drink. Point out that their level of drinking is not typical of others their age and that most older people drink less than they do; and/or discuss the use of psychoactive medications with any alcohol, depending on the situation.
- Review this material in a matter-of-fact manner.
- This section can evoke a number of strong reactions from older adults (minimizing, concern, embarrassment). It is important to avoid creating additional resistance. It is very important to roll with individuals' reluctance to further examine their drinking behavior in an empathetic manner.

Dialogue Examples:

"National guidelines recommend that men your age drink no more than [7 drinks per week; no more than 1 per day]. Your pattern of alcohol use puts you at more risk for some consequences related to alcohol" (use of alcohol/psychoactive medications).

"From what you've said, I can see that you do not see yourself fitting into the at-risk drinking category. It seems that you drink more than a light drinker and I'd like to look at some of the potential things that can happen at your level of alcohol use" (use of any alcohol while using this medicine for sleep).

5. ***Consequences of at-risk and problem drinking and psychoactive medication use***. This discussion relates consequences to any potential or ongoing health problem that is currently important in the person's care (e.g., hypertension, pain management, anxiety, gastrointestinal problems, anxiety, etc). It should be noted that some older adults might also begin to recognize that their use is problematic to them. This may facilitate a change in behavior.

This section addresses reasons for drinking, and weighing the positives and negatives of drinking and use of psychoactive medications. This is particularly important because the service provider needs to understand both the positive and negative role of alcohol and medications in the context of the older patient's life, including coping with loss and loneliness. This section is also designed to facilitate patients' understanding of the potential social, emotional, and physical consequences of drinking and misuse of medications. This is an important aspect of motivational interviewing. It provides a climate in which patients can obtain greater clarity of how alcohol and/or psychoactive medication are or could be negatively affecting their lives.

Key Points to Consider:

- Some older patients may experience problems in physical, psychological, or social functioning, even though they are drinking below cutoff levels, particularly if they are taking psychoactive medications and using alcohol.
- Note that some of the things on the list in the workbook could be problems they indicated they were having. Other items are common problems people could have if they continued their current level of drinking or drink and use psychoactive medications.
- Maintaining independence, physical health, and mental capacity can be key motivators in this age group.
- Some patients may minimize the contribution of alcohol to their problems. Again, roll with resistance, don't argue.

Dialogue Examples:

"We've spent some time talking before about your sleep problems, your blood pressure problems, the fall you took in the bathroom, and your loneliness since your wife died."

"Even though your drinking is close to the limit for people your age and you drank at this level for years, I am concerned about some of the health problems you've had and about your loneliness. Alcohol can play a role in some of these issues."

"I am concerned that the amount you are drinking could be making some of these problems worse. I know that one of your goals is to remain as independent as possible and have a good quality of life."

"Although alcohol use has been linked to such problems, you have to evaluate your situation yourself. We can discuss some of these issues together."

It should be noted that some patients might also begin to recognize that their drinking is problematic. Try to elicit motivational statements with evocative questions (e.g., *"In what way does this concern you?"; "What do you think will happen if you don't make a change?"*).

6. ***Reasons to quit or cut down on use***. This is a very brief discussion of how changing their use could have important benefits for the individual.

Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels. This section reviews the potential social, emotional, and physical benefits of changing their drinking.

Key Points to Consider:

- Be careful not to promise miracles or cures. Alcohol use is often a component of health problems not the sole etiology.
- Before moving to the next section, you should make an effort to elicit self-motivational statements.
- Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, working with their doctor about their sleep or pain medications, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.

Dialogue Example:

"From what you've said, you are really concerned about being able to continue living in your own house. There are a number of things that you can do to help to maintain your independence. Cutting back on your drinking is one important thing you can do."

" Talking to your doctor about the medications you are using for sleep/pain/anxiety is important since you are still experiencing problems in this area and alcohol can have a really negative reaction with this/these medication(s)."

7. ***Negotiated agreement for alcohol and/or psychoactive medications***. Drinking limits or actions needed to address psychoactive medication use in the form of an agreement can be negotiated and signed by the patient and the intervener. *Clients take the workbook, including the agreement, with them when they leave the office*. This formal agreement is a particularly effective tool in changing behavior. A followup visit or phone call can help patients stay on track with any changes they are making.

Key Points to Consider:

- Give guidance on abstinence vs. cutting down. Complete the negotiated agreement. Make sure to allow older adults to decide which plan they prefer.
- Older adults who have a serious health problem or take medications that interact with alcohol should be advised to abstain. Others may be appropriate candidates to cut down on drinking to below recommended limits.

- Provide guidance by recommending a low level of alcohol use or abstinence. Remember, you may have to negotiate up, so start low.
- The drinking agreement form contains a space to write what you have negotiated (e.g., stop or cut down on drinking; when to begin; how frequently to drink; for what period of time; what to do about psychoactive medications).
- Older adults who are using psychoactive medications should be advised to consult their primary physician to get help with what they should do (continue with medication, cut down, stop use) and can be advised that these medications and alcohol can be a dangerous combination.
- If patients are reluctant to sign agreements, try to determine the reason for their reluctance and alleviate their concerns if possible. If they do not want to sign, that is OK. The service staff person can write in their recommendations and what the older adult indicated that they wanted to do. The workbook will go home with the older adult.

Dialogue Examples:

"I would suggest that you drink no more than three days a week, no more than one standard drink on any drinking day. What do you think about that level of alcohol use?"

"I see that you like to have a bottle of beer each night with dinner. Do you think you can limit it to no more than one 12-oz. bottle of beer a day?"

"I am concerned about your sleep medication, that you have been taking a bit more than the doctor prescribed because you cannot sleep, and how that medicine interacts with alcohol. Given this, I would recommend that you not use any alcohol for now and talk with your doctor about the sleep medication to see if there are other techniques that can also help with sleep. What do you think of this recommendation?" **(see Appendix 1 for List of Targeted Psychoactive Medications of Concern).**

"It is up to you to decide if you should do anything about your drinking. I would still like to review the rest of the workbook with you. You may find some of it to be helpful, and if you decide to make some changes, this might be useful."

8. ***Coping with risky situations***. Social isolation, boredom, pain, and negative family interactions can present special problems for individuals trying to change their behavior. It helps if the individual can identify situations and moods that can be risky and identify some individualized cognitive and behavioral coping alternatives.

Note: This step may be done at the time of the initial intervention or can take place after the older adult has had a chance to try out cutting back or stopping, etc. (2-week followup; 1-month followup, etc.)

Key Points to Consider:

- Work with older adults to develop strategies to deal with such issues as social isolation and negative family interactions.
- It is important to encourage older adults to come up with their own alternatives, and to provide the minimal guidance necessary.
- Remember that by providing individualized feedback, the intervention is concerned with their unique situations.
- Review at least one roadblock and solution, and review the rest as you have time. Role-playing specific stressful situations can be helpful. The role-play exercises will vary depending on patients' particular situations.
- Remember, motivation to change occurs as the perceived benefits of change outweigh their reasons for drinking (the barriers to change).

Dialogue Example:

"You've said that one of the reasons you drink over recommended limits is that since you retired and your wife died you have nothing to occupy your time and

that you are lonely. You also have said that you and your wife used to play cards at the senior center. Have you thought about going back to the senior center to start doing some of the things you like to do there?"

"Sometimes quitting or cutting back on drinking involves making some very difficult decisions, like deciding not to get together with certain friends or not going to certain places like the bar or club. We can think together about what kind of things would be just as rewarding for you to participate in."

"You say that you drink because you enjoy meeting your friends at the bar. Have you considered other places that you could meet these friends or how you might meet some new friends?"

9. ***Summary of the session.*** The summary should include a review of the session, including a review of the agreed-upon drinking and/or psychoactive medication goals, a discussion of the drinking and medication diary cards (calendar) to be completed for the next 6 weeks, and the recommendation to refer back to the workbook materials given to patients during intervention sessions.

Key Points:

- The tone of the summary should be empathetic, encouraging, and positive.
- Give an appointment card for the 6-week followup session (or whatever you would normally arrange with clients).
- Thank the older adult for his/her time and patience.

Dialogue Example:

"We've covered a lot of material today in a very short time and you've done really well in identifying how alcohol has been affecting your health and continued drinking above limits can make your health conditions worse. You have a good plan for cutting down on your drinking. I know that you can reach your goal of drinking no more than one drink a day."

"Sometimes people have days when they drink more than they think they will. Just record the number of drinks you had on the drinking diary card. Don't be discouraged. Start over the next day following the limits we set together."

For additional brief intervention resources, the NIAAA has also developed guidelines for intervening. These materials are based on the research conducted by a mix of the authors listed in this manual (National Institute on Alcohol Abuse and Alcoholism, 2005 [http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm]).

SECTION II:

Developing the Infrastructure To Implement Alcohol and Psychoactive Medication Screening and Brief Interventions

KEY STEPS IN SUCCESSFUL IMPLEMENTATION

Introduction

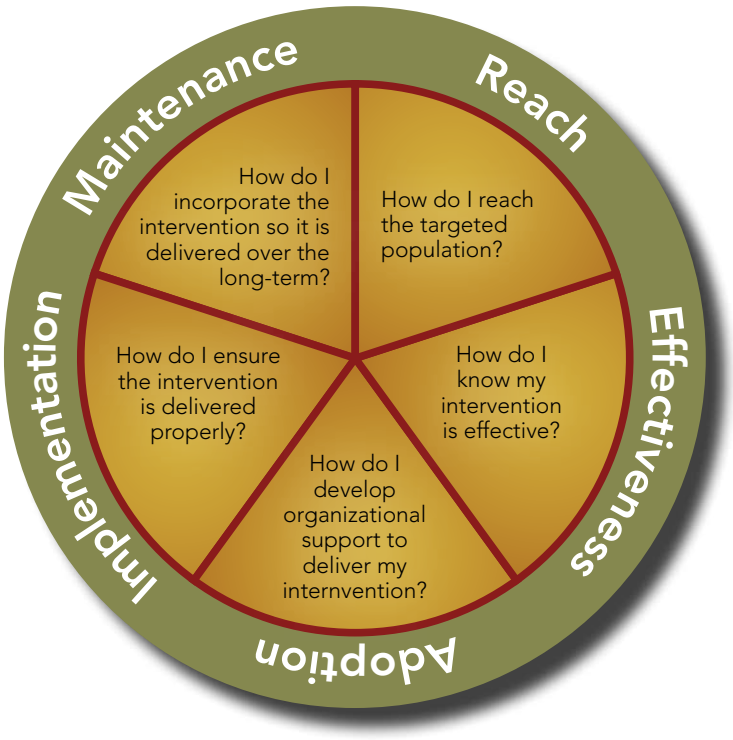
Evidence-based prevention interventions such as screening and brief interventions (SBI) have many elements that are critical to successful implementation. With all the moving parts, it is useful to employ a model for considering the various dimensions of implementation. A model can help implementers recognize the work that needs to occur in the various elements, often requiring simultaneous action by various members of an implementation team.

The RE-AIM model of program implementation (Glasgow, et al., 1999) offers a useful frame for implementation of SBI and other evidence-based disease and disability prevention programs. The goal of RE-AIM is to encourage program planners, administrators, funders, evaluators, and policymakers to pay more attention to essential program elements that improve the sustainable adoption and implementation of effective evidence-based health promotion programs.[1] Paying attention to all these program elements increases the likelihood of improving the health of the entire population at risk of alcohol and/or medication misuse. The model is fully described on the RE-AIM Web site (http://cancercontrol.cancer.gov/IS/reaim/index.html) and the National Council on Aging's Web site (http://www.healthyagingprograms.org), where you will find an Issue Brief, *RE-AIM for Program Planning: Overview and Applications* (Belza, et al., 2007).

The National Council on Aging (NCOA) in its work with the Administration on Aging (AoA) and others has added Planning and Partnerships (P) to the model and now refers to the model as (P)RE-AIM. Organizations that successfully implement evidence-based practices (EBPs) are attentive to and perform well in the following (P)RE-AIM elements:

- **Planning and Partnerships.** Recruit partners; set goals; determine accountability for areas of work; structure collaboration and communication; define quality assurance processes, including fidelity; define program assessment, data analysis, and reporting requirements and processes.
- **Reach.** Identify, recruit and retain clients who can benefit from the intervention. Engage key referral sources.

FIGURE 2 RE-AIM FRAMEWORK



[1]The RE-AIM model parallels the model developed by Dean Fixsen and used by some SAMHSA projects. The Fixsen model identifies the following stages: Exploration and Adoption, Program Installation, Initial Implementation, Full Operation, Innovation, and Sustainability. The model considers the following components in each stage: Systems Interventions, Staffing, Training/Coaching, Evaluation, and Administrative Supports.

FIGURE 3 (P)RE-AIM IMPLEMENTATION MODEL

- **Effectiveness.** Identify evaluation needs, specify expected outcomes, and plan evaluation.
- **Adoption.** Identify communities and a range of organizations that are suitable for the intervention, garner support from leadership and staff, manage training, and manage interface with national SBI practice disseminators, researchers, and trainers.
- **Implementation.** Develop program/practice infrastructure with local host sites (such as a health system, an area agency on aging, a prevention network) and with implementation sites (such as clinics, hospital emergency departments, community service agencies and centers); manage training; schedule, promote, and conduct intervention; implement quality assurance processes/system including fidelity; and conduct monitoring and assessment.
- **Maintenance and Sustainability.** Embed EBP structure into host organizations and local and statewide systems; develop plans for sustainability.

The original RE-AIM diagram is presented here (see Figure 2). Think of the *Planning and Partnerships* element as surrounding the diagram—as the pre-work that allows an organization and its partners to think through how to *Reach* older adults, design for *Effectiveness, Adopt* the intervention for your community, *Implement* the intervention, and *Maintain and Sustain* the program.

Using the full (P)RE-AIM implementation model aids an organization or partnership in developing a coherent picture of how it will move the intervention into practice for the long term. All of the (P)RE-AIM elements are discussed in this manual; most are addressed in this section.

Figure 3 is essentially a map of how you will walk through the (P)RE-AIM model elements—the map for organizations and collaboratives to use in starting an SBI initiative in their community. As you move through each element, you will see a "highway sign" from Figure 3 showing where you are on the map.

P in (P)RE-AIM—Planning

SBI may be implemented by a single organization; however, experience indicates that implementation through a *multiple-organization partnership* is advantageous. Multiple organizations are in a better position to reach more older adults, link participants to treatment and other needed services, enhance the services of several community organizations, develop or build on community service systems, and build community support for sustainability.

Organizations implementing evidence-based prevention programs like SBI for older adults have found the following actions useful in planning for implementation. How does this planning process work?

- It is iterative—Revisiting earlier decisions is a good thing.
- It moves from vision and strategy to more tangible decisions about operations and structure—All of these elements get refined during actual implementation.
- It never stops—As you monitor the program, you'll learn more about what can change to help more older adults more effectively.
- It builds partnerships.

Bring together leaders from behavioral health, public health, aging services, and consumer groups to consider health needs of older adults around issues of alcohol and medication misuse.

Each community has its own set of leaders, resources, and history. Thus, the lead organization or partnership can reorder the steps below to fit its environment and to find a good starting point.

Exploring

- **Convene leaders to gain common understanding of needs and prevention efforts underway.** Bring together leaders from behavioral health, public health, aging services, and consumer groups to consider health needs of older adults around issues of alcohol and medication misuse. This exploration looks at broad questions such as:
  - Is there any interest in the SBI program?
  - Which older adults seem to be at risk? (Consult "Reach" element below for thoughts on defining the target group.)
  - Do we need to do prevention?
  - What are community priorities for health improvement, considering available State and local data and needs assessments?
  - What prevention work is underway at the local and State levels that might offer partnership potential?

- **Establish a collaborative of organizations to address alcohol and medication misuse prevention.** If the initial exploration surfaces other organizations that are interested in launching this program, then it's time to take the next step and create a more formal collaborative. Select key representatives who can support and strengthen the local initiative. The collaborative can grow as more organizations are recruited. If a collaborative does not seem appropriate to start this effort, establish an Advisory Committee that could later become a collaborative. Involve older adults in the planning process; representatives of the target audience provide valuable information and perspectives. (Consult "Lead and Partner Organizations" below for more guidance.)
- Learn about SBI. Brief leaders in the collaborative on the SBI model and research findings. Articulate how SBI can address priority needs.
- GO or NO GO decision should be made at this point.

Setting the Strategy

- **Identify the GOALS of the collaborative.** Working as a group, collaborative members can define goals, such as:
  - To reduce alcohol and/or psychoactive medication misuse/abuse in at-risk older adults in community settings.
  - To optimize the use of the proven SBI protocol in a wide variety of healthcare and social service settings that serve older individuals, many of whom are at-risk for the negative consequences of alcohol and/or psychoactive prescription medication use.
  - To assess the effectiveness of SBI in reducing alcohol and/or psychoactive medication misuse in the community.
  - Improve the health and quality of life for older adults in the community.

Designing the Community's Approach to the Initiative

- **Identify OUTCOMES for the initiative that are tied to the GOALS.** Collaboratives often find it useful to identify:
  - Participant outcomes (example: ~up to 50% of older adults receiving one brief intervention session (20-30 minutes) will reduce risky drinking and /or risky use of psychoactive medications. Some older adults will need more time and additional sessions to make changes).
  - Program delivery outcomes (example: 90 percent of target population is prescreened; 90 percent of those with positive scores receive full screening; 90 percent with positive scores on full screen receive brief intervention).
  - Planned system outcomes (example: SBI routinely offered to new clients).
- **Identify SERVICE OBJECTIVES.** In setting objectives, it is helpful to base projections on research experience regarding typical participation rates in different elements of SBI. Using the following ratios or percentages, a community might set objectives such as:
  - Prescreening—500 older adults per year
  - Screening—150 older adults per year (estimated 30 percent of those prescreened will have positive scores indicating need for full screen)
  - Brief Intervention—38 older adults per year (estimated 25 percent of those completing full screen will have positive scores indicating need for brief intervention)
  - Followup—32 older adults per year (estimated 85% of those receiving the brief intervention will agree and be located for follow-up).
- **Gain common understanding of the essential program elements of screening and brief interventions.** Section I ("Practical Guide to Screening and Brief Interventions," p. 19) gives a picture of how staff and an older adult work together

A community initiative selects the model that best fits its needs and partner capabilities and resources.

to complete a screen and, if indicated, a brief intervention. Each element of the process must be completed; "Practical Guide to Screening and Brief Interventions" offers options for some of the elements. Should the implementing organization require further information, it is important to consult with the scientific team, Drs. Frederic Blow or Kristen Barry at the University of Michigan. If adaptations are made, document adaptations to the protocol offered in this manual so that outcomes can be considered in light of adaptations.

