**TIP 26**

**TREATING SUBSTANCE USE DISORDER IN OLDER ADULTS**

Chapter 2—Principles of Care for Older Adults

* Incorporating age-sensitive and age-speciﬁc treatment practices into your program is important for engaging older clients and improving their retention in treatment.
* The older adult population is culturally, racially, and ethnically diverse. Recognize and address diversity and health disparity issues related to aging.
* Collaboration among service providers across settings is essential when working with older adults who misuse substances, particularly for those with co-occurring medical conditions and mental disorders.
* Hiring, training, and retaining staff who demonstrate high motivation and

commitment to serving older adults are vital to successfully implementing substance

use disorder (SUD) treatment programs and services for this population.

**KEY MESSAGES**

**Chapter 2 of this Treatment Improvement Protocol (TIP) will most beneﬁt healthcare, mental health, addiction treatment, and social service providers who work with older adults.** It addresses principles of care for older clients who present across settings with substance misuse.

By tailoring traditional treatment methods and adopting age-speciﬁc, age-sensitive, science- informed interventions, providers can better fulﬁll the needs of a growing population of older adults who misuse substances. Older adults receive services in many settings besides SUD treatment programs: mental health service programs, primary care practices, emergency departments, senior centers, adult day programs, faith-based organizations, and assisted living and residential

care facilities. Across settings, early identiﬁcation, universal screening, and education for substance misuse can facilitate brief intervention and referral to treatment.

# Organization of Chapter 2 of This TIP

**Chapter 2 addresses the general principles of care—across service settings—for older adults with a history of substance misuse. The following are essential principles of care:**

* Understand the developmental issues of aging.
* Acknowledge and address the diversity among older adults.
* Recognize the difference between early- and late-onset SUDs among older adults.
* Emphasize client education, early identiﬁcation, screening, and brief treatment.
* Engage in health risk reduction practices.
* Provide person-centered care.
* Build alliances with older clients; use age- sensitive strategies to engage/retain them in treatment.
* Help older clients use social networks and community-based services.
* Encourage family and caregiver involvement.
* Coordinate care and develop service linkages.
* Make programmatic changes to effectively serve older adults with SUDs.
* Invest in age-sensitive workforce development.

**Chapter 2 concludes with a list of targeted resources to support the delivery of older adult– focused services to address substance misuse.**

A more detailed resource guide is available in Chapter 9 of this TIP.

Exhibit 2.1 provides deﬁnitions for key terms that appear in Chapter 2.

## EXHIBIT 2.1. Key Terms

* + **Addiction\*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and

recovery.

* + **Age-sensitive:** Adaptations to existing treatment approaches that accommodate older adults’ unique needs (e.g., a large-print handout on the signs of substance misuse).
	+ **Age-speciﬁc:** Treatment approaches and practices speciﬁcally developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
	+ **Alcohol misuse:** The use of alcohol in any harmful way, including heavy drinking, binge drinking, and alcohol use disorder (AUD).
	+ **At-risk/high-risk drinking:** Drinking alcohol in excessive amounts. This deﬁnition encompasses both binge drinking and heavy drinking. Additionally, any alcohol consumption is considered risky when

carried out by individuals with certain medical conditions that are worsened by alcohol, those taking medicine that can interact harmfully with alcohol, those driving a car or engaged in other activities that require alertness, or people recovering from AUD. 223,224 Note that for purposes of this TIP, at-risk drinking and high-risk drinking are synonymous and either term is acceptable to describe an older adult’s drinking patterns.

* + **Binge drinking:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and ﬁve or more drinks

for men.225,226 However, older adults are more sensitive to the effects of alcohol, and treatment providers may need to lower these numbers when screening for alcohol misuse.227 Additionally, other factors such as weight, decrease in enzyme activity, and body composition (e.g., amount of muscle tissue present in the body) can also affect alcohol absorption rates.

* + **Caregivers:** Informal caregivers provide unpaid care. They assist others with activities of daily living (ADLs), including health and medical tasks. Informal caregivers may be spouses, partners, family

members, friends, neighbors, or others who have a signiﬁcant personal relationship with the person who needs care. Formal caregivers are paid providers who offer care in one’s home or in a facility.228 Most older adults do not need caregivers and are as able to address their own needs as younger adults, whether or not substance misuse is a factor in their lives.