- **Identify partners to deliver screening and brief interventions.** While staying focused on the overall goal and designated outcomes, the partners should work out primary roles and decide who will deliver what services. (See "Lead and Partner Organizations" section below, which provides guidance.) Essentially, the purpose is to configure the structure and distribute responsibilities:
  - Identify a Lead Organization to manage the initiative, arrange for SBI training, establish communication and referral systems, and (if desired) establish a common data collection system
  - Identify Implementation Sites for prescreening, screening, brief intervention, referral to treatment and other services, and followup
  - Identify referral resources needed for behavioral health, physical health, and social services.
- **Design an SBI implementation model.** Working out partner roles (the step above) and designing what the program will look like, requires going back and forth between this step and the step above, while also considering the implementation section below. It is important to be clear on how the separate roles and responsibilities will combine to achieve goals and outcomes. There are several implementation models that may be used. A community initiative selects the model that best fits its needs and partner capabilities and resources. Models can include:
  - One or more organizations offer all elements in multiple sites (i.e., prescreening, screening, brief intervention, referral to treatment and other services, and followup).
  - Several organizations offer prescreening only and refer people with positive prescreens to another organization for screening and other elements. For example, prescreens can be conducted at a health fair, senior center, etc. as part of an overall health assessment, and those with a positive prescreen can be referred for a full screen. One advantage to this method is that more people may be reached. However, a disadvantage is that some people may not be available for followup.
  - One organization sends staff to conduct all SBI elements on site in different organizations.

This step and the prior step are iterative. As partners explore how best to design the program, more options will surface about who carries what role. This is a time to be creative about new ways of organizing the services and realistic about where each group's strengths lie. The ultimate design is one that places every organization in its most effective role to achieve the maximum benefit for the maximum number of older adults at-risk in your community.

Designing the Operations

- **National trainers conduct SBI leader training.** Before designing the operations in more detail, it is important for leadership and other key staff to develop a more in-depth, operational perspective on how SBI can work in practice. The "Kickoff Training" includes leadership from all participating sites in an organization, plus partner organizations. The initial orientation session explains: 1) the extent of the problem; 2) screening approaches; 3) brief interventions; 4) how to refer for further

assessment, if needed; 5) elements and procedures for monitoring process and outcomes; 6) the use of onsite "champions"/opinion leaders to enhance implementation; 7) any potential barriers to implementation to troubleshoot pre-implementation; 8) plans for onsite training of personnel who will conduct prescreening and screening, and 9) delivery of prevention materials and brief interventions. The National Trainers can be reached by email: Kristen Barry, Ph.D., at barry@umich.edu; Frederic Blow , Ph.D. at fredblow@umich.edu.

- **Design the delivery system.** Here, the collaborative translates the SBI model into a more detailed, tangible plan. It means designating the responsibilities, work flow, and communication among organizations, staff, and participants. Successful program implementation aligns staff, training, supervision, data systems, work flow processes, policies, and procedures. Organizations are encouraged to embed SBI in ongoing services (see the next bullet). Other decisions will occur here, such as selecting the screening instruments to be used.
- **Develop Operations Plans To Embed the SBI** into local (and possibly statewide) systems that provide community-based services and supports to older adults to help them maintain their health and independence in the community. Continuously revisit the stated goals and outcomes—will your design and operations plan actually reach and benefit the largest number of older adults at risk? Assuming success of SBI adoption, identify strategy to include program in organization and community long-term plans. (Embedding SBI is discussed below.)
- **Invite Additional Agencies To Consider Partnership** for purposes of increased access to older

TABLE 2 SELECTION CRITERIA FOR LEAD ORGANIZATION

SUGGESTED CRITERIA FOR SELECTING A LEAD ORGANIZATION

- The infrastructure to implement this intervention (e.g., experience with other EBPs)
- Access to the number and groups of older adults to be reached with SBI, or takes responsibility for engaging partners that have access
- Existing staff experienced with assessment (a must)
- Current assessment tools can be modified to include (or add on) the prescreening questions (e.g., health screening, wellness); some assessment tools and surveys may already include questions related to alcohol and medications
- A data collection system in place.
- A champion for substance abuse prevention who is truly committed to the program
- Resources/systems (or is willing to develop them) for referral to treatment for alcohol and medication misuse issues, co-occurring disorders, and mental health issues, if these are identified by SBI
- Promotes empowerment of older adults as a group and as individuals
- Demonstrates cultural competence relative to the populations being served
- A track record of leading and being a member of community partnerships/collaborations

ADDITIONAL CHARACTERISTICS TO CONSIDER IN SELECTION

- Multiple funding sources and success in sustaining programs
- A partnership with a researcher (e.g., from local university/college)
- Willingness to brief and invite participation from the State Unit on Aging and the Single State Authority (for substance abuse) in implementation and sustainability

adults at risk and referral sources, and improved rates of positive outcomes.

- **Identify Infrastructure Roles, Responsibilities, and Individuals** for leadership, management, development, and support of partnerships, operationalizing plans, monitoring, reporting, and communicating. Identify staff members who can move the project forward, ensure fidelity and achieve results. Connect staff with tools and resources. (Staffing discussed below.)

P in (P)RE-AIM—Partnerships: Lead and Partner Organizations

This section discusses identifying a strong lead organization, plus identifying, engaging, motivating, and sustaining community partners and local experts and resources that are needed for successful implementation of SBI.

Planning and Partnerships

Lead and Partner Organizations → Who will design and deliver services?

Selecting the Lead Organization: The collaborating organizations or funders interested in establishing SBI in a community are encouraged to consider the criteria listed in Table 2 in selecting the lead organization.

Organizations may want to assess their readiness for a lead role. **Appendix 7** is the NCOA Center for Healthy Aging organizational tool for "Self-Assessing Readiness for Implementing Evidence-based Health Promotion and Self-Management Programs."

Selecting Partner Organizations: It is ideal to conduct SBI through a multiorganizational partnership with one lead organization. Ideally, a community will have evidence of previous successful collaboration and coordinated efforts around other prevention interventions.

In any community, the list of potential partners is long. To guide the selection of partners, the core collaborative will want to define what they need from partners. Examples include the following:

- Collaboration among different sectors and types of organizations can help expand the reach of the program.
- Find partners that can help long term sustainability; organizations with access to resources and sustaining financing.
- Seek out groups likely to champion the initiative, such as aging, substance abuse, mental health, and public health networks.
- Identify partners that can take a role in the delivery system.
- Coordinate or integrate delivery of new prevention programs with existing evidence-based community prevention programs for older adults. Experience counts!

Many of the types of potential partner organizations are listed below.

Partners for Reaching Target Population Age 55+ with Prescreening, Screening, and Brief Interventions

- Aging services
- Healthy aging evidence-based prevention programs and other health education programs
- Case management and care management for home and community-based services

TABLE 3 MARKETING BENEFITS OF SBI

MARKETING TO POTENTIAL PARTNERS

Participation in a community alcohol and psychoactive medication SBI initiative will provide partner organizations with the following opportunities:

- Evidence-based prevention model with national leaders involved
- Enhanced capacity to provide services to a changing aging population
- Medication and alcohol misuse prevention experience
- Working relationships with key organizations and leaders in community
- A prevention intervention that is brief, low cost, and efficient
- Community partnership structure that may be used for other projects
- A forum for organizations to market their services

BENEFITS OF OFFERING EVIDENCE-BASED PREVENTION PROGRAMS

- Clear health benefit to participants
- Achieve organization's mission
- Establish new partnerships
- Positive reactions by participants

- Case management and care coordination in health systems
- Social service organizations (senior or family services organizations, faith-based services)
- Medical homes, health homes, accountable care organizations
- Home health agencies
- Medicaid health services and managed care
- Primary healthcare settings, health clinics
- Aging and Disability Resource Centers (ADRCs)
- Home-delivered and congregate meal programs (e.g., Meals on Wheels)
- Hospital emergency departments
- Urgent care centers and clinics
- Hospital discharge/transition services
- Senior housing
- Pharmacies
- Health fairs
- Senior centers

Partners To Offer Additional Resources for Behavioral Health and Services to Meet Other Needs

- Substance abuse treatment facilities and outpatient programs
- Community Mental Health Centers
- Psychiatry and psychology practices
- Alcoholics Anonymous and other 12-Step Meetings
- ADRCs
- Aging services
- Benefits counselors
- Pharmacists, especially those with expertise in geriatric pharmacotherapy

Partners for SBI Sustainability

- Area Agency on Aging and Healthy Aging Prevention Partnerships
- Local and State Prevention Networks
- Local Mental Health Board
- Health Systems

- State Unit on Aging, Single State Authority (for substance abuse), State Mental Health Authority, State Public Health
- Local and regional foundations, and United Way

Recruiting, Engaging and Sustaining Partner Organizations

- Develop a process to identify and engage partners; include organizations with ready access to potential participants, funders, researchers, and service providers.
- Attract potential partners by presenting a preview of the SBI initiative to many groups clearly explaining the purpose, expected outcomes, required elements, types of organizations sought for partnership. (See the Table 3 on marketing to partners.)
- Meet with potential partners to learn what they are best suited to do and would like to provide to the effort, as well as how they hope to benefit from participation. Know partners' needs and interests. Clearly specify program benefits, and, to the extent feasible, provide partners what they need.
- Select the best partners for the initiative to meet community needs.
  - Make sure potential partners are clear on program requirements.
  - Assess partner capacity and readiness to conduct all or some elements of SBI including prescreening, screening, brief intervention, conduct followup, and/or accept referrals for treatment or other needed services.
  - Ensure buy-in at multiple levels: Tap into a recognized need and identify a champion in each partner organization.
  - Identify multidisciplinary resources in partner selection.
- Consider a formal memorandum of agreement or other vehicle to solidify commitment; include a shared vision statement endorsed by each organization. Roles and responsibilities in the collaborative can be added.
- Sustain partnerships from the beginning by engaging partners in planning, giving high visibility and credit to partner organizations, and building opportunities for meaningful recognition, feedback, and access to new funding sources.

R in (P)RE-AIM—Reach

Reach is the extent to which a program engages its intended audience. The screening and brief interventions offered in this manual target older adults (age 55 and older) in community settings, who may be at risk for the negative consequences of alcohol and/or psychoactive medication misuse or abuse. At-risk older adults are found across the population aged 55 and older. To reach the most people, "universal" prescreening of clients in participating organizations is recommended. Organizations interested in conducting this intervention are encouraged to prescreen all clients/members and those contacted through outreach. If an organization decides not to conduct a short prescreen, then a full screen is recommended for all of the organization's clients age 55+.

It is wise to consider the population regularly served by the implementing organization and supplement this reach by partnering with organizations that serve

additional groups of older adults who may be at risk. Some specific groups, including men, are sometimes underrepresented in aging services networks, so partnering with organizations that serve a variety of older adults can have broader reach and greater impact on the problem of alcohol and psychoactive medication misuse.

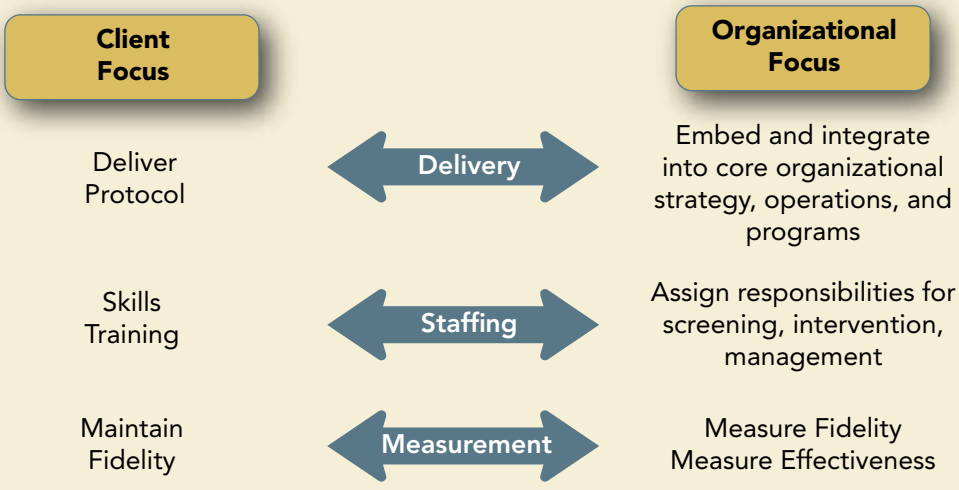
General guidance for working with the initiative's target group draws from traditional outreach and marketing constructs—whether you are trying to engage the older adults you currently serve or recruit new individuals into the program. For example, strategies and materials targeting older adults need to be culturally sensitive to the unique issues that various older adults face, such as worries about the loss of independence, unwillingness to seek medical attention, and fears of the medical system (National Eye Institute, 2011). Organizations are encouraged to consider the following when promoting the SBI initiative:

- Identify what the older adult population values (e.g., independence and aging in place, family relationships).
- Meet older adults where they are (e.g., social services, senior housing, congregate meal sites, community centers) and embed this approach into routine operations.

Partnering with organizations that serve a variety of older adults can have broader reach and greater impact

- Engage businesses, faith-based organizations, libraries, retiree clubs, etc. in educating customers and members and facilitating referrals.
- Address special and cultural needs including low literacy, language requirements, and flexibility.
- Account for unique access barriers for older adults, including transportation.
- Recognize and plan for barriers to recruitment, including stigma, especially for substance misuse and mental health programs.
- Project the message of health! Promote this program as part of health promotion and disease prevention efforts and use medical and less stigmatized language (e.g., medications versus drugs; drink versus alcohol).

Adoption and Implementation



A and I of (P)RE-AIM—Adoption and Implementation

Adoption and implementation focus on both the client work and the organizational infrastructure. The diagram below shows how the organization and/or collaborative will work on both tracks together. As before, some of the decisions will be iterative. What differs is that you are moving into a new level of detail.

The lead organization is responsible for the Adoption and Implementation tasks in the (P) RE-AIM framework. The lead organization oversees and coordinates local efforts, including gaining support from leaders and staff of all adopting organizations. Additionally, the lead organization facilitates and organizes deliberations on client flow and protocols, as well as infrastructure decisions.

Earlier, in sections on planning, partnerships, and reach, suggestions were presented on garnering support at all levels for delivering SBI. Here we will focus on specifics of implementation. Early in the development process, the entire team/collaboration must focus on defining the specifics of the intervention. **Appendix 8**—(SBI Implementation Decisions) outlines some of these key decisions. Examples include the following:

- What scores define a positive screen?
- What consumer education materials are needed?
- What is the followup protocol?
- Who is the contact for clinical questions?
- How will confidentiality be protected?

With a very detailed protocol in place, the next steps focus on preparing to launch the initiative. Staff across organizations is trained for their roles. Implementation sites make final preparations. Referral networks are established. The scope of these prelaunch tasks follows:

- Work with national trainers to tailor training and SBI elements that can be adapted to local leaders and sites. **National Trainers: Kristen Barry, Ph.D., at barry@umich.edu; Frederic Blow, Ph.D. at fredblow@umich.edu.**
- Ensure the lead organization and key partners provide strong leadership.
- Manage training provided by national SBI trainers of staff from lead and partner implementation sites. (See description below.)
- Guide, assist, support, and monitor SBI implementation sites.
- Provide feedback to SBI leaders and sites.
- Locate and mobilize clinicians and other resources to receive referrals that may be needed by older adults participating in SBI.
- Make SBI materials available to staff and partner sites and other collaborating organizations.
- Promote the initiative.

On-site staff training is critically important. Training can be conducted for services staff in one meeting or in separate meetings across sites, depending on the size of the collaborative. Training should cover: 1) the extent of the

CONFIDENTIALITY

Staff conducting SBI need to exercise extreme caution regarding the release of any records, either verbally or in written form. This arises when family members call to ask about older adults or step in at the end of sessions. The intervener needs to discuss with the older adult what information can be released prior to any discussion with family members or other care providers. Check the Health Information Portability and Accountability Act (HIPAA) and agency requirements regarding confidentiality.

ADOPTION AND IMPLEMENTATION QUESTIONS

The following have proven helpful in preparing implementation plans.

1. Describe the primary partner site(s) that will implement SBI and the populations served by these site(s).
2. What formal agreements will be put in place with the partner sites?
3. In general, how will SBI be implemented at each site?
4. How will SBI be integrated into current service delivery at each site?
5. Who will do SBI at the site(s) (e.g., case managers, nurses, health educators)?
6. How will the lead organization and partner sites ensure that the community SBI service objectives will be met? In other words, is each organization willing to commit to reaching and offering the prescreen or screen and/or brief interventions to target numbers of older adults to reach the local objectives?
7. What approaches will the lead organization and partner sites use to maximize the number of older adults who will be followed up at 6 months post-intervention?
8. How will the screening and followup data be collected, managed and relayed back to implementation sites for quality assurance?
9. What are your preliminary thoughts on sustainability of SBI after start-up?

problem in the implementation community; 2) screening approaches (background, screening instruments, and practice administering screening tools); 3) brief interventions (background, use of workbooks, and practice delivering brief interventions); 4) how to refer for further assessment, if needed; 5) elements and procedures for monitoring process and outcomes; 6) discussion of any potential barriers to implementation that need to be addressed before the start of implementation.

Sites may want to ask their staff to complete an **Initial Staff Survey (see Appendix 9)** before implementation begins, and a **Staff Satisfaction Survey (see Appendix 10)** every 6 months to monitor progress and troubleshoot any emerging issues.

Another set of parallel decisions focuses on the infrastructure needed to launch, manage, and monitor the initiative. Components of the infrastructure include the following:

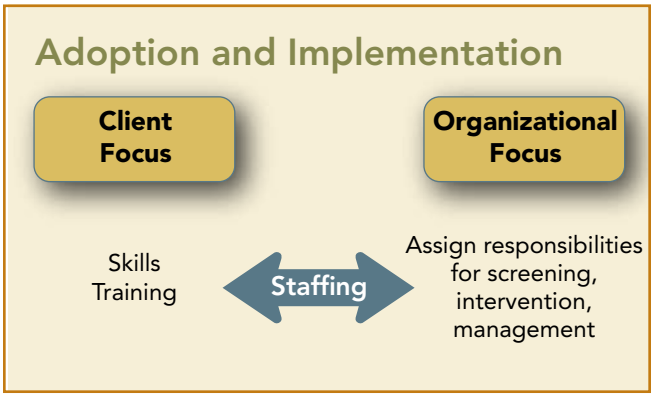
- Establish a centralized program management/support/oversight function with clear roles and processes for program administration.
- Organize ongoing partner site management, provide a list of requirements and expectations, and provide implementation tools.
- Set realistic implementation steps and time lines. Ensure strong communication with partners implementing SBI and resources for referral.
- Develop a quality assurance program as a component of the delivery system that ensures the program is delivered with fidelity and achieves results. Collaborate with national SBI leaders and local partners to develop the quality assurance system. Establish data collection and reporting system.
- Conduct program monitoring activities that will allow for continuous quality improvement.
- Balance implementation site autonomy and oversight. Visit partner sites on a regular basis to provide guidance and monitor fidelity.
- Conduct ongoing monitoring and training; ensure direct supervision, direct or videotape observation, and refresher training; use SBI tools.
- Establish efficiency and cost management procedures over time.

The following discussions about staffing, ensuring fidelity, embedding SBI, and effectiveness are all part of the Adoption and Implementation elements of (P) RE-AIM.

I in (P)RE-AIM—Implementation: Staffing

Who can conduct Screening and Brief Alcohol and Psychoactive Medication Interventions? Staff with various education and training backgrounds can conduct SBI. It is most important that those implementing SBI follow the science-based protocols. Social service providers, behavioral healthcare providers, physicians and nonphysician healthcare providers in primary care settings, and others who provide social and health services to older adults in a variety of community settings can be recruited to screen their clients/residents for at-risk use of alcohol and/or psychoactive medications and to implement a brief alcohol intervention with those who are determined to be at-risk drinkers and/or users of psychoactive medications. Examples of staff members that can be trained to provide screening and/or brief interventions include:

- Physicians
- Nurses/Nurse Practitioners
- Physician Assistants
- Pharmacists
- Social Workers
- Case managers (in social service and healthcare organizations)



- Counselors
- Psychologists
- Social Service Providers
- Senior Housing Service Coordinators
- Activity Directors
- Psychologists
- Health Educators
- Substance Abuse Counselors
- Community Health Workers
- Allied Health Providers
- Graduate Social Work Student Interns

I in (P)RE-AIM—Implementation: Ensuring Fidelity

Fidelity calls for being faithful to the core elements of the program, in the way it was intended to be delivered, so that changes in the participants can be attributed to the program—and not something else. SBI is being implemented with fidelity when it is being delivered in a manner consistent with the original design in different settings and by different staff. (See page 19 Practical Guide to Brief Interventions and page 21 Brief Prevention Interventions: Process and Use of Workbook.)

SBI is being implemented with fidelity when it is being delivered in a manner consistent with the original design in different settings and by different staff.

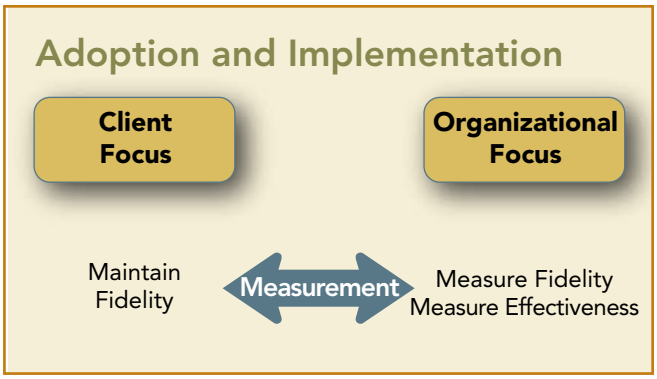
Fidelity is important during training and initial implementation, as well as in ongoing training and operation. Implementing organizations make sure that they have valid and reliable results in implementing SBI through fidelity checks.

National SBI trainers ensure fidelity in training by using the approach used in training for the initial research. National SBI trainers are able to train local trainers to conduct training for new staff or refresher training. National trainers usually supervise the initial training by local trainers to monitor for fidelity.

Prescreening fidelity requires reaching out to all potential participants, as called for in the implementation plan, and offering the prescreen to all clients, unless they have characteristics excluded in the implementation plan. Organizations may exclude people with major cognitive impairment, because SBI requires cognitive skill (minor cognitive impairment does not disqualify participation). When staff makes independent decisions about whom to prescreen, fidelity to the model is lost. Prescreening has merit in prevention and must be applied to all clients to be effective. Fidelity also requires asking the questions as they are presented in this manual or other SBIRT manuals. If different staff or organizations are conducting the full screening, then people with positive prescreens must be seamlessly referred to screeners for followup.

Screening fidelity requires conducting full screening with all persons who have positive results from the prescreen. The full screen must be administered using the precise language set forth in the screening questions. It is advantageous for people who have positive results from the full screening to immediately receive the brief intervention. If different staff or organizations are conducting the brief intervention, then people with positive full screens must be seamlessly referred to those conducting brief interventions, so that the individuals can be reached. The information on positive screens should be recorded so that followup contacts can be made in 6 months.

Brief intervention fidelity requires that all persons who screen positive on the full screen are offered the brief intervention. It is recommended that the brief intervention be conducted with the Health Promotion



Workbook **(see Appendix 4)**, using the steps set forth in the instructions in Section I including filling out the workbook completely. If this workbook is not used, other brief intervention protocols may be used from other SBIRT manuals.

To ensure fidelity., the Intervener Exit Form **(see Appendix 5)** should be completed by staff at the end of each brief intervention. This form measures fidelity by asking if screening was conducted, results of screening, positive scores on alcohol and psychoactive medication measures; completion of elements of brief intervention; and drinking and psychoactive medication decision made in the brief intervention. This form inquires about fidelity to the protocol and fidelity to the implementation of the SBI initiative.

Fidelity for referral to treatment and other services can be adhered to by following the procedures set forth by the SBI implementation organizations and the referral sources.

Followup fidelity requires using standardized, systematic methods to track and contact all persons who received the brief intervention and who can be reached. SBI implementation organizations must develop a coding system to determine when a given client should receive a 6-month followup interview. All of the followup questions must be asked using the text of a standard followup instrument (see **Appendix 6** for Six-Month Followup).

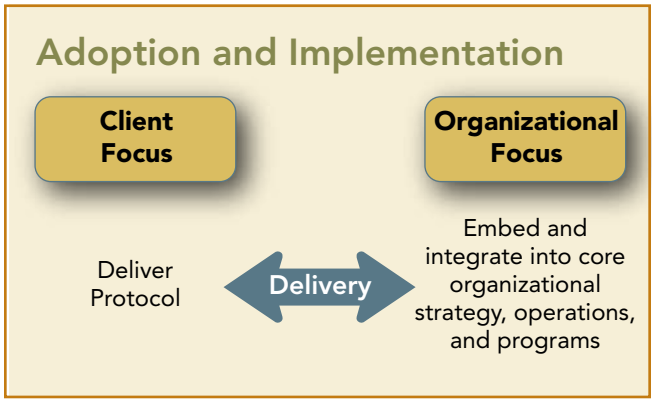
SBI implementation can foster fidelity and avoid bias by documenting the steps and participation, and standardizing discussion about the initiative with those participating. We encourage local SBI programs to:

- Document all clients seen in the organization. The Organizational Baseline Survey, (see **Appendix 11**) may be used.
- Document numbers of clients approached to complete prescreener and screener.
- Document all refusals.
- Approach all clients in the same manner.
- Standardize discussion of the SBI implementation and its evaluation, consent forms, etc.
- Use TA from the national SBI trainers for trouble-shooting.

I in (P)RE-AIM—Implementation: Embedding and Integrating SBI into Current Programs

SBI lends itself to embedding or integration into the services of many types of organizations. Embedding SBI will help organizations offer SBI on a routine basis and help sustain the practice. There is no need for SBI to be a stand-alone service. In fact, such an approach would likely be difficult to operationalize.

Most aging health and social service organizations already use some type of registration, intake, or assessment with older adult clients. This first step serves as a natural place for prescreening. Health and social service agencies, health promotion and disease prevention programs, case management, emergency departments, and primary care practices typically include a handoff from the staff member performing intake, or the SBI prescreen, to other staff offering routine services. A positive prescreen would be indicated as part of the handoff protocol, triggering SBI as part of routine services.



Some organizations, such as home health agencies, health systems, and some social service programs, already ask questions about medications. This presents an opportunity to embed SBI by asking the prescreen questions about alcohol and psychoactive medication use.

EXAMPLES OF EMBEDDING SBI

Case management in social or health services is ideal for SBI. The prescreen and the full screen can be added to the current assessment form or some current questions may be modified to use the SBI questions. The protocol is maintained wherein only positive prescreens trigger full screens. Local and State agencies may be amenable to changing assessment questions when the case can be made for using the science-based questions of the SBI screens.

A senior center health promotion program could integrate SBI into the current assessment and provide the intervention where appropriate as part of normal services.

Some agencies conduct intake, screening and assessments telephonically. SBI can be embedded in such a system thus the screening and brief intervention would be provided over the telephone. When phone intake is followed by in person meetings, the full screen and intervention can be conducted in this manner.

Data collection for SBI is best embedded in routine data management systems. Follow-up reminder systems can be employed to trigger six months follow-up calls or visits.

E in (P)RE-AIM—Effectiveness

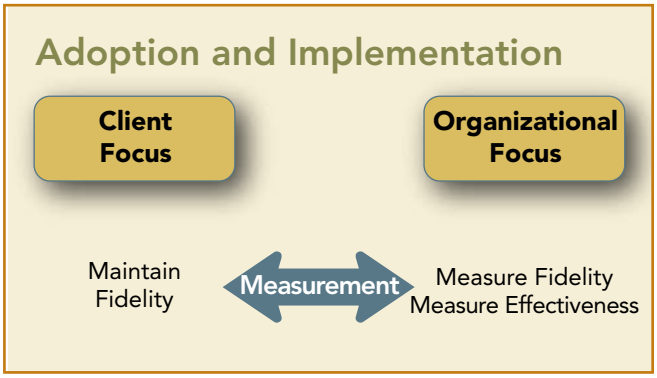
From the perspectives of implementation, evaluation, funding, and potential reimbursement, it is very important to measure the effectiveness of an SBI initiative offered through multiple organizations.

Effectiveness is measured by the following:

- Assess impact on health, disease, and broader outcomes such as physical and psychosocial functioning and quality of life.
- Monitor and report adverse consequences related to the intervention.
- Track mechanisms of change (e.g., delivery of brief interventions).
- Use tools and methods from original studies.
- Compare your results to those from original studies as discussed in Section I Evidence for Screening and Brief Interventions, page 16.

This manual offers instruments **(see Appendices 2 and 6)** used in original SBIRT research, with the addition of questions regarding psychoactive medication use. Using the Prescreen, Screen, and Six-Month Followup Survey will assure measurement of effectiveness.

A major consideration for effectiveness of SBI relates to decreased use of alcohol and psychoactive medications that are risky to an individual based on age, condition and the other medications taken. By knowing how individuals use alcohol and psychoactive medications at the time of screening and the brief intervention and then how they use (or if they use) these substances 6 months later, effectiveness of the brief intervention can be measured. Staff delivering SBI need to know



whether the older adult's use changes in accord with the goals set in the intervention.

SBIRT research shows that brief interventions have efficacy for at least 12 months, with some studies showing longer term effects. Organizations implementing SBI should seek the same efficacy.

Organizations implementing SBI are encouraged to:

- Establish a program evaluation plan.
- Adopt the outcome measures in the instruments in this manual and/or work with SBI experts and local partners to refine outcome indicators of importance to the community.
- Employ user-friendly data collection methods that fit population and organization needs for continuous quality improvement (CQI) purposes; use measures to minimize participant burden; use existing tools where feasible; use Web-based data entry at sites when feasible.
- Ensure required reporting and data collection occurs.

KEY STEPS TO SUSTAIN SBI

M in (P)RE-AIM—MAINTENANCE: SUSTAINABILITY

Sustaining evidence-based programs is a challenge all organizations and their partners face. Part of the challenge is to start building a sustainable program from the very beginning—when selecting partners and designing the program. For example, embedding the initiative in a funded system creates a longer term platform.

This section provides a framework to develop a sustainability plan for SBI. The overview is intended to help communities find partners and continue the important work—reaching older adults at risk for alcohol and psychoactive prescription drug misuse. The tools for sustainability planning are flexible and modifiable to the needs of your organization .

Sustainability Definition

Sustainability has become a popular buzzword in health and human services. This trend is positive but what does sustainability mean? Sustainability is more than funding. Sustained programs utilize many nonmonetary resources, including human resources, data management and operation systems. Internal and external resources can be leveraged. Sustainability is a complex and fluid process. Ongoing assessment helps ensure ongoing maintenance and delivery of services in continuously changing environments. The formal definition of sustainability adopted for this project is: "The extent to which an evidence-based intervention can deliver its intended benefits over an extended period of time after external support from the donor agency is terminated" (Rabin et al., 2008).

A sustained program (Mancini and Marek, 2004):

- Continues to deliver programming to intended audiences over the long term, consistent with program goals and objectives
- Modifies as necessary through expansion and contraction
- Supports community capacity—communities with high capacity can better respond to community need.

The following metrics can be used to assess sustainability (Scheirer, 2005):

- continued program activities
- continued measured benefits or outcomes, and
- maintained community capacity.

The failure of sustainability is a considerable concern to funders, researchers, and implementers of evidence-based health programs. As many as 40 percent of all new programs are not sustained beyond the first few years after termination of initial funding (Bracht et al.,1994; Chovav and Weinstein, 1997; Mancini and Marek, 1998; O'Loughlin et al., 1998; Steadman et al., 2002).

SUSTAINABILITY

the extent to which an evidence-based intervention can deliver its intended benefits over an extended period of time after external support from the donor agency is terminated.

Sustainability Planning: Why It Is Important

Begin by articulating what the organization wants to achieve through its work and then clearly identify the strategies and activities to reach these goals.

A sustainability plan helps:

- Clarify where you are and where you want to go
- Develop strategies for long-term success
- Provide benchmarks to measure progress
- Demonstrate the value of your work
- Provide overarching guidance for your initiative over time.

Additional reasons to develop and implement a sustainability plan:

- Many funding sources supporting prevention/intervention initiatives are short-term in nature.
- We operate in a rapidly changing environment (political, economic, and demographic changes).
- We can't afford to lose quality programs and important innovations.

Key Strategies to Sustaining SBI

Sustainability is challenging but not impossible. Start planning for sustainability from the beginning. Begin with a self-assessment/needs assessment. Clearly articulate what needs to be sustained, including the scope of activities, the scale of operation, and the time line. This diagnostic process can guide development of a sustainability plan (see Figure 4).

A new report that focuses on lessons learned about the sustainability of older adult community behavioral health services may be instructive in sustaining SBI programs (forthcoming from NCOA late 2011). The Sustainability Framework articulated in this report combines research and the experiences of past grantees on what factors influence sustainability of evidence-based programs, particularly community behavioral health services for older adults. Factors related to the program, organization, or community that can strengthen SBI sustainability are identified in Table 4.

The Sustainability Framework identifies many important factors including the following considerations.

- **Identify available resources.** Do all partners plan to continue participating in the future? In the same capacity?

TABLE 4 SUSTAINABILITY FRAMEWORK

SUSTAINABILITY FRAMEWORK

Program Factors

- Demonstrated effectiveness
- Designed for results
- Fits with mission
- Readily perceived benefits
- Financial resources and financing strategy
- Articulated theory of change
- Flexibility
- Human resources

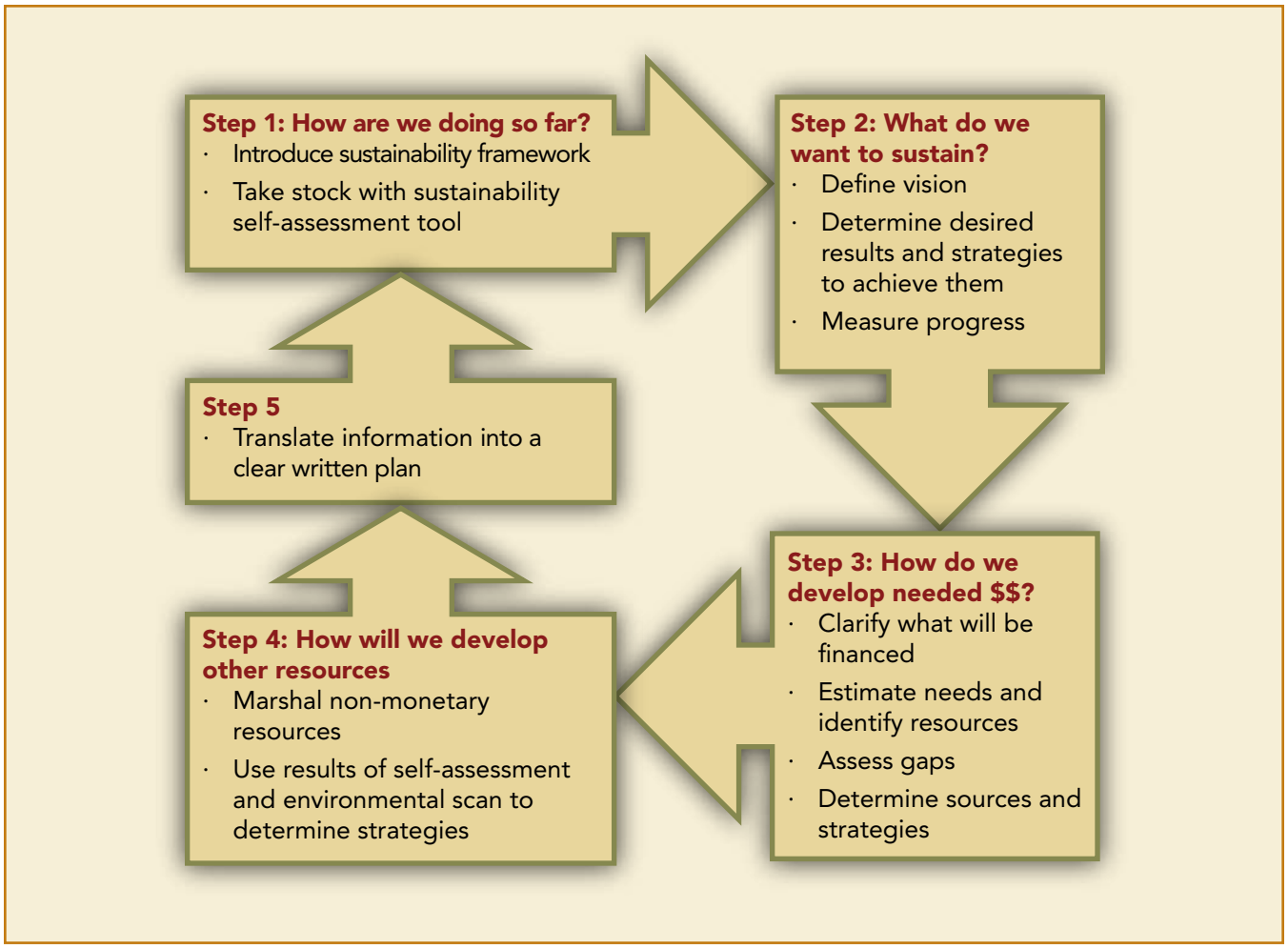
Organizational Factors

- Program champions
- Leadership by CEO
- Managerial and systems support
- Integration in the organization
- Organization stability and flexibility
- Sustainability plan and action

Community Factors

- Community/State support for program
- Availability of resources
- Political legitimacy

FIGURE 4 SUSTAINABILITY PLANNING PROCESS



- **Clarify intended results.** Be clear about the results you want to achieve for your target population as well as the systems that serve them. Use indicators and performance measures to track progress.
- **Division of labor.** There are distinct steps in the SBI process: prescreen, screen, brief intervention and referral to treatment . All, one, or a combination of services can be performed by a partner organization. Prior implementations of SBI have found collaborative partnerships among local providers to be advantageous to sustainability. It is important to emphasize that each partner need not implement the entire intervention for the community effort to be successful.
- **Effectiveness.** Assess impact and communicate results.
- **Leadership** ("champions") and buy-in at all organizational levels, particularly at the top, decisionmaking level.
- **Embedding.** Integration of SBI within the lead organization and partners, including acceptance by staff and clients, and effective use of technology.
- **Collaboration and Coalition.** Strong collaborative partnerships among agencies that are developed and nurtured over time. Connection to a well-functioning coalition can be a great facilitator for sustainability, particularly for community prevention programs (Kyler et al., 2010).