* + **Drug–drug interaction:** The interaction of one substance (e.g., alcohol, medication, an illicit drug) with another substance. Drug–drug interactions may change the effectiveness of medications, introduce

or alter the intensity of side effects, and increase a substance’s toxicity or the concentration of that substance in a person’s blood. Potentially serious interactions can also occur with certain foods, beverages, and dietary supplements.229

* + **Drug use:** The full range of severity of illicit drug use, from a single instance of use to meeting criteria for a drug use disorder.
	+ **Heavy drinking:** Consuming ﬁve or more drinks for men and four or more drinks for women in one period on each of 5 or more days in the past 30 days.230
	+ **Moderate drinking:** According to the 2015–2020 *Dietary Guidelines for Americans*, moderate drinking is deﬁned as up to two drinks per day for men and up to one drink per day for women.231,232 However, the

Centers for Disease Control and Prevention (CDC) notes that these numbers apply to any given day and are not meant as an average over several days.233 Additionally, individuals who don’t metabolize alcohol well may need to consume even lower quantities. Some people, particularly those with certain alcohol- related illnesses or engaging in tasks requiring concentration, should not consume alcohol at all. The *Dietary Guidelines* stipulate that those who don’t drink should not begin drinking for any reason.234

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* + **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups

consist entirely of people who volunteer their time and typically have no ofﬁcial connection to treatment programs. Most are self-supporting. Although 12-Step groups such as Alcoholics Anonymous and Narcotics Anonymous are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups afﬁliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART [Self-Management and Recovery Training] Recovery, Women for Sobriety).

* + **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring

training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.

* + **Recovery\*:** A process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can,

with help, overcome them and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, prosocial feature.

* + **Relapse\*:** A return to substance use after a signiﬁcant period of abstinence.
	+ **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease or disorder. The ﬁfth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) deﬁnes remission

as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).235 Remission is an essential element of recovery.

* + **Substance misuse\*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would

constitute misuse (e.g., underage drinking, injection drug use).

* + **Substance use disorder\*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,236 SUDs are characterized by clinically signiﬁcant impairments in health and social

function, and by impaired control over substance use. They are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors inﬂuence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. Note: A severe SUD is commonly called an addiction. A mild SUD is generally equivalent to what previous editions of DSM called substance abuse; a moderate or severe SUD is generally equivalent to what was formerly called substance dependence.

\* The deﬁnitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health.* This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (https://addiction.surgeongeneral.gov/sites/default/ﬁles/surgeon-generals-report.pdf).

# General Principles of Care

Older adults tend to do as well as or better than younger adults in mixed-age SUD treatment.237,238 Moreover, growing evidence links age-speciﬁc treatment to better treatment adherence and long-term outcomes for many older adults.239 Even so, only about 23 percent of SUD treatment programs in the United States offer a program or group speciﬁcally tailored to older adults.240

**Few SUD treatment approaches are designed speciﬁcally for older adults. Therefore, this TIP provides general principles of care that can inform a ﬂexible approach for age-sensitive, age-speciﬁc treatment** of substance misuse

among older adults. The principles are a framework to guide your work with older adults across settings to address issues related to their misuse of substances.

## Understand the Developmental Issues of Aging

**Older adults are not a homogenous group.** As with any group, older adults may hold a diverse range of opinions and attitudes toward alcohol and drug use. For example, within the older adult population, **people in various age ranges differ from one another in signiﬁcant ways that may**

**inﬂuence which approaches will most successfully address substance misuse.**

**Earlier cohorts of older adults (e.g., adults born before or during World War II) are more likely to have moralistic attitudes about drinking and drug use—**attitudes that, for some, were shaped by Prohibition and the Temperance Movement.241 They may feel deeply ashamed about alcohol

misuse or drug use. If they attribute their substance

misuse to a moral failing, they may be less likely to seek SUD treatment.242 These cohorts are likelier to **beneﬁt from screening and brief intervention with a healthcare provider when questions about drinking and drug use are part of an overall approach to health assessments.**