Develop a Sustainability Plan

1. **Take stock.** Assess the strengths and weaknesses of the lead and partner organizations in early implementation of SBI, reaching target populations and soundness of plans to attain outcomes and service objectives.
2. **What to sustain.** Clearly articulate what pieces of work will be continued.
3. **Strategies.** Identify strategies to obtain needed resources and overcome challenges.
4. **Funding plan.** Determine funding needs and plan for how those needs will be met over time through available and potential resources.
5. **Action plan and Timetable.** Include communication plan with key partners.

Funding

Planning to sustain your SBI program can be pragmatic, simple, and built into the existing systems and routines of your project. It may require the use of multiple resources, in the form of small grants or awards from community, State, or national organizations. It may be paid for (at least in part) through public and private health insurance.

Additional Resources

NCOA Center for Healthy Aging (CHA) Web site offers Lessons Learned for implementing evidence-based health promotion programs using the (P)RE-AIM framework, available at http://www.healthyagingprograms.org/lessons-learned/. The NCOA CHA Lessons Learned site identifies numerous issues in each of the categories and links readers to program documents that provide insight and examples of how the issues have been addressed successfully in different programs and various implementation sites.

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Appendices

Appendix 1: Psychoactive Medications of Concern

Alphabetical List by Brand Name
(all medications on this list interact negatively with alcohol)

Brand Name	Generic Name	Medication Category
Actiq® Lozenge/Lollipop	fentanyl	opioid analgesic
Alurate®	aprobarbital	barbiturate
Amytal®	amobarbital	barbiturate
Anexsia®	hydrocodone and acetaminophen	opioid analgesic
Astramorph®	morphine	opioid analgesic
Ativan®	lorazepam	benzodiazepine
Avinza®	morphine extended release	opioid analgesic
Butisol®	butabarbital	barbiturate
Butrans Skin Patch®	buprenorphine	opioid analgesic
Capital® with codeine	codeine and acetaminophen	opioid analgesic
Dalmane®	flurazepam	benzodiazepine
Demerol®	meperidine	opioid analgesic
Dilaudid®/Dilaudid HP®	hydromorphone	opioid analgesic
Dolophine®	methodone	opioid analgesic
Doral®	quazepam	benzodiazepine
Doriden®*	gluthemide*	sedative/hypnotic
Duragesic® Skin Patches	fentanyl	opioid analgesic
Empirin® with codeine	codeine and aspirin	opioid analgesic
Endocet®	oxycodone and acetaminophen	opioid analgesic
Endocodone®	oxycodone immediate release	opioid analgesic
Endodan®	oxycodone and aspirin	opioid analgesic
Esgic®	butalbital, acetaminophen, caffeine	barbiturate with analgesic for headaches
Exalgo®	hydromorphone	opioid analgesic
Femcet®	butalbital, acetaminophen, caffeine	barbiturate with analgesic for headaches
Fioricet®	butalbital, acetaminophen, caffeine	barbiturate with analgesic for headaches
Fiorinal®	butalbital, aspirin, and caffeine	barbiturate with analgesic for headaches
Fiorinal® with codeine	codeine, butalbital, aspirin, caffeine	opioid analgesic, barbiturate
Gen-Xene®	clorazepate	benzodiazepine
Halcion®	triazolam	benzodiazepine
Kadian®	morphine	opioid analgesic
Klonopin®	clonazepam	benzodiazepine
Libri-tabs®	chlordiazepoxide	benzodiazepine

Alphabetical List by Brand Name (all medications on this list interact negatively with alcohol)

Brand Name	Generic Name	Medication Category
Librium®	chlordiazepoxide	benzodiazepine
Lomotil®	diphenoxylate and atropine	opioid-like substance for diarrhea
Lorcet®, Lorcet Plus®	hydrocodone and acetaminophen	opioid analgesic
Lortab®	hydrocodone and acetaminophen	opioid analgesic
Lortab ASA®	hydrocodone and aspirin	opioid analgesic
Luminal®	phenobarbital	barbiturate
Maxidone®	hydrocodone and acetaminophen	opioid analgesic
Mebaral®	mephrobarbital	barbiturate
MS Contin®	morphine controlled release	opioid analgesic
MS IR®	morphine immediate release	opioid analgesic
Nembutal®	pentobarbital	barbiturate
Noctec®*	chloral hydrate*	sedative/hypnotic
Norco®	hydrocodone and acetaminophen	opioid analgesic
OxyContin®	oxycodone controlled release	opioid analgesic
OxyIR®	oxycodone immediate release	opioid analgesic
Panasal® 5/500	hydrocodone and aspirin	opioid analgesic
Paxipam®	halazepam	benzodiazepine
Percocet®	oxycodone and acetaminophen	opioid analgesic
Percodan®	oxycodone and aspirin	opioid analgesic
ProSom®	estazolam	benzodiazepine
Restoril®	temazepam	benzodiazepine
Robitussin AC®	codeine, guaifenesin	opioid for cough suppression
Roxanol®	morphine	opioid analgesic
Roxicet®	oxycodone and acetaminophen	opioid analgesic
Roxipirin®	oxycodone and aspirin	opioid analgesic
Seconal®	secobarbital	barbiturate
Serax®	oxazepam	benzodiazepine
Stadol® Nasal Spray	Buprenorphine	opioid analgesic
Talwin®	pentazocine	opioid analgesic
Tranxene®/Tranxene-SD®	clorazepate	benzodiazepine
Tuinal®	secobarbital and amobarbital	Barbiturate combination
Tussionex®	hydrocodone and chlorpheniramine	opioid for cough suppression plus an antihistamine
Tylenol 2®, Tylenol 3®, Tylenol 4®	codeine and acetaminophen	opioid analgesic
Tylox®	oxycodone and acetaminophen	opioid analgesic
Valium®	diazepam	benzodiazepine
Vicodin®, Vicodin ES®	hydrocodone and acetaminophen	opioid analgesic
Xanax®	alprazolam	benzodiazepine
Zamicet®	hydrocodone and acetaminophen	opioid analgesic
Zydone®	hydrocodone and acetaminophen	opioid analgesic

*Rarely prescribed today.

Alphabetical List by Generic Name (all medications on this list interact negatively with alcohol)

Generic Name	Brand Name(s)	Medication Category
alprazolam	Xanax	benzodiazepine
amobarbital	Amytal	barbiturate
aprobarbital	Alurate	barbiturate
buprenorphine	Butrans Skin Patch, Stadol Nasal Spray	opioid analgesic
butabarbital	Butisol	barbiturate
butalbital, acetaminophen, caffeine	Esgic	barbiturate with analgesic for headaches
butalbital, acetaminophen, caffeine	Femcet	barbiturate with analgesic for headaches
butalbital, acetaminophen, caffeine	Fioricet	barbiturate with analgesic for headaches
butalbital, aspirin, and caffeine	Fiorinal	barbiturate with analgesic for headaches
chloral hydrate*	Noctec*	sedative/hypnotic
chlordiazepoxide	Libri-tabs	benzodiazepine
chlordiazepoxide	Librium	benzodiazepine
clonazepam	Klonopin	benzodiazepine
clorazepate	Gen-Xene	benzodiazepine
clorazepate	Tranxene/Tranxene-SD	benzodiazepine
codeine and acetaminophen	Tylenol #2, Tylenol #3, Tylenol #4, Capital with codeine	opioid analgesic
codeine and aspirin	Empirin with codeine	opioid analgesic
codeine, butalbital, aspirin, caffeine	Fiorinal with codeine	opioid analgesic, barbiturate
codeine, guaifenesin	Robitussin AC	opioid for cough suppression
diazepam	Valium	benzodiazepine
diphenoxylate and atropine	Lomotil	opioid-like substance for diarrhea
estazolam	ProSom	benzodiazepine
fentanyl	Duragesic Skin Patches, Actiq Lozenge/ Lollipop	opioid analgesic
flurazepam	Dalmane	benzodiazepine
Gluthemide*	Doriden*	sedative/hypnotic
halazepam	Paxipam	benzodiazepine
hydrocodone and acetaminophen	Vicodin, Vicodin ES, Lorcet, Lorcet Plus, Lortab, Anexsia, Maxidone, Norco, Zamicet, Zydone	opioid analgesic
hydrocodone and aspirin	Panasal 5/500, Lortab ASA	opioid analgesic
hydrocodone and chlorpheniramine	Tussionex	opioid for cough suppression plus an antihistamine
hydromorphone	Dilaudid/Dilaudid HP, Exalgo	opioid analgesic
lorazepam	Ativan	benzodiazepine
meperidine	Demerol	opioid analgesic
mephobarbital	Mebaral	barbiturate

Alphabetical List by Generic Name (all medications on this list interact negatively with alcohol)

Generic Name	Brand Name(s)	Medication Category
methodone	Dolophine	opioid analgesic
morphine	MS Contin, Kadian, Astramorph, Avinza, MS IR, Roxanol	opioid analgesic
oxazepam	Serax	benzodiazepine
oxycodone immediate release	OxyIR, Endocodone	opioid analgesic
oxycodone controlled release	OxyContin	opioid analgesic
oxycodone and acetaminophen	Percocet, Endocet, Roxicet, Tylox	opioid analgesic
oxycodone and aspirin	Percodan, Endodan, Roxipirin	opioid analgesic
pentazocine	Talwin	opioid analgesic
pentobarbital	Nembutal	barbiturate
phenobarbital	Luminal	barbiturate
quazepam	Doral	benzodiazepine
secobarbital	Seconal	barbiturate
secobarbital and amobarbital	Tuinal	Barbiturate combination
temazepam	Restoril	benzodiazepine
triazolam	Halcion	benzodiazepine

*Rarely prescribed today

Appendix 2a: Prescreen-Staff

(For administration by agency/organizational staff)

1. During the past 3 months, have you used any prescription medications for pain for problems like back pain, muscle pain, headaches, arthritis, fibromyalgia, etc.?

   ❒ Yes ❒ No

   If No, continue with Question 4.

2. If yes, what medication(s) for pain have you taken? _____

3. Is this medication(s) on the targeted list of pain medications?

   ❒ Yes ❒ No ❒ Do Not Know

   See list of targeted pain medications on reverse side.
   If this medication is o n the list of targeted pain medications, this is a POSITIVE prescreen.
   If Do Not Know, assume a POSITIVE screen.

4. During the past 3 months, have you used any prescription medications to help you fall asleep, for anxiety, for your nerves, or because you were feeling agitated?

   ❒ Yes ❒ No

   If Yes, then this is a POSITIVE prescreen.

5. During the past 3 months, have you had anything to drink containing alcohol (beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

   ❒ Yes ❒ No

   If No to Question 5, and the responses to Questions 1 or 3 and 4 are No, then this is a NEGATIVE prescreen.
   If yes to Question 5, this is a POSITIVE prescreen. Continue with the full screen.

END OF PRESCREEN

Medications for Pain

Generic Name(s)	Brand Name(s)
buprenorphine	Butrans Skin Patch®, Stadol Nasal Spray®
codeine and acetaminophen	Tylenol 2®, Tylenol 3®, Tylenol 4®, Capital® with codeine
codeine and aspirin	Empirin® with codeine
codeine, butalbital, aspirin, caffeine	Fiorinal® with codeine
fentanyl lozenge	Actiq® Lozenge/Lollipop
fentanyl skin patch	Duragesic® Skin Patches
hydrocodone and acetaminophen	Vicodin®, Vicodin ES®, Lorcet®, Lorcet Plus®, Lortab®, Anexsia®, Maxidone®, Norco®, Zamicet®, Zydone®
hydrocodone and aspirin	Panasal 5/500®, Lortab ASA®
hydromorphone	Dilaudid®, Dilaudid HP®, Exalgo®
meperidine	Demerol®
methodone	Dolophine®
morphine	MS Contin®, Kadian®, Astramorph®, Avinza®, MS IR®, Roxanol®
oxycodone immediate release	OxyIR®, Endocodone®
oxycodone controlled release	OxyContin®
oxycodone and acetaminophen	Percocet®, Tylox®, Roxicet®, Endocet®
oxycodone and aspirin	Percodan®, Roxipirin®, Endodan
pentazocine	Talwin®

Appendix 2a: Prescreen-Self

For self-administration by older adults)

1. During the past 3 months, have you used any prescription medications for pain for problems like back pain, muscle pain, headaches, arthritis, fibromyalgia, etc.?

   ❒ Yes ❒ No

   If No, continue with Question 4.

2. If yes, what medication(s) for pain have you taken? _____

3. Is this medication(s) on the list of pain medications on the other side of this survey?

   ❒ Yes ❒ No ❒ Do Not Know

   See list of pain medications on other side of this form.

4. During the past 3 months, have you used any prescription medications to help you fall asleep, for anxiety, for your nerves, or because you were feeling agitated?

   ❒ Yes ❒ No

5. During the past 3 months, have you had anything to drink containing alcohol (beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

   ❒ Yes ❒ No

END OF PRESCREEN

Medications for Pain

Generic Name(s)	Brand Name(s)
buprenorphine	Butrans Skin Patch®, Stadol Nasal Spray®
codeine and acetaminophen	Tylenol 2®, Tylenol 3®, Tylenol 4®, Capital® with codeine
codeine and aspirin	Empirin® with codeine
codeine, butalbital, aspirin, caffeine	Fiorinal® with codeine
fentanyl lozenge	Actiq® Lozenge/Lollipop
fentanyl skin patch	Duragesic® Skin Patches
hydrocodone and acetaminophen	Vicodin®, Vicodin ES®, Lorcet®, Lorcet Plus®, Lortab®, Anexsia®, Maxidone®, Norco®, Zamicet®, Zydone®
hydrocodone and aspirin	Panasal 5/500®, Lortab ASA®
hydromorphone	Dilaudid®, Dilaudid HP®, Exalgo®
meperidine	Demerol®
methodone	Dolophine®
morphine	MS Contin®, Kadian®, Astramorph®, Avinza®, MS IR®, Roxanol®
oxycodone immediate release	OxyIR®, Endocodone®
oxycodone controlled release	OxyContin®
oxycodone and acetaminophen	Percocet®, Tylox®, Roxicet®, Endocet®
oxycodone and aspirin	Percodan®, Roxipirin®, Endodan
pentazocine	Talwin®

Appendix 2b: Screen/Outcomes Instrument-Staff

(For administration by agency/organizational staff)

Demographic Questions

1. What is your gender? (Check one)

- ❒ Male ❒ Female

2. What is your race?

- ❒ American Indian or Alaska Native
- ❒ Asian
- ❒ Black or African American
- ❒ Native Hawaiian or Other Pacific Islander
- ❒ White

3. What is your ethnicity?

- ❒ Hispanic or Latino
- ❒ Not Hispanic or Latino

4. What is your date of birth?

|__|__|/|__|__|/|__|__|__|__|

M M / D D / Y Y Y Y

5. What is the highest level of education you have finished, whether or not you received a degree? (01=1st grade, 12=12th grade, 13=college freshman, 16=college completion, etc.)

|___|___| Level in years

5a. (If less than 12 years of education) Do you have a GED (General Equivalency Diploma)?

- ❒ Yes ❒ No

Physical and Mental Health Functioning

6. In general, would you say your health is:

- ❒ Excellent (1)
- ❒ Very Good (2)
- ❒ Good (3)
- ❒ Fair (4)
- ❒ Poor (5)

The following two questions are about activities you might do during a typical day.

7. Does YOUR HEALTH NOW LIMIT YOU in MODERATE ACTIVITIES, such as moving a table, bowling, playing golf, etc.? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

8. Does YOUR HEALTH NOW LIMIT YOU in Climbing SEVERAL flights of stairs? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

9. During the PAST 4 WEEKS have you ACCOMPLISHED LESS than you would like with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

10. During the PAST 4 WEEKS were you limited in the KIND of work or other activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

11. During the PAST 4 WEEKS, did you ACCOMPLISH LESS than you would like AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

12. During the PAST 4 WEEKS, did you not do work or other activities as CAREFULLY as usual AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

13. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- ❒ Not At All (1)
- ❒ A Little Bit (2)
- ❒ Moderately (3)
- ❒ Quite A Bit (4)
- ❒ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS:

14. Have you felt calm and peaceful?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

15. Did you have a lot of energy?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

16. Have you felt downhearted and blue?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

17. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

Depressed Feelings

Please choose the answer that best describes how you have felt over the past week.

18. Are you basically satisfied with your life?

- ❒ Yes (1)
- ❒ No (2)

19. Do you often get bored?

- ❒ Yes (1)
- ❒ No (2)

20. Do you often feel helpless?

- ❒ Yes (1)
- ❒ No (2)

21. Do you prefer to stay at home, rather than going out and doing new things?

- ❒ Yes (1)
- ❒ No (2)

22. Do you feel pretty worthless the way you are now?

- ❒ Yes (1)
- ❒ No (2)

Alcohol Consumption (Frequency, Quantity, and Binge Drinking)

23. In the last 3 months, have you been drinking alcoholic drinks at all (e.g., beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

❒ Yes ❒ No

If YES to Question 23, continue with Question 24.
If NO to Question 23, continue with Question 28.

24. In the last 3 months, on average how many days a week have you been drinking alcohol?

None 1 2 3 4 5 6 7

25. On a day when you have had alcohol to drink, how many drinks have you had?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 or more

26. In the last 3 months, how many times have you had: 4 or more drinks on one occasion (men); 3 or more drinks on one occasion (women)? (scale 1 to 10 or more)

None 1 2 3 4 5 6 7 8 9 10 or more

Positive Screen =

Consumption:
14 or more drinks/week (men) =
Question 24 x Question 25

10 or more drinks/week (women) =
Question 24 x Question 25

Binge Drinking:
2 or more binge occasions in last 3 months
(Binge=4 or more drinks/occasion for men;
3 or more drinks/occasion for women)

27. Think back over the past 30 days and report how many days, if any, you used alcoholic beverages, including beer, wine, wine coolers, malt beverages, and liquor. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

_____# of days

Medications for Pain

If the client answered Yes to Question 3 on the Prescreen, ask the following questions related to use of medications for pain.

28. What prescription medication(s) do you currently take for pain?

_____
_____

Positive Screen =

If this pain medication is on the targeted list and the client answered Yes to Question 23 about the use of alcohol, this is a POSITIVE screen for the combination of alcohol and a psychoactive medication.

If this pain medication is on the targeted list, then continue with Questions 29.

If this pain medication is NOT on the targeted list, continue with Question 35.

29. In the past 3 months, how often have you used the medication(s) you mentioned for pain for reasons or in doses other than prescribed?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

For any recent nonmedical pain medication use (for reasons or in doses other than prescribed), ask Questions 30–34.

If answer is NEVER, continue with Question 35.

30. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for pain?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

31. During the past 3 months, how often has the use of the medication(s) you mentioned for pain led to problems related to health, social, legal, or financial issues?

- ☐ Never (0)
- ☐ Once or Twice (4)
- ☐ Monthly (5)
- ☐ Weekly (6)
- ☐ Daily or Almost Daily (7)

32. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for pain you mentioned?

- ☐ Never (0)
- ☐ Once or Twice (5)
- ☐ Monthly (6)
- ☐ Weekly (7)
- ☐ Daily or Almost Daily (8)

33. Has a friend or relative ever expressed concern about your use of the medication(s) for pain you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

34. Have you ever tried and failed to control, cut down, or stousing the medication(s) for pain you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

For pain medications, add up the scores received for questions 30–34. This is the Substance Abuse Involvement (SI) score and determines the level of risk associated with opioid analgesic medications.

- 0–5: Lower Risk
- 6–26: Moderate Risk
- 27+: High Risk

Clients in the Moderate and High-Risk level should receive the Brief Intervention.

Medications for Sleep, Anxiety, Nerves, Agitation (Anxiolytics/Sedative/Hypnotics)

If the client answered Yes to Question 4 on the Prescreen, ask the following:

35. What prescription medication(s) do you currently take to helyou fall asleep, for anxiety, for your nerves, or for feeling agitated?

_____

_____

Positive Screen =

If this anxiolytic/sedative/hypnotic medication is on the targeted list and the client answered Yes to Question 23 about the use of alcohol, this is a positive screen for the combination of alcohol and psychoactive medications.

If this anxiolytic/sedative/hypnotic medication is on the targeted list, then continue with Questions 36.

If this anxiolytic/sedative/hypnotic medication is NOT on the targeted list, then continue with Questions 42.

36. In the past 3 months, how often have you used the medication(s) you mentioned for reasons or in doses other than prescribed?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

For any recent nonmedical use of medications for sleep, anxiety, etc. (for reasons or in doses other than prescribed), ask Question 37–41.

If NEVER, continue with Question 42.

37. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for sleep, anxiety, etc.?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

38. During the past 3 months, how often has the use of the medication(s) you mentioned for sleep, anxiety, etc. led to problems related to health, social, legal, or financial issues?

- ☐ Never (0)
- ☐ Once or Twice (4)
- ☐ Monthly (5)
- ☐ Weekly (6)
- ☐ Daily or Almost Daily (7)

39. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ☐ Never (0)
- ☐ Once or Twice (5)
- ☐ Monthly (6)
- ☐ Weekly (7)
- ☐ Daily or Almost Daily (8)

40. Has a friend or relative ever expressed concern about your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

41. Have you ever tried and failed to control, cut down, or stousing the medication(s) for sleep, anxiety, etc. you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

For anxiolytic/sedative/hypnotic medications, add uthe scores received for questions 37–41. This is the Substance Abuse Involvement (SI) score and determines the level of risk associated with anxiolytic/sedative/hypnotic medications.

- 0–5: Lower Risk
- 6–26: Moderate Risk
- 27+: High Risk

Clients in the Moderate and High-Risk level should receive the Brief Intervention.

Social Connectedness and Family Communication Around Drug Use

42. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, how many times have you talked with a family member or friend about the dangers or problems associated with your use of alcohol or medications?

- ❒ a. 0
- ❒ b. 1 or 2 times
- ❒ c. A few times
- ❒ d. Many times
- ❒ e. Don't know/can't say

Perceived Risk/Harm of Use

43. How much do you think older people risk harming themselves physically or in other ways when they have four or more drinks (three or more for females) of an ALCOHOLIC BEVERAGE once or twice a week?

- ❒ a. No risk
- ❒ b. Slight risk
- ❒ c. Moderate risk
- ❒ d. Great risk
- ❒ e. Don't know or can't say

Appendix 2b: Screen/Outcomes Instrument-Staff

(For self-administration by older adults)

1. What is your gender? (Check one)

- ❒ Male ❒ Female

2. What is your race?

- ❒ American Indian or Alaska Native
- ❒ Asian
- ❒ Black or African American
- ❒ Native Hawaiian or Other Pacific Islander
- ❒ White

3. What is your ethnicity?

- ❒ Hispanic or Latino
- ❒ Not Hispanic or Latino

4. What is your date of birth?

|__|__|/|__|__|/|__|__|__|__|

M M / D D / Y Y Y Y

5. What is the highest level of education you have finished, whether or not you received a degree? (01=1st grade, 12=12th grade, 13=college freshman, 16=college completion, etc.)

|___|___| Level in years

5a. (If less than 12 years of education) Do you have a GED (General Equivalency Diploma)?

- ❒ Yes ❒ No

6. In general, would you say your health is:

- ❒ Excellent (1)
- ❒ Very Good (2)
- ❒ Good (3)
- ❒ Fair (4)
- ❒ Poor (5)

The following two questions are about activities you might do during a typical day.

7. Does YOUR HEALTH NOW LIMIT YOU in MODERATE ACTIVITIES, such as moving a table, bowling, playing golf, etc.? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

8. Does YOUR HEALTH NOW LIMIT YOU in Climbing SEVERAL flights of stairs? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

9. During the PAST 4 WEEKS have you ACCOMPLISHED LESS than you would like with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

10. During the PAST 4 WEEKS were you limited in the KIND of work or other activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

11. During the PAST 4 WEEKS, did you ACCOMPLISH LESS than you would like AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

12. During the PAST 4 WEEKS, did you not do work or other activities as CAREFULLY as usual AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

13. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- ❒ Not At All (1)
- ❒ A Little Bit (2)
- ❒ Moderately (3)
- ❒ Quite A Bit (4)
- ❒ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS:

14. Have you felt calm and peaceful?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

15. Did you have a lot of energy?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

16. Have you felt downhearted and blue?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

17. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

For Questions 18–22, please choose the answer that best describes how you have felt over the past week.

18. Are you basically satisfied with your life?

- ❒ Yes (1)
- ❒ No (2)

19. Do you often get bored?

- ❒ Yes (1)
- ❒ No (2)

20. Do you often feel helpless?

- ❒ Yes (1)
- ❒ No (2)

21. Do you prefer to stay at home, rather than going out and doing new things?

- ❒ Yes (1)
- ❒ No (2)

22. Do you feel pretty worthless the way you are now?

- ❒ Yes (1)
- ❒ No (2)

23. In the last 3 months, have you been drinking alcoholic drinks at all (e.g., beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

❒ Yes ❒ No

If YES to Question 23, continue with Question 24.
If NO to Question 23, continue with Question 28.

24. In the last 3 months, on average how many days a week have you been drinking alcohol?

None 1 2 3 4 5 6 7

25. On a day when you have had alcohol to drink, how many drinks have you had?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 or more

26. In the last 3 months, how many times have you had: 4 or more drinks on one occasion (men); 3 or more drinks on one occasion (women)? (scale 1 to 10 or more)

None 1 2 3 4 5 6 7 8 9 10 or more

27. Think back over the past 30 days and report how many days, if any, you used alcoholic beverages, including beer, wine, wine coolers, malt beverages, and liquor. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

_____# of days

28. What prescription medication(s) do you currently take for pain?

_____

_____

If this pain medication is on the targeted list, then continue with Questions 29.

If this pain medication is NOT on the targeted list, continue with Question 35.

29. In the past 3 months, how often have you used the medication(s) you mentioned for pain for reasons or in doses other than prescribed?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

If answer is NEVER, continue with Question 35.

If answer is Once or Twice, Monthly, Weekly, Daily or Almost Daily, continue with Question 30.

30. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for pain?

- ☐ Never (0)
- ☐ Once or Twice (2)
- ☐ Monthly (3)
- ☐ Weekly (4)
- ☐ Daily or Almost Daily (6)

31. During the past 3 months, how often has the use of the medication(s) you mentioned for pain led to problems related to health, social, legal, or financial issues?

- ☐ Never (0)
- ☐ Once or Twice (4)
- ☐ Monthly (5)
- ☐ Weekly (6)
- ☐ Daily or Almost Daily (7)

32. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for pain you mentioned?

- ☐ Never (0)
- ☐ Once or Twice (5)
- ☐ Monthly (6)
- ☐ Weekly (7)
- ☐ Daily or Almost Daily (8)

33. Has a friend of relative ever expressed concern about your use of the medication(s) for pain you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

34. Have you ever tried and failed to control, cut down, or stop using the medication(s) for pain you mentioned?

- ☐ No, Never (0)
- ☐ Yes, but not in the past 3 months (3)
- ☐ Yes, in the past 3 months (6)

35. What prescription medication(s) do you currently take to help you fall asleep, for anxiety, for your nerves, or for feeling agitated?

_____

_____

If this medication is on the targeted list, then continue with Questions 36.

If this medication is NOT on the targeted list, then continue with Questions 42.

36. In the past 3 months, how often have you used the medication(s) you mentioned for reasons or in doses other than prescribed?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

If answer is NEVER, continue with Question 42.

If answer is Once or Twice, Monthly, Weekly, Daily or Almost Daily, continue with Question 37.

37. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for sleep, anxiety, etc.?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

38. During the past 3 months, how often has the use of the medication(s) you mentioned for sleep, anxiety, etc. led to problems related to health, social, legal, or financial issues?

- ❒ Never (0)
- ❒ Once or Twice (4)
- ❒ Monthly (5)
- ❒ Weekly (6)
- ❒ Daily or Almost Daily (7)

39. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ Never (0)
- ❒ Once or Twice (5)
- ❒ Monthly (6)
- ❒ Weekly (7)
- ❒ Daily or Almost Daily (8)

40. Has a friend or relative ever expressed concern about your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

41. Have you ever tried and failed to control, cut down, or stop using the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

42. Now think about the past 12 months through today. DURING THE PAST 12 MONTHS, how many times have you talked with a family member or friend about the dangers or problems associated with your use of alcohol or medications?

- ❒ a. 0
- ❒ b. 1 or 2 times
- ❒ c. A few times
- ❒ d. Many times
- ❒ e. Don't know/can't say

43. How much do you think older people risk harming themselves physically or in other ways when they have four or more drinks (three or more for females) of an ALCOHOLIC BEVERAGE once or twice a week?

- ❒ a. No risk
- ❒ b. Slight risk
- ❒ c. Moderate risk
- ❒ d. Great risk
- ❒ e. Don't know or can't say

Appendix 2c: Audit Questionnaire

Directions: For each of the following questions, Please check the box next to the most appropriate response.

1. How often to you have a drink containing alcohol?

- ☐ 0 Never
- ☐ 1 Monthly or less
- ☐ 2 2 to 4 times a month
- ☐ 3 2 to 3 times a month
- ☐ 4 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- ☐ 0 1 or 2
- ☐ 1 3 or 4
- ☐ 2 5 or 6
- ☐ 3 7 or 9
- ☐ 4 10 or more

3. How often do you have 6 or more drinks on one occasions?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

7. How often during the last year have you had a feeling of quilt or remorse after drinking?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?

- ☐ 0 Never
- ☐ 1 Less than monthly
- ☐ 2 Monthly
- ☐ 3 Weekly
- ☐ 4 Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- ☐ 0 No
- ☐ 2 Yes, but not in the last year
- ☐ 4 Yes, during the last year

10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- ☐ 0 No
- ☐ 2 Yes, but not in the last year
- ☐ 4 Yes, during the last year

Record sum of individual item scores here:_____
See next page for scoring:

Scoring

In a Non-Dual Diagnosis Population:

- 0-4: Lower risk use
- 5-8: At-risk use
- 8-10: Alcohol abuse
- 11-up: Alcohol dependence

Appendix 2c: Short Michigan Alcoholism Screening Test -Geriatric Version (S-MAST-G)

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Please check either yes or no for each queestion, then tally at the end	Yes (1)	No (0)
1. When talking with others, do you ever underestimate how much you actually drink?	❐	❐
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	❐	❐
3. Does having a few drinks help decrease your shakiness or tremors?	❐	❐
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?	❐	❐
5. Do you usually take a drink to relax or calm your nerves?	❐	❐
6. Do you drink to take your mind off your problems?	❐	❐
7. Have you ever increased your drinking after experiencing a loss in your life?	❐	❐
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?	❐	❐
9. Have you ever made rules to manage your drinking?	❐	❐
10. When you feel lonely, does having a drink help?	❐	❐
TOTAL S-MAST-G SCORE (0-10)	_____	

Scoring: 2 or more "yes" responses indicative of alcohol problem.

For further information, contact Frederic Blow, Ph.D., at University of Michigan Alcohol Research Center, 4250 Plymouth Road, SPC 5765, Ann Arbor, MI 48109-5765.

Appendix 3: Consumer Resources

Pamphlets and Brochures About the Safe Use of Alcohol and Medications for Older Adults

- Aging, Medicines, and Alcohol (SAMHSA)—Designed to increase awareness among older adult consumers about possible problems related to the misuse of alcohol, prescription drugs, or over-the-counter drugs. Lists signs of misuse and suggests actions the elderly can take to avoid or deal with problems.

  store.samhsa.gov/product/Aging-Medicines-and-Alcohol/SMA08-3619

- As You Age (SAMHSA)—Raises awareness among the elderly about the dangers of prescription drug and over-the-counter drug interactions and misuse, as well as the mix of alcohol and medicines.

  store.samhsa.gov/product/As-You-Age-Ask-Guard-Educate/AVD188

- Older Adults and Alcohol (NIAAA)

  www.nia.nih.gov/NR/rdonlyres/28DDEE88-38FB-4ED7-BD6C-4738381E1659/0/NIAAlcoholBooklet218final.pdf

- Age Page: Alcohol Use in Older People (NIA)

  www.nia.nih.gov/NR/rdonlyres/89CF17D6-ADF4-498A-AD58-F4C85D606E66/12935/AlcoholpartAPFINALforWeb71709.pdf

- Age Page: Medicines: Use Them Safely (NIA)

  www.nia.nih.gov/HealthInformation/Publications/medicines.htm

  Spanish version: www.nia.nih.gov/HealthInformation/Publications/Spanish/medicines-sp.htm

- Safe Use of Medicines (NIA)

  www.nia.nih.gov/HealthInformation/Publications/SafeUseMeds

- Talking with your Doctor

  www.nia.nih.gov/HealthInformation/Publications/TalkingWithYourDoctor/

  Spanish version: www.nia.nih.gov/HealthInformation/Publications/Spanish/conversando.htm

- Prescription Drugs: Abuse and Addiction (NIDA)

  www.nida.nih.gov/PDF/RRPrescription.pdf

- Your Medicines: Be Safe, Be Smart (AHRQ)

  www.ahrq.gov/consumer/safemeds/yourmeds.pdf

- Age Page: A Good Night's Sleep (NIA)—Information and practical advice for older adults with sleep difficulties, including non-pharmacological approaches to improving sleep.

  http://www.nia.nih.gov/healthinformation/publications/sleep.htm

- Age Page: Pain: You Can Get Help (NIA)—Information, treatment options, and practical advice for older adults who suffer from painful conditions.

  http://www.nia.nih.gov/HealthInformation/Publications/pain.htm

Appendix 4a: Health Promotion Workbook

Health Promotion Workbook for Older Adults

© Kristen Lawton Barry, Ph.D., David W. Oslin, M.D,. and Frederic C. Blow, Ph.D.

Today's Date _____/_____/_____

Part 1: Identifying Future Goals

We will start by talking about some of your future goals. By that we mean, how would you like your life to improve and be different in the future? It is often important to think about future goals when thinking about making changes in health habits.

1. What are some of your goals for the next three months to a year regarding your physical and emotional health?

2. What are some of your goals for the next three months to one year regarding activities and hobbies?

3. What are some of your goals for the next three months to a year regarding your relationships and social life?

4. What are some of your goals in the next three months to a year regarding your financial situation or other parts of your life?

Part 2: Summary Of Health Habits

Let's review some of the information about your health, behavior, or health habits which you shared in the clinic.

Exercise

5. Days per week you participated in vigorous activity
   - ❒ none
   - ❒ seldom
   - ❒ 1-2 days per week
   - ❒ 3-5 days per week
   - ❒ 6-7 days per week

6. Minutes of exercise per day
   - ❒ not applicable
   - ❒ less than 15 minutes
   - ❒ 15-30 minutes
   - ❒ more than 30 minutes

Nutrition

7. Weight change in last six months
   - ❒ no change in weight
   - ❒ gained more than 10 pounds
   - ❒ lost more than 10 pounds
   - ❒ don't know

Tobacco Use

8. Tobacco used in last six months
   - ❒ no
   - ❒ yes—If yes, which ones?
     - ❒ cigarettes
     - ❒ chewing tobacco
     - ❒ pipe

9. Average cigarettes smoked per day in the last six months

- ❒ not applicable
- ❒ 1-9
- ❒ 10-19
- ❒ 20-29
- ❒ 30+

Alcohol Use

10. Drinking days per week

- ❒ 1-2 days per week
- ❒ 3-4 days per week
- ❒ 5-6 days per week
- ❒ 7 days per week

11. Drinks per day

- ❒ 1-2 drinks
- ❒ 3-4 drinks
- ❒ 5-6 drinks
- ❒ 7 or more

12. Binge drinking within last month (four or more drinks/occasion for women; four or more drinks/occasion for men)

- ❒ none
- ❒ 1-2 binges
- ❒ 3-5 binges
- ❒ 6-7 binges
- ❒ 8 or more

13. On days that you do not drink do you feel anxious, have greater difficulty sleeping than usual, feel your heart racing, have heart palpitations, or have the shakes or hand tremors?

- ❒ No
- ❒ Yes

14. Are there any of these health behaviors (exercise, nutrition, tobacco use, alcohol use) with which you would like some help?

- ❒ No
- ❒ Yes—If yes, which ones?
  - ❒ exercise
  - ❒ nutrition
  - ❒ tobacco use
  - ❒ alcohol use

Part 3: Standard Drinks

The drinks shown below, in normal measure, contain roughly the same amount of pure alcohol. You can think of each one as a standard drink.

What's a standard drink?