**Baby boomers (i.e., adults born between 1946 and 1964)** grew up in a time when substance use was more culturally acceptable. They **may have more permissive attitudes toward drinking and drug use. They are also more likely to be willing to seek and agree to specialized addiction treatment.**243

**Older adults have unique developmental challenges that younger adults may not have.** These include possibly losing a spouse or partner, as well as experiencing:

* Increasing numbers of deaths of friends in the same age cohort.
* Role changes in families and work-related activities.
* Reduced opportunities for increasing or maintaining income levels.
* Normal age-related cognitive and physical decline leading to loss of functioning and reduced capacity to carry out ADLs.244

**Providing age-sensitive, age-speciﬁc treatment approaches helps older adults feel more comfortable** discussing personal issues and age- related changes than they would feel doing so in mixed-age treatment programs.245 Whether or not you can offer age-speciﬁc treatment options, your program needs to **create an environment that responds to older adults’ needs** (Exhibit 2.2).

## EXHIBIT 2.2. How Administrators Can Create a Treatment Environment Responsive to Older Adults246

Older adults have speciﬁc developmental needs. To create an environment that is responsive to older adults’ needs, the entire organization, not just providers, must be committed to this purpose. Some of the strategies administrators can use to create an age-sensitive treatment or service environment include:

* + Make a commitment to understanding the developmental needs and cohort differences.
	+ Review and update your vision and mission statement to reﬂect your commitment to older adults.
	+ Conduct an organizational self-assessment of attitudes, knowledge, and skills needed to effectively respond to older adults in your program.
	+ Conduct an organizational self-assessment of the physical environment and other barriers to access that must be addressed to provide services to older adults.
	+ Address organization-wide competence in the developmental needs of older adults and cohort differences in your strategic planning process.
	+ Assign one staff member to oversee the development of age-speciﬁc practices and services.
	+ Develop an advisory board or task group with older adult members from the community.
	+ Engage clients, staff, and community members in planning/developing age-speciﬁc services and programs.
	+ Develop and review policies and procedures to ensure that all staff are responsive to older adults’ needs.
	+ Create an older adult-friendly environment that enhances engagement and retention of clients.
	+ Develop outreach strategies to improve access to care.

**The consensus panel recommends that you engage your clients in discussions about their attitudes toward substance misuse, create an age-sensitive treatment environment that is responsive to older adults, and offer age-speciﬁc treatment options when possible.**

## Acknowledge and Address Older Adults’ Diversity

The older adult population is as culturally diverse as other age groups. Yet **older adults who are members of racial/ethnic and other minority groups are often at greater risk of poor health, disability, social isolation, and poverty** than

are their younger counterparts. Older adults from diverse racial and ethnic backgrounds are also more likely to be underinsured and receive fewer routine screenings for health concerns.247 Therefore, they face more barriers to accessing health care and experience greater health disparities.248 These **disparities increase risk for developing SUDs and increase barriers to treatment.**

Higher rates of deaths, disability, and chronic illness are more common among older adults who identify with diverse racial and ethnic groups.249

**Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) older adults may experience poor health care and lack of access to services.** Given discrimination and prejudice, they may have to hide, or feel the need to hide, their LGBTQ identity to receive care.250

**Gender-related disparities can create or compound health disparities in older adults.** Older women are at higher risk for co-occurring mental disorders and social isolation than older men.251 They are also more likely to be prescribed medications (e.g., benzodiazepines) that negatively interact with alcohol and to be prescribed them

for longer periods of time, increasing the risk of SUDs.252

**OLDER WOMEN**


### are at higher risk for

**CO-OCCURRING**

### mental disorders and social isolation than older men.

Providers and program administrators must learn how older clients’ race, ethnicity, sexual orientation, gender identity, and socioeconomic status inﬂuence overall health, substance misuse, and availability of healthcare and behavioral health services.253 They should **also recognize that older adults can draw on their cultural heritage in ways that improve health and well-being.**254

As people age, they shape their world in ways