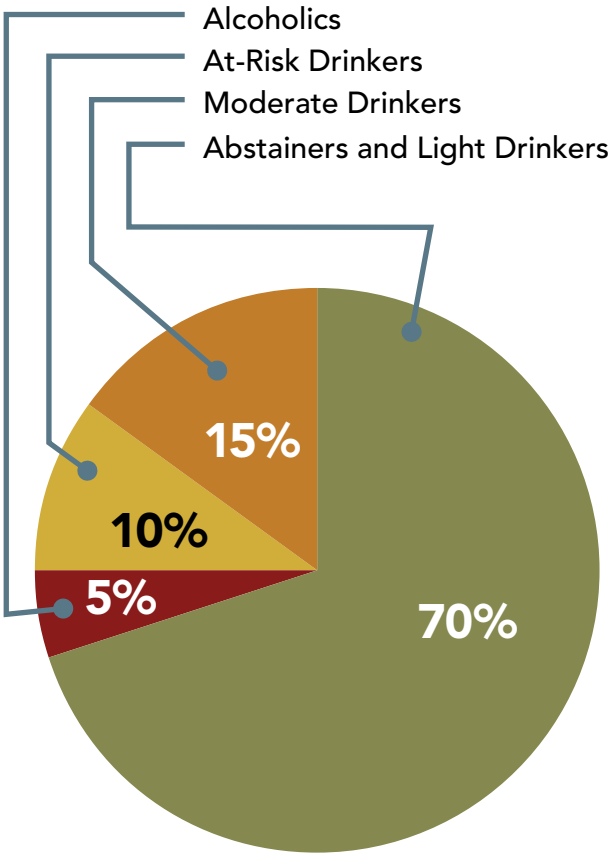
1 standard drink=

1 can of ordinary beer or ale (12oz)	A single shot of spirits—whiskey, gin, vodka, etc. (1.5oz)	A glass of wine (6oz)	A small glass of sherry (4oz)	A small glass of liqueur or aperitif (4oz)

Part 4: Types Of Older Drinkers In The U.S. Population

It is helpful to think about the amount of alcohol consumed by older adults in the United States and by you. There are different types of drinkers among the older adult population, and these types can be explained by different patterns of alcohol consumption. These include:

Types	Patterns of alcohol consumption
Abstainers and light drinkers	• drink no alcohol or less than three drinks per month • alcohol use does not affect health or result in negative consequences
Moderate drinkers	• drink three or fewer times per week • drink one to two standard drinks per occasion • alcohol use does not affect health or result in negative consequences • at times moderate drinkers consume NO alcohol, such as before driving, while operating machinery, and so on.
At-risk drinkers	• drink over seven standard drinks per week • at risk for negative health and social consequences
Alcoholics	• heavy drinking has led to a physical need for alcohol and to other problems



Part 5: Consequences Of At-Risk Or Problem Drinking

Drinking alcohol can affect your physical health, emotional and social well being, and relationships.

15. The following are some of the positive effects that people sometimes describe as a result of drinking alcohol. Let's place a check mark by the ones that you feel apply to you.

- ❒ Temporary high
- ❒ Forget problems
- ❒ Enjoy the taste
- ❒ Social ease
- ❒ Relaxation
- ❒ Sense of confidence
- ❒ Temporary lower stress
- ❒ Avoid uncomfortable feelings
- ❒ Ease in speaking one's mind

16. The following are some of the negative consequences that may result from drinking. Let's place a check mark by any of these problems that are affecting you regardless of whether you believe they are related to your drinking.

- ❒ Difficulty coping with stressful situations
- ❒ Depression
- ❒ Loss of independence
- ❒ Problems in community activities
- ❒ High blood pressure
- ❒ Sexual performance problems
- ❒ Sleep problems
- ❒ Memory problems or confusion
- ❒ Malnutrition
- ❒ Reduced effectiveness of medications
- ❒ Increased side effects from medication
- ❒ Accidents/falls
- ❒ Relationship problems
- ❒ Increased risk of assault
- ❒ Financial problems
- ❒ Stomach pain
- ❒ Liver problems

Part 6: Reasons To Quit Or Cut Down On Your Drinking

The purpose of this step is to think about the best reason for you to quit or cut down on your drinking. The reasons will be different for different people.

17. The following list identifies some of the reasons for which people decide to cut down or quit drinking. Put an X in the box by the three most important reasons that YOU want to quit or cut down on your drinking. Perhaps you can think of other reasons that are not on this list.

- ❒ To consume fewer empty calories (alcoholic drinks contain many calories).
- ❒ To sleep better.
- ❒ To maintain independence.
- ❒ To feel better
- ❒ To save money.
- ❒ To be happier.
- ❒ To reduce the possibility that I will be injured in a car crash.
- ❒ To have better family relationships.
- ❒ To participate more in community activities.
- ❒ To have better friendships.
- ❒ Other: _____

18. Write down the three most important reasons you choose to cut down or quit drinking.

A. _____

_____

B. _____

_____

C. _____

_____

19. Think about the consequences of continuing to drink heavily. Now think about how your life might improve if you decide to change your drinking habits by cutting down or quitting. What improvements do you anticipate?

A. Physical health:

B. Mental health:

C. Family:

D. Other relationships:

E. Activities:

Part 7: Alcohol Use Agreement

The purpose of this step is to decide on a drinking limit for yourself for a particular period of time. Negotiate with your health care provider so you can both agree on a reasonable goal. A reasonable goal for some people is abstinence-not drinking any alcohol.

As you develop this agreement, answer the following questions:

- How many standard drinks (see below)?
- How frequently?
- For what period of time?

Agreement

Date _____

_____

_____

_____

Client signature _____

Clinician signature _____

Drinking Diary Card

One way to keep track of how much you drink is the use of drinking diary cards. One card is used for each week. Every day record the number of drinks you had. At the end of the week add up the total number of drinks you had during the week.

Card A

Keep Track Of What You Drink Over The Next 7 Days

Starting Date _____

	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Card B

Keep Track Of What You Drink Over The Next 7 Days

Starting Date _____

	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Part 8: Handling Risky Situations

Your desire to drink may change according to your mood, the people you are with, and the availability of alcohol. Think about your last periods of drinking.

Here are examples of risky situations. The following list may help you remember situations that can result in at-risk drinking.

- social get-togethers
- sleeplessness
- anger
- boredom
- family
- watching television
- tension
- friends
- other people drinking
- feeling lonely
- criticism
- certain places
- feelings of failure
- dinner parties
- after regular daily activities
- frustration
- children and grandchildren
- weekends
- use of tobacco
- TV or magazine ads
- arguments

19. What are situations that make you want to drink at a risky level. Please write them down.

A. _____

_____

B. _____

_____

C. _____

_____

WAYS TO COPE WITH RISKY SITUATIONS

It is important to figure out how you can make sure you will not go over drinking limits when you are tempted. Here are examples:

- Telephone a friend
- Call on a neighbor
- Read a book
- Go for a walk
- Watch a movie
- Participate in an activity you like

Some of these ideas may not work for you, but other methods of dealing with risky situations may work. Identify ways you could cope with the specific risky situations you listed above.

A. For the first risky situation or feeling, write down different ways of coping. _____

_____

_____

B. For the second risky situation or feeling, write down different ways of coping. _____

_____

_____

Think about other situations and ways you could cope without using alcohol.

Part 9: Visit Summary

We've covered a great deal of information today. Changing your behavior, especially drinking patterns, can be a difficult challenge. The following pointers may help you stick with your new behavior and maintain the drinking limit agreement, especially during the first few weeks when it is most difficult. Remember that you are changing a habit, and that it can be hard work. It becomes easier with time.

- ❒ Remember your drinking limit goal: _____
- ❒ Read this workbook frequently.
- ❒ Every time you are tempted to drink above limits and are able to resist, congratulate yourself because you are breaking an old habit.
- ❒ Whenever you feel very uncomfortable, tell yourself that the feeling will pass.
- ❒ At the end of each week, think about how many days you have been abstinent (consumed no alcohol) or have been a light or moderate drinker.
- ❒ Some people have days during which they drink too much. If that happens to you, DON'T GIVE UP. Just start again the next day.
- ❒ You should always feel welcome to call your physician for assistance or in case of an emergency.

Thanks for trying this program.

Appendix 4b: Health Promotion Workbook

Health Promotion Workbook for Older Adults

© Kristen Lawton Barry, Ph.D., David W. Oslin, M.D,. and Frederic C. Blow, Ph.D.

Today's Date _____/_____/_____

Part 1: Identifying Future Goals

We will start by talking about some of your future goals. By that we mean, how would you like your life to improve and be different in the future? It is often important to think about future goals when thinking about making changes in health habits.

1. What are some of your goals for the next three months to a year regarding your physical and emotional health?

2. What are some of your goals for the next three months to one year regarding activities and hobbies?

3. What are some of your goals for the next three months to a year regarding your relationships and social life?

4. What are some of your goals in the next three months to a year regarding your financial situation or other parts of your life?

Part 2: Summary Of Health Habits

Let's review some of the information about your health, behavior, or health habits.

Exercise

5. Days per week you participated in vigorous activity
   - ❒ none
   - ❒ seldom
   - ❒ 1-2 days per week
   - ❒ 3-5 days per week
   - ❒ 6-7 days per week

6. Minutes of exercise per day
   - ❒ not applicable
   - ❒ less than 15 minutes
   - ❒ 15-30 minutes
   - ❒ more than 30 minutes

Nutrition

7. Weight change in last six months
   - ❒ no change in weight
   - ❒ gained more than 10 pounds
   - ❒ lost more than 10 pounds
   - ❒ don't know

Tobacco Use

8. Tobacco used in last six months
   - ❒ no
   - ❒ yes—If yes, which ones?
     - ❒ cigarettes
     - ❒ chewing tobacco
     - ❒ pipe

9. Average cigarettes smoked per day in the last six months

- ❒ not applicable
- ❒ 1-9
- ❒ 10-19
- ❒ 20-29
- ❒ 30+

Alcohol Use

10. Drinking days per week

- ❒ 1-2 days per week
- ❒ 3-4 days per week
- ❒ 5-6 days per week
- ❒ 7 days per week

11. Drinks per day

- ❒ 1-2 drinks
- ❒ 3-4 drinks
- ❒ 5-6 drinks
- ❒ 7 or more

12. Binge drinking within last month (four or more drinks/occasion for women; four or more drinks/occasion for men)

- ❒ none
- ❒ 1-2 binges
- ❒ 3-5 binges
- ❒ 6-7 binges
- ❒ 8 or more

13. On days that you do not drink do you feel anxious, have greater difficulty sleeping than usual, feel your heart racing, have heart palpitations, or have the shakes or hand tremors?

- ❒ No
- ❒ Yes

Medication Use

14. Primary prescription medications used currently:

_____

_____

_____

Drug use

15. Using any drugs? (e.g. marijuana, cocaine, etc.)

- ❒ No
- ❒ Yes

16. Are there any of these health behaviors (exercise, nutrition, tobacco use, alcohol use, or medications) with which you would like some help?

- ❒ No
- ❒ Yes—If yes, which ones?
  - ❒ exercise
  - ❒ nutrition
  - ❒ tobacco use
  - ❒ alcohol use
  - ❒ mediications
  - ❒ illegal drugs

Part 3: Standard Drinks

The drinks shown below, in normal measure, contain roughly the same amount of pure alcohol. You can think of each one as a standard drink.

What's a standard drink?

1 standard drink=

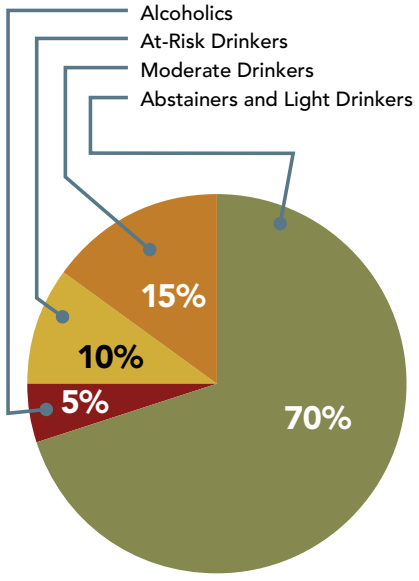
1 can of ordinary beer or ale (12oz)	A single shot of spirits—whiskey, gin, vodka, etc. (1.5oz)	A glass of wine (6oz)	A small glass of sherry (4oz)	A small glass of liqueur or aperitif (4oz)

Guidelines: Men under age 60: no more than 2 drinks/day (14 drinks/week); Women under 60: no more than 1 drink/day (7 drinks/week); **Men and women age 60+: no more than 1 drink/day**

Part 4: Types Of Older Drinkers In The U.S. Population

It is helpful to think about the amount of alcohol consumed by older adults in the United States and by you. There are different types of drinkers among the older adult population, and these types can be explained by different patterns of alcohol consumption. These include:

Types	Patterns of alcohol consumption
Abstainers and light drinkers	• drink no alcohol or less than three drinks per month • alcohol use does not affect health or result in negative consequences
Moderate drinkers	• drink three or fewer times per week • drink one to two standard drinks per occasion • alcohol use does not affect health or result in negative consequences • at times moderate drinkers consume NO alcohol, such as before driving, while operating machinery, and so on.
At-risk drinkers	• drink over 14 standard drinks per week below age 65, or over 7 standard drinks over age 65. • at risk for negative health and social consequences
Alcohol abuse or depenedence	• heavy drinking has led to a physical need for alcohol and to other problems



Part 5: Interaction of Alcohol, Medical Conditions, and Medications

Some of the medical conditions that can be made worse by using alcohol (e.g. high blood pressure; stomach problems; diabetes; depression, anxiety)

Some medications (particularly prescription medications for pain, anxiety, and sleep) can interact with alcohol. They can also be a problem by themselves if you:

- Take extra doses
- Do not follow prescription directions
- Take the medication for longer than prescribed
- Share or borrow extra pills

There are two common types of medications that can be a problem:

A. Opioid pain relievers (also called narcotic pain relievers)

- Codeine (Tylenol 3®, Empirin with codeine®, Fiorinol with codeine®, Robitussin A-C®)
- Oxycodone (OxyContin®, Percocet®, Percodan®)
- Hydrocodone (Vicodin®, Lortab®, Lorcet®, Tussionex®)
- Morphine (MS Contin®, Roxanol®, Duramorph®, Kadian®, Avinza®)
- Meperidine (Demerol®)
- Fentanyl (Duragesic®)

B. Sedatives or tranquilizers used for sleep, anxiety/nerves, and panic disorder include the following medications which are called benzodiazepines:

- Alprazolam (Xanax®)
- Chlordiazepoxide (Librium®)
- Clorazepate (Tranxene®)
- Diazepam (Valium®)
- Estazolam (ProSom®)
- Flurazepam (Dalmane®)
- Lorazepam (Ativan®)
- Oxazepam (Serax®)
- Quazepam (Doral®)
- Temazepam (Restoril®)
- Triazolam (Halcion®)

Part 6: Consequences Of At-Risk Or Problem Drinking and Problems with Using Some Medications

(e.g., prescriptions medications for pain, sleep) ***Drinking alcohol can affect your physical health, emotional and social well being, and relationships.***

17. The following are some of the positive effects that people sometimes describe as a result of drinking alcohol. Let's place a check mark by the ones that you feel apply to you.

- ❒ Temporary high
- ❒ Forget problems
- ❒ Enjoy the taste
- ❒ Social ease
- ❒ Relaxation
- ❒ Sense of confidence
- ❒ Temporary lower stress
- ❒ Avoid uncomfortable feelings
- ❒ Ease in speaking one's mind

18. The following are some of the negative consequences that may result from drinking. Let's place a check mark by any of these problems that are affecting you regardless of whether you believe they are related to your drinking.

- ❒ Difficulty coping with stressful situations
- ❒ Depression
- ❒ Loss of independence
- ❒ Problems in community activities
- ❒ High blood pressure
- ❒ Sexual performance problems
- ❒ Sleep problems
- ❒ Memory problems or confusion
- ❒ Malnutrition
- ❒ Reduced effectiveness of medications
- ❒ Increased side effects from medication
- ❒ Accidents/falls
- ❒ Relationship problems
- ❒ Increased risk of assault
- ❒ Financial problems
- ❒ Stomach pain
- ❒ Liver problems

19. The following are some of the ***negative consequences*** that may result from problems with medication misuse. Let's put a check mark by any of these problems that are affecting you regardless of whether you believe they are related to your medication use.

- ❒ Excessive daytime drowsiness
- ❒ Dizziness
- ❒ Loss of coordination, unsteady gait
- ❒ Falls and fractures
- ❒ Depression
- ❒ Anxiety
- ❒ Difficulty thinking clearly, concentrating and remembering things
- ❒ Urinary problems
- ❒ Weakness
- ❒ Loss of appetite
- ❒ Constipation
- ❒ Itching
- ❒ Insomnia
- ❒ Confusion and delirium
- ❒ Accidents
- ❒ Low blood pressure
- ❒ Nausea and vomiting
- ❒ Withdrawal problems such as flu-like symptoms, sweating, tremors, seizures
- ❒ Overdose

Part 7: Reasons To Quit Or Cut Down On Your Drinking

The purpose of this step is to think about the best reason for you to quit or cut down on your drinking. The reasons will be different for different people.

20. The following list identifies some of the reasons for which people decide to cut down or quit drinking. Put an X in the box by the three most important reasons that YOU want to quit or cut down on your drinking. Perhaps you can think of other reasons that are not on this list.

- ❒ To consume fewer empty calories (alcoholic drinks contain many calories).
- ❒ To sleep better.
- ❒ To maintain independence.
- ❒ To feel better
- ❒ To save money.
- ❒ To be happier.
- ❒ To reduce the possibility that I will be injured in a car crash.
- ❒ To have better family relationships.
- ❒ To participate more in community activities.
- ❒ To have better friendships.
- ❒ Other: _____

21. Write down the three most important reasons you choose to cut down or quit drinking.

A. _____

_____

B. _____

_____

C. _____

_____

22. Think about the consequences of continuing to drink heavily. Now think about how your life might improve if you decide to change your drinking habits by cutting down or quitting. What improvements do you anticipate?

A. Physical health:

B. Mental health:

C. Family:

D. Other relationships:

E. Activities:

Part 8: Alcohol Use Agreement

The purpose of this step is to decide on a drinking limit for you for a particular period of time. We will work together to come up with a plan that can work for you. A reasonable goal for some people (depending on their medical conditions and medication use/problems) is not drinking any alcohol.

Alcohol and Medication Use Plan

Date _____

_____

_____

_____

_____

_____

Client signature _____

Clinician signature _____

Alcohol Diary Card

One way to keep track of how much you drink is the use of drinking diary cards. One card is used for each week. Every day record the number of drinks you had. At the end of the week add up the total number of drinks you had during the week.

Card A

Keep Track Of What You Drink Over The Next 7 Days

Starting Date _____

	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Card B

Keep Track Of What You Drink Over The Next 7 Days

Starting Date _____

	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Medication Diary Card

One way to keep track of how much you use of a particular medication is the use of diary cards. One card is used for each week. Every day record the number of medications you used. At the end of the week, you can add up the total number of medications you used during the week.

Card A

Keep Track of the times you take your medication for the next 7 Days

Name of medication _____
Directions for use _____

	Time	Time	Time	Time
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Card B

Keep Track of the times you take your medication for the next 7 Days

Name of medication _____
Directions for use _____

	Time	Time	Time	Time
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Part 9: Handling Risky Situations

Your desire to drink may change according to your mood, the people you are with, and the availability of alcohol. Think about your last periods of drinking.

Here are examples of risky situations. The following list may help you remember situations that can result in at-risk drinking.

- social get-togethers
- sleeplessness
- anger
- boredom
- family
- watching television
- tension
- friends
- other people drinking
- feeling lonely
- criticism
- certain places
- feelings of failure
- dinner parties
- after regular daily activities
- frustration
- children and grand-children
- weekends
- use of tobacco
- TV or magazine ads
- arguments

19. What are situations that make you want to drink at a risky level. Please write them down.

A. _____

_____

B. _____

_____

C. _____

_____

WAYS TO COPE WITH RISKY SITUATIONS

It is important to figure out how you can make sure you will not go over drinking limits when you are tempted. Here are examples:

- Telephone a friend
- Call on a neighbor
- Read a book
- Go for a walk
- Watch a movie
- Participate in an activity you like

Some of these ideas may not work for you, but other methods of dealing with risky situations may work. Identify ways you could cope with the specific risky situations you listed above.

A. For the first risky situation or feeling, write down different ways of coping. _____

_____

_____

B. For the second risky situation or feeling, write down different ways of coping. _____

_____

_____

Think about other situations and ways you could cope without using alcohol.

Part 10: Visit Summary

We've covered a great deal of information today. Changing your behavior, especially drinking or medication use, can be difficult. The following pointers may help you stick with your new behavior, especially during the first few weeks when it is most difficult. If you have problems with medication overuse, we can help you consult your physician. Remember that you are changing a habit, and that it can be hard work. It becomes easier with time.

- ❒ Remember your drinking limit goal and/or medication use goal: _____
- ❒ Read this workbook frequently.
- ❒ Every time you are tempted to drink or take a medication above limits and are able to resist, congratulate yourself because you are breaking an old habit.
- ❒ Whenever you feel very uncomfortable, tell yourself that the feeling will pass.
- ❒ At the end of each week, think about how many days you have been abstinent (consumed no alcohol) or have been a light or moderate drinker.
- ❒ Some people have days during which they drink too much. If that happens to you, DON'T GIVE UP. Just start again the next day.
- ❒ You should always feel welcome to call your primary care provider for assistance, for example if you are experiencing excessive pain, anxiety, having sleepless nights or in case of an emergency.

Thanks for trying this program.

Appendix 5: Intervener Exit Form

Please complete this form at the end of each screen and brief intervention.

Screen

Negative: ___

If "negative," did you give the client a prevention pamphlet/brochure on safe use of alcohol and medications? ❒ Yes ❒ No

Positive: ____

Scores: Please indicate the score for each of the following:

- Alcohol
  - Quantity Score: _____
  - Frequency Score: _____
  - Binge Drinking: _____
- Psychoactive Medications
  - Medications for Pain: _____
  - Medications for Sleep, Anxiety, Nerves:_____
- Combination:
  - ❒ Yes ❒ No

Brief Intervention

Was the Workbook completed? ❒ Yes ❒ No

Was a plan/contract agreed upon? ❒ Yes ❒ No

What drinking limit was set? _____

What was the medication-related action step(s)? _____

What other goals or next steps were discussed? _____

Appendix 6a: Six-Month Followup Instrument-Staff

(For administration by agency/organizational staff to clients who receive a brief intervention)

Physical and Mental Health Functioning

1. In general, would you say your health is:

- ❒ Excellent (1)
- ❒ Very Good (2)
- ❒ Good (3)
- ❒ Fair (4)
- ❒ Poor (5)

The following two questions are about activities you might do during a typical day.

2. Does YOUR HEALTH NOW LIMIT YOU in MODERATE ACTIVITIES, such as moving a table, bowling, playing golf, etc.? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

3. Does YOUR HEALTH NOW LIMIT YOU in climbing SEVERAL flights of stairs? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

4. During the PAST 4 WEEKS have you ACCOMPLISHED LESS than you would like with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

5. During the PAST 4 WEEKS were you limited in the KIND of work or other activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

6. During the PAST 4 WEEKS, did you ACCOMPLISH LESS than you would like AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

7. During the PAST 4 WEEKS, did you not do work or other activities as CAREFULLY as usual AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- ❒ Not At All (1)
- ❒ A Little Bit (2)
- ❒ Moderately (3)
- ❒ Quite A Bit (4)
- ❒ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS:

9. Have you felt calm and peaceful?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

10. Did you have a lot of energy?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

11. Have you felt downhearted and blue?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

Depressed Feelings

Please choose the answer that best describes how you have felt over the past week.

13. Are you basically satisfied with your life?

- ❒ Yes (1)
- ❒ No (2)

14. Do you often get bored?

- ❒ Yes (1)
- ❒ No (2)

15. Do you often feel helpless?

- ❒ Yes (1)
- ❒ No (2)

16. Do you prefer to stay at home, rather than going out and doing new things?

- ❒ Yes (1)
- ❒ No (2)

17. Do you feel pretty worthless the way you are now?

- ❒ Yes (1)
- ❒ No (2)

Alcohol Consumption (Frequency, Quantity, and Binge Drinking)

18. In the last 3 months, have you been drinking alcoholic drinks at all (e.g., beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

❒ Yes ❒ No

If YES to Question 18, continue with Question 19.
If NO to Question 18, continue with Question 23.

19. In the last 3 months, on average how many days a week have you been drinking alcohol?

None 1 2 3 4 5 6 7

20. On a day when you have had alcohol to drink, how many drinks have you had?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 or more

21. In the last 3 months, how many times have you had: 4 or more drinks on one occasion (men); 3 or more drinks on one occasion (women)? (scale 1 to 10 or more)

None 1 2 3 4 5 6 7 8 9 10 or more

At-risk drinking =

Consumption: 14 or more drinks/week (men) = Question 24 x Question 25

10 or more drinks/week (women) = Question 24 x Question 25

Binge Drinking: 2 or more binge occasions in last 3 months (Binge=4 or more drinks/occasion for men; 3 or more drinks/occasion for women)

22. Think back over the past 30 days and report how many days, if any, you used alcoholic beverages, including beer, wine, wine coolers, malt beverages, and liquor. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

_____# of days

Medications for Pain

23. What prescription medication(s) do you take for pain?

_____

_____

If this pain medication is on the targeted list and the client answered Yes to Question 18 about the use of alcohol, this is positive for the combination of alcohol and a psychoactive medication.

If this pain medication is on the targeted list, then continue with Question 24.

If this pain medication is NOT on the targeted list, continue with Question 30.

24. In the past 3 months, how often have you used the medication(s) you mentioned for pain for reasons or in doses other than prescribed?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

If NEVER, continue with Question 30.

For any recent nonmedical pain medication use (for reasons or in doses other than prescribed), ask Questions 25-29.

25. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for pain?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

26. During the past 3 months, how often has the use of the medication(s) you mentioned for pain led to problems related to health, social, legal, or financial issues?

- ❒ Never (0)
- ❒ Once or Twice (4)
- ❒ Monthly (5)
- ❒ Weekly (6)
- ❒ Daily or Almost Daily (7)

27. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for pain you mentioned?

- ❒ Never (0)
- ❒ Once or Twice (5)
- ❒ Monthly (6)
- ❒ Weekly (7)
- ❒ Daily or Almost Daily (8)

28. Has a friend of relative ever expressed concern about your use of the medication(s) for pain you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

29. Have you ever tried and failed to control, cut down, or stop using the medication(s) for pain you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

For pain medications, add up the scores received for Questions 25-29. This is the Substance Abuse Involvement (SI) score and determines the level of risk associated with different psychoactive medications.

- 0–5: Lower Risk
- 6–26: Moderate Risk
- 27+: High Risk

Clients in the Moderate and High-Risk level should receive the Brief Intervention.

Medications for Sleep, Anxiety, Nerves, Agitation (Anxiolytics/Sedative/Hypnotics)

30. What prescription medication(s) do you take to help you fall asleep, for anxiety, for your nerves, or for feeling agitated?

_____

_____

Positive =

If this anxiolytic/sedative/hypnotic medication is on the targeted list and the client answered Yes to Question 18 about the use of alcohol, this is a positive for the combination of alcohol and psychoactive medications.

If this anxiolytic/sedative/hypnotic medication is on the targeted list, then continue with Question 31.

If this anxiolytic/sedative/hypnotic medication is NOT on the targeted list, then continue with Question 37.

31. In the past 3 months, how often have you used the medication(s) you mentioned for reasons or in doses other than prescribed?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

For any recent nonmedical use of medications for sleep, anxiety, etc. (for reasons or in doses other than prescribed), ask Question 32–36.

If NEVER, continue with Question 37.

32. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for sleep, anxiety, etc.?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

33. During the past 3 months, how often has the use of the medication(s) you mentioned for sleep, anxiety, etc. led to problems related to health, social, legal, or financial issues?

- ❒ Never (0)
- ❒ Once or Twice (4)
- ❒ Monthly (5)
- ❒ Weekly (6)
- ❒ Daily or Almost Daily (7)

34. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ Never (0)
- ❒ Once or Twice (5)
- ❒ Monthly (6)
- ❒ Weekly (7)
- ❒ Daily or Almost Daily (8)

35. Has a friend or relative ever expressed concern about your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

36. Have you ever tried and failed to control, cut down, or stop using the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

For anxiolytic/sedative/hypnotic medications, add up the scores received for Questions 37–41. This is the Substance Abuse Involvement (SI) score and determines the level of risk associated with different psychoactive medications.

- 0–5—Lower Risk
- 6–26—Moderate Risk
- 27+ —High Risk

Clients in the Moderate and High-Risk level should receive the Brief Intervention.

Social connectedness and family communication around drug use

37. Now think about the past 6 months through today. DURING THE PAST 6 MONTHS, how many times have you talked with a family member or friend about the dangers or problems associated with your use of alcohol or medications?

- ❒ a. 0
- ❒ b. 1 or 2 times
- ❒ c. A few times
- ❒ d. Many times
- ❒ e. Don't know/can't say

Perceived risk/harm of use

38. How much do you think older people risk harming themselves physically or in other ways when they have four or more drinks (three or more for females) of an ALCOHOLIC BEVERAGE once or twice a week?

- ❒ a. No risk
- ❒ b. Slight risk
- ❒ c. Moderate risk
- ❒ d. Great risk
- ❒ e. Don't know or can't say

Appendix 6b: Six-Month Followup Instrument-Self

(For self-administration by older adults)

1. In general, would you say your health is:

- ❒ Excellent (1)
- ❒ Very Good (2)
- ❒ Good (3)
- ❒ Fair (4)
- ❒ Poor (5)

The following two questions are about activities you might do during a typical day.

2. Does YOUR HEALTH NOW LIMIT YOU in MODERATE ACTIVITIES, such as moving a table, bowling, playing golf, etc.? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

3. Does YOUR HEALTH NOW LIMIT YOU in climbing SEVERAL flights of stairs? If so, how much?

- ❒ Yes, Limited A Lot (1)
- ❒ Yes, Limited A Little (2)
- ❒ No, Not Limited At All (3)

4. During the PAST 4 WEEKS have you ACCOMPLISHED LESS than you would like with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

5. During the PAST 4 WEEKS were you limited in the KIND of work or other activities AS A RESULT OF YOUR PHYSICAL HEALTH?

- ❒ Yes (1)
- ❒ No (2)

6. During the PAST 4 WEEKS, did you ACCOMPLISH LESS than you would like AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

7. During the PAST 4 WEEKS, did you not do work or other activities as CAREFULLY as usual AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

- ❒ Yes (1)
- ❒ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- ❒ Not At All (1)
- ❒ A Little Bit (2)
- ❒ Moderately (3)
- ❒ Quite A Bit (4)
- ❒ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS:

9. Have you felt calm and peaceful?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

10. Did you have a lot of energy?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

11. Have you felt downhearted and blue?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- ❒ All of the Time (1)
- ❒ Most of the Time (2)
- ❒ A Good Bit of the Time (3)
- ❒ Some of the Time (4)
- ❒ A Little of the Time (5)
- ❒ None of the Time (6)

Please choose the answer that best describes how you have felt over the past week.

13. Are you basically satisfied with your life?

- ❒ Yes (1)
- ❒ No (2)

14. Do you often get bored?

- ❒ Yes (1)
- ❒ No (2)

15. Do you often feel helpless?

- ❒ Yes (1)
- ❒ No (2)

16. Do you prefer to stay at home, rather than going out and doing new things?

- ❒ Yes (1)
- ❒ No (2)

17. Do you feel pretty worthless the way you are now?

- ❒ Yes (1)
- ❒ No (2)

18. In the last 3 months, have you been drinking alcoholic drinks at all (e.g., beer, wine, wine cooler, sherry, gin, vodka, or other hard liquor)?

❒ Yes ❒ No

If YES to Question 18, continue with Question 19.
If NO to Question 18, continue with Question 23.

19. In the last 3 months, on average how many days a week have you been drinking alcohol?

None 1 2 3 4 5 6 7

20. On a day when you have had alcohol to drink, how many drinks have you had?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 or more

21. In the last 3 months, how many times have you had: 4 or more drinks on one occasion (men); 3 or more drinks on one occasion (women)? (scale 1 to 10 or more)

None 1 2 3 4 5 6 7 8 9 10 or more

22. Think back over the past 30 days and report how many days, if any, you used alcoholic beverages, including beer, wine, wine coolers, malt beverages, and liquor. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

_____# of days

23. What prescription medication(s) do you take for pain?

_____
_____

If this pain medication is on the targeted list, then continue with Question 24.
If this pain medication is NOT on the targeted list, continue with Question 30.

24. In the past 3 months, how often have you used the medication(s) you mentioned for pain for reasons or in doses other than prescribed?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

If answer is NEVER, continue with Question 30.
If answer is Once or Twice, Monthly, Weekly, Daily or Almost Daily, continue with Questions 25–29.

25. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for pain?

- ❒ Never (0)

- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

26. During the past 3 months, how often has the use of the medication(s) you mentioned for pain led to problems related to health, social, legal, or financial issues?

- ❒ Never (0)
- ❒ Once or Twice (4)
- ❒ Monthly (5)
- ❒ Weekly (6)
- ❒ Daily or Almost Daily (7)

27. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for pain you mentioned?

- ❒ Never (0)
- ❒ Once or Twice (5)
- ❒ Monthly (6)
- ❒ Weekly (7)
- ❒ Daily or Almost Daily (8)

28. Has a friend of relative ever expressed concern about your use of the medication(s) for pain you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

29. Have you ever tried and failed to control, cut down, or stop using the medication(s) for pain you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

30. What prescription medication(s) do you take to help you fall asleep or for anxiety or for your nerves or for feeling agitated?

_____

_____

If this medication is on the targeted list, then continue with Question 31.

If this medication is NOT on the targeted list, then continue with Question 37.

31. In the past 3 months, how often have you used the medication(s) you mentioned for reasons or in doses other than prescribed?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

If answer is NEVER, continue with Question 37.

If answer is Once or Twice, Monthly, Weekly, Daily or Almost Daily, continue with Questions 32-36.

32. In the past 3 months, how often have you had a strong desire or urge to use the medication(s) you mentioned for sleep, anxiety, etc.?

- ❒ Never (0)
- ❒ Once or Twice (2)
- ❒ Monthly (3)
- ❒ Weekly (4)
- ❒ Daily or Almost Daily (6)

33. During the past 3 months, how often has the use of the medication(s) you mentioned for sleep, anxiety, etc. led to problems related to health, social, legal, or financial issues?

- ❒ Never (0)
- ❒ Once or Twice (4)
- ❒ Monthly (5)
- ❒ Weekly (6)
- ❒ Daily or Almost Daily (7)

34. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ Never (0)
- ❒ Once or Twice (5)
- ❒ Monthly (6)
- ❒ Weekly (7)
- ❒ Daily or Almost Daily (8)

35. Has a friend or relative ever expressed concern about your use of the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

36. Have you ever tried and failed to control, cut down, or stop using the medication(s) for sleep, anxiety, etc. you mentioned?

- ❒ No, Never (0)
- ❒ Yes, but not in the past 3 months (3)
- ❒ Yes, in the past 3 months (6)

37. Now think about the past 6 months through today. DURING THE PAST 6 MONTHS, how many times have you talked with a family member or friend about the dangers or problems associated with your use of alcohol or medications?

- ❒ a. 0
- ❒ b. 1 or 2 times
- ❒ c. A few times
- ❒ d. Many times
- ❒ e. Don't know/can't say

38. How much do you think older people risk harming themselves physically or in other ways when they have four or more drinks (three or more for females) of an ALCOHOLIC BEVERAGE once or twice a week?

- ❒ a. No risk
- ❒ b. Slight risk
- ❒ c. Moderate risk
- ❒ d. Great risk
- ❒ e. Don't know or can't say

Appendix 7: Self-Assessing Readiness for Implementing Evidence-based Health Promotion and Self-Management Programs

NCOA Center for Healthy Aging Tool

The following set of questions provides a framework for discussions within a community aging service provider organization or, more appropriately, among partnering organizations, interested in offering evidence-based health promotion and self-management programming. The tool focuses specifically on how to assess "readiness" to proceed with implementation. There are four key questions that should be addressed when determining whether an agency/partnership is ready to begin implementing evidence-based health programs. The answers to these questions will help estimate potential for success with these types of projects. Ideally, organizations and partners will have a positive response to each question before moving forward with implementation. If not, they can work on enhancing readiness by addressing those areas that still need attention.

1. Is the agency/partnership willing to do evidence-based health programs and stay true to the model(s) being implemented? The organizations:
   - Can distinguish between evidence-based health programs and other programs
   - Can build off existing health programming experience
   - Can gain and keep the support of healthcare organizations
   - Can preserve fidelity to key interventions and provide quality control while making necessary modifications.

2. Is there funding for the program? New funding and/or willingness to reallocate current resources to support evidence-based health programming. The organizations:
   - Can secure sustainable funding for evidence-based health promotion and self-management programs
   - Can engage a variety of funders in the importance of evidence-based health programs
   - Can reallocate current funds to support new evidence-based health programs
   - Can meet the demands of continuously increasing numbers of program participants.

3. Is there access both to personnel with the expertise to do these programs and to the population that needs these programs? The organizations:
   - Can recruit and retain staff or contractors who have knowledge of specific health promotion and self-management topic(s) and/or behavior change methods
   - Can recruit and retain lay leaders, peer supporters, and other "volunteers"
   - Can draw upon appropriate experts to offer introductory and followup training and guidance
   - Can attract the target population and continue to recruit on an ongoing basis
   - Can offer programming at times and places that are convenient for the target population.

4. Is there buy-in from senior leadership and key partners as reflected in both programmatic and financial support? The organizations:
   - Can ensure that programs receive necessary time and attention by knowledgeable staff and agency leaders
   - Have boards that are aware of move to evidence-based health programming and are supportive
   - Have partners that can commit existing funds or have identified new funding to build and sustain the program.

Appendix 8: SBI Implementation Decisions

Organizations preparing to implement the SBI for older adults described in this Guide need to make several important decisions in planning the implementation and establishing the organizational SBI protocol. These decisions should be made in conjunction with SBI leader training.

1. **Prescreen. Will the organization conduct prescreening?** Universal prescreening is recommended for all people age 55 and older. Organizations may prescreen all older adults with whom they have contact. Participants must be able to understand and respond to the prescreening questions. This Guide recommends a set of five prescreening questions and provides guidance on a positive prescreen that is followed by a full screen.

   When using prescreening questions, organizations should suggest language for the staff to use before the prescreen as well as after the questions. What, if anything, should be said if the prescreen is negative? How will a person be offered the full screen if the prescreen is positive? How will the arrangement be made for the screening? Something simple is best.

2. **Decide how to proceed when the name of the prescribed psychoactive medication is not available.** If an individual is taking a prescription medication for pain, sleep, or anxiety but does not know the name of the medication, an organization may ask the person to get the name of the medication(s) and go through the prescreen again. Or an organization may decide to ask the person to get the name of the medication(s), skip the prescreen, and offer the full screening to the person.

3. **Screening.** What screening instrument will the organization use? This Guide offers a broad screening instrument composed of several sections (see Appendix 2b). Identified in the following table are question groups from this screening instrument that are either required or optional.

4. **Set Scores for Positive Screen To Offer Brief Intervention.** The screening instrument in this Guide identifies at risk drinking recommendations for setting "positive screen scores" that should trigger an organization to offer the brief intervention. Individuals should be offered the brief intervention if they have:

   - Positive Alcohol Consumption Scores: 14 or more drinks/week (men); 10 or more drinks/week (women)

   OR

   - Binge Drinking: 2 or more binge occasions in last 3 months (binge = 4 or more drinks/occasion for men; 3 or more drinks/occasion for women).

   Organizations have the option to set a lower score for a positive screen to offer individuals the brief intervention. Organizations may not want to make the score lower than the NIAAA recommended limit for alcohol consumption for older adults.

   A person may also screen positive to receive a brief intervention if he/she has consumed any alcohol in last 3 months and takes prescription medications for pain, sleep, or anxiety as noted on the screening instrument.

   The screening instrument also includes recommendations for when an individual should receive a brief intervention based on their Substance Abuse Involvement (SI) score for the use of psychoactive medications.

5. **Decide who will offer the prescreen, screen, and brief intervention.** Section II of this Guide identifies the broad range of professionals who may conduct screening and offer the brief intervention.

6. **Decide what consumer education materials will be used and when they will be offered.** Appendix 3 of this Guide is a list of consumer materials/resources on the safe use of alcohol and prescription medications. Program staff is encouraged to provide these materials to everyone who is prescreened or screened as a means of offering public health education.

7. **Prepare step for addressing illicit drug use.** The SBI in this Guide does not address illicit drug use. If an individual indicates he/she uses illicit drugs and wants help for overcoming the use, the organization may encourage the individual to get an assessment through a referral to a substance abuse counselor or treatment facility.

8. **Will the organization use a brief intervention workbook?** While a brief intervention can be conducted without a workbook, it is recommended that program staff use of the "Health Promotion Workbook" (see Appendix 4). For the SBI to be offered with fidelity, all of the sections of the workbook are required.

9. **Confirm or establish referral protocols.** Organizations need to have substance abuse assessment and treatment specialists available for referral and protocol for "a warm handoff" if the client is willing to be referred. Organizations will use their established referral mechanisms to help individuals with other needs, such as benefits, housing, transportation, etc. that may be identified through the screening and/or brief intervention.

Screening Instrument Question Groups for Appendix 2b Screen

Focus of Questions	Screening Question Numbers	Source of Questions	Comments	What is being measured/collected?
Demographics	1–5	SAMHSA/ CSAP National Outcome Measures	Optional. Demographic questions are not required for SBI. Organizations may desire to use their own demographic questions or those offered here for program assessment or evaluation.	Measures basic demographics: age, gender, race, ethnicity, and education.
Physical and Mental Health Functioning	6–17	SF-12	Optional. Organizations may desire to use their own functioning questions or those offered here for program assessment/ evaluation.	Measures self-report of overall physical and mental health functioning and health-related quality of life. Useful in monitoring changes in function and quality of life based on changes in alcohol/psychoactive medication use.
Depressed Feelings	18–22	Geriatric Depression Scale (GDS) – Short Version (5 questions)	Optional. Organization may desire to use this instrument or another valid instrument, such as PHQ 9 or 10. Depressed feelings are questioned when the organization intends to make referrals for depression assessment and/or symptom management. Organization may wish to track for program assessment/evaluation.	Screen for signs and symptoms of depression. The five questions have been shown to be as effective as the 15-item Geriatric Depression Scale for screening for depression.
Alcohol Consumption (Frequency, Quantity, and Binge Drinking)	23–27	Question 27 is from the SAMHSA/ CSAP National Outcome Measures	Valid Alcohol Use Screen Required. Organization may use the screen presented in this Guide, the Short Michigan Alcoholism Test - Geriatric Version, or the AUDIT instrument. If an organization is not asking the questions above or others, it is recommend that some neutral or "softer question" be asked before the alcohol consumption questions. Question 27 is optional.	Measures at-risk drinking based on frequency (Question 24) and quantity of drinking (Question 25), and binge drinking episodes (Question 26). At-risk drinking will determine need for brief intervention.
Medications for Pain	28–34	Adapted from the NIDA-Modified ASSIST	Required for SBI with Psychoactive Medication component. Used for scoring.	Measures the Substance Abuse Involvement (SI) score and determines the level of risk associated with psychoactive pain medications, specifically, opioid analgesic medications. Level of risk determines need for brief intervention.
Medication for Sleep, Anxiety, Nerves, Agitation (Anxiolytics, Sedative, Hypnotics)	35–41	Adapted from the NIDA-Modified ASSIST	Required for SBI with Psychoactive Medication component. Used for scoring.	Measures the Substance Abuse Involvement (SI) score and determines the level of risk associated with psychoactive medications for insomnia, anxiety/ panic, and agitation, specifically, benzodiazepines and barbiturates. Level of risk determines need for brief intervention.
Social Connectedness and Family Communication Around Drug Use	42	SAMHSA/ CSAP National Outcome Measures	Optional. Useful for identifying potential problems.	Measures family communication around alcohol and psychoactive medication use.
Perceived Risk/ Harm of Use	43	SAMHSA/ CSAP National Outcome Measures	Optional. For use as pre/post knowledge/ perception question.	Measures perceived risk and harm from using alcohol.

10. **Establish Followup Protocol.** Organizations may have in place or set guidelines for followup for purposes of encouraging an individual to modify risky behavior. An organization may also set followup for 6 months or other time period for purposes of conducting a program assessment or evaluation.

11. **Identify who should be contacted by staff for assistance with clinical questions.**

12. **Identify materials to be reviewed by staff.** It is recommended that staff review this Guide and its appendices, as well as the free SAMHSA publication *Substance Abuse Among Older Adults: A Guide for Social Service Providers—TIP 26 Concise Desk Reference Guide*. This publication gives social service providers an overview of alcohol abuse, and abuse of prescription drugs and over-the-counter drugs by the elderly. It also addresses screening, assessment, referral, and treatment for seniors, and discusses outcomes and cost, and ethical and legal issues. Also Physicians Guide available. See *store.samhsa.gov* for ordering.

13. **What level of practice sessions on brief intervention will the organization require?** It is recommended that 10 productive practices with peers are needed to prepare an individual to conduct a brief intervention.

Appendix 9-Initial Staff Survey

This survey should be completed by staff conducting screening and/or brief interventions for alcohol and psychoactive medication misuse/abuse for older adults.

DIRECTIONS: The following questions ask you to provide information about yourself. Please fill in the blank or check the appropriate response for each question.

1. What is your age? _____

2. What is your gender?

- ❒ Male
- ❒ Female

3. What is your race?

- ❒ American Indian or Alaska Native
- ❒ Asian
- ❒ Black or African American
- ❒ Native Hawaiian or Other Pacific Islander
- ❒ White

4. What is your ethnicity?

- ❒ Hispanic or Latino
- ❒ Not Hispanic or Latino

5. Which of the following best describes your job position?

- ❒ Social Worker
- ❒ Case manager
- ❒ Home health care provider
- ❒ Senior center employee
- ❒ Nurse/Nurse Practitioner
- ❒ Other (specify: _____)

6. How many years have you been in practice?

_____Years

7. How satisfied are you with the ability of the staff at your site to address the needs of clients with alcohol and/or psychoactive medication misuse?

- ❒ Extremely satisfied
- ❒ Pretty satisfied
- ❒ Somewhat satisfied
- ❒ Slightly satisfied
- ❒ Not at all satisfied

8. Are there programs/services available in your community where you can refer clients who have more serious problems related to their use of alcohol and/or psychoactive medications?

- ❒ Yes
- ❒ No

9. Have you had any training related to alcohol and/or psychoactive medications?

- ❒ Yes
- ❒ No

10. Have you had any direct experience providing services related to alcohol and/or psychoactive medication use?

- ❒ Yes
- ❒ No

11. How comfortable are you being the "first-line" response for people with alcohol and psychoactive medication misuse?

- ❒ Extremely comfortable
- ❒ Pretty comfortable
- ❒ Somewhat comfortable
- ❒ Slightly comfortable
- ❒ Not comfortable

12. What impact does working with clients who have alcohol/psychoactive medication misuse have on your satisfaction with your job?

- ❒ Very positive impact
- ❒ Positive impact
- ❒ No impact
- ❒ Negative impact
- ❒ Very negative impact

Thank you for completing this survey. Your time is greatly appreciated.

Appendix 10: Staff Satisfaction Survey

It is recommended that this survey should be completed every 6 months by staff conducting screenings and/or brief terventions. Your feedback is important to us. Please answer each question below.

1. How often do you use alcohol/psychoactive medication use screening protocols from the screening and brief intervention (SBI) program?

☐ Daily ☐ More than once a week ☐ Weekly ☐ A few times a month ☐ Monthly ☐ Less than once a month ☐ Never

2. How would you rate your satisfaction with use of the alcohol/psychoactive medication use screening protocols from the SBI program?

☐ Extremely Satisfied ☐ Pretty Satisfied ☐ Somewhat Satisfied ☐ Slightly Satisfied ☐ NOT at All Satisfied

3. How often do you use alcohol/psychoactive medication use brief intervention protocols from the SBI program?

☐ Daily ☐ More than once a week ☐ Weekly ☐ A few times a month ☐ Monthly ☐ Less than once a month ☐ Never

4. How would you rate your satisfaction with use of the alcohol/psychoactive medication use brief intervention protocols from the SBI program?

☐ Extremely Satisfied ☐ Pretty Satisfied ☐ Somewhat Satisfied ☐ Slightly Satisfied ☐ NOT at All Satisfied

5. How helpful has the use of alcohol/psychoactive medication screening and brief intervention protocols been for your clients at your site?

☐ Extremely Helpful ☐ Pretty Helpful ☐ Somewhat Helpful ☐ Slightly Helpful ☐ NOT at All Helpful

6. To what extent do you agree with the following statement? I would recommend to my colleagues that they use SBI screening techniques with their clients.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree

7. To what extent do you agree with the following statement? I would recommend to my colleagues that they use SBI brief intervention techniques with their clients.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree

8. How helpful would additional training be for the staff at your site regarding prevention and early identification of alcohol and psychoactive medication misuse?

☐ Extremely ☐ Pretty Helpful ☐ Somewhat Helpful ☐ Slightly Helpful ☐ NOT at All Helpful

9. If you think additional training for staff would be helpful, what specific training(s) do you think would be most beneficial?

10. To what extent do you agree with the following statement? The use of the SBI screening and brief intervention increases ease of access to alcohol/drug services for the clients that my site serves.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree

11. How satisfied are you with the ability of the staff at your site to address the needs of clients with alcohol/psychoactive medication misuse?

☐ Extremely Satisfied ☐ Pretty Satisfied ☐ Somewhat Satisfied ☐ Slightly Satisfied ☐ NOT at All Satisfied

12. How comfortable are you being the "first-line" response for people with alcohol and/or psychoactive medication misuse issues?

❐ Extremely Comfortable ❐ Pretty Comfortable ❐ Somewhat Comfortable ❐ Slightly Comfortable ❐ NOT at All Comfortable

13. What impact does working with clients who have alcohol and/or psychoactive medication misuse issues have on your satisfaction with your job?

❐ Very positive impact ❐ Positive impact ❐ No impact ❐ Negative impact ❐ Very negative impact

14. What are the most important aspects of your site's SBI program?

	Not Important	Minimally Important	Somewhat Important	Very Important	Most Important
A. Reduction of stigma among clients when receiving help for alcohol/psychoactive medication misuse	❐	❐	❐	❐	❐
B. Empowering clients to make change through the use of Brief Preventive Interventions for Alcohol and/or Psychoactive Prescription Medications	❐	❐	❐	❐	❐
C. Increased comfort among staff working with clients about issues related to alcohol and/or psychoactive medication use	❐	❐	❐	❐	❐
D. Staff gain new expertise in working with clients about their use of alcohol and/or psychoactive medications	❐	❐	❐	❐	❐
E. Other (please specify)	_____				

15. What things could be changed to improve the SBI Project at your site?

Thank you for your time to complete this survey.

Appendix 11: Organizational Baseline Survey

This survey is designed to collect information on the structure of the implementation sites, including the characteristics of the site, staffing, services available, communication approaches, and clients served.

Suggested personnel to complete this survey:

Director/manager

Clinical supervisor

Financial manager

Section 1: Site Organization

A. Characteristics of Organization/Agency

Site name _____

Mailing Address _____

Phone _____

Questionnaire completed by (name and title) _____

1. How long has this site been in operation?

2. This study site is primarily

- ❒ Urban
- ❒ Rural
- ❒ Suburban

3. This site is best described as (check all that apply):

- ❒ Area Agency on Aging
- ❒ County health department
- ❒ Educational institution (community college, university, extension program)
- ❒ Faith-based organization (church, synagogue)
- ❒ Healthcare organization (hospital, community health clinic, adult day health center)
- ❒ Library
- ❒ Multipurpose social services organization (community center, nutrition site)
- ❒ Recreational organization
- ❒ Residential facility (senior housing, assisted or independent living)
- ❒ Senior center (including Councils on Aging)
- ❒ Tribal center
- ❒ Workplace (any location where the program is provided to employees)
- ❒ Other, please specify: _____

4. The tax status of this site is:

- ❒ Private for profit
- ❒ Private not for profit
- ❒ Public

B. Human Resources/Staffing

1. How many full-time equivalent (FTE) employees are at this site?
Please indicate how many of the following types of personnel currently work in your program?

	Total number employed	Total FTE
a. Psychologists		
b. Physician assistants (PAs)		
c. Psychiatric nurse practitioners (NPs, CRNPs)		
d. Psychiatric clinical nurse specialists		
e. Psychiatrists (MDs or DOs)		
f. General medical physicians (e.g., internists)		
g. Other general medical clinicians (e.g. NPs)		
h. Registered nurses (RNs)		
i. Social workers		
j. Case Managers		
k. Addiction specialists or substance use counselors		
l. Health educators		
m. Other service staff		
n. Other staff (e.g., administrative or clerical staff)		

2. What is the average length of time your professional staff has worked for this organization/agency?

3. What is the race of your staff? Please indicate percentages below.

	Professional (Admin; Social Worker; Case Manager, etc.)	Other Staff (Tech, Aides, etc.)	Total
a. American Indian or Alaska Native	% _____	% _____	% _____
b. Asian	% _____	% _____	% _____
c. Black or African American	% _____	% _____	% _____
d. Native Hawaiian or Other Pacific Islander	% _____	% _____	% _____
e. White	% _____	% _____	% _____

4. What is the ethnicity of your staff? Please indicate percentages below.

	Professional (Admin; Social Worker; Case Manager, etc.)	Other Staff (Tech, Aides, etc.)	Total
Hispanic or Latino	% _____	% _____	% _____

Section 2: Services

Please check all types of service options that are currently available within your organization/agency for older adults.

- ❒ a. General case management
- ❒ b. Social service evaluation
- ❒ c. Mental health intensive case management
- ❒ d. Information and assistance
- ❒ e. Home care
- ❒ f. Family education and counseling
- ❒ g. Specific Evidence-Based Practices (e.g., depression, physical activity, Chronic Disease Self-Management Program, other):Specify type: _____
- ❒ h. Other (specify) _____

Section 3: Communication And Referrals

1. Are there regular staff/team meetings?
   ❒ Yes ❒ No

2. If yes, what is the frequency of these meetings? _____

3. If yes, what team member is designated to facilitate the meetings? _____

4. Are there programs/services available in your community where you can refer clients who have more serious problems related to their use of alcohol/psychoactive medications?
   ❒ Yes ❒ No

5. What percentage of clients does your site currently refer to a substance abuse provider? _____

6. How often do you have difficulty arranging an appointment for one of your clients with a substance use disorder specialist (e.g., addiction specialist, psychologist, etc.)?
   ❒ Never
   ❒ Rarely
   ❒ Sometimes
   ❒ Always

Section 4: Clients

1. How many clients does your organization serve in a year? _____

2. In a typical week, how many client visits/appointments occur? _____

3. Does your site serve a culturally diverse population?
   ❒ Yes ❒ No

4. If yes, which of the following does your organization/agency do?
   ❒ Hire racially, culturally, and linguistically diverse staff for the population you serve
   ❒ Use ethnically specific media to perform outreach appropriate to the population mix
   ❒ Other approaches to reach and serve an ethnically diverse population.
   ❒ Please specify:_____

5. Which languages do your clients speak? _____

6. What percentage of staff speaks a language (other than English) that is spoken by clients?_____

7. Does your site hire staff from within the community you serve?
   - ❒ Yes ❒ No

8. General Client Demographics: Please indicate the percentage for each item below.

	% Males	% Females
Age		
< 50	% _____	% _____
51–60	% _____	% _____
61–70	% _____	% _____
71–80	% _____	% _____
81+	% _____	% _____
Race		
American Indian or Alaska Native	% _____	% _____
Asian	% _____	% _____
Black or African American	% _____	% _____
Native Hawaiian or Other Pacific Islander	% _____	% _____
White	% _____	% _____
Ethnicity		
Hispanic or Latino	% _____	% _____
Not Hispanic or Latino	% _____	% _____

Section 5: Client Record

1. Are your client records computerized?
   - ❒ Fully computerized
   - ❒ Part of the records are computerized
   - ❒ Paper records are used exclusively

2. Are billing data integrated into documentation of client contacts?
   - ❒ Fully integrated, with professional staff putting billing code on their note
   - ❒ There is some integration, but billing is separate
   - ❒ Billing is completely separate from staff documentation

3. Which of the following items will you be able to provide in a semiannual report for the SAMHSA Substance Abuse Prevention Older Americans Technical Assistance Center Project evaluation. (Check all that apply.)
   - ❒ Number of clients at your site
   - ❒ Number of clients at your site who are screened for alcohol/psychoactive medication misuse
   - ❒ Number of clients at your site who receive brief interventions
   - ❒ Number of clients at your site who are referred to substance abuse assessment/treatment provider
   - ❒ Number staff participating in the SAMHSA project

- ❒ Number of clients who receive the 6-month followup for the SAMHSA project

Please provide any additional comments about your site and participation in the SAMHSA Substance Abuse Prevention Older Americans Technical Assistance Center Project:

Thank you for your time to complete this survey.

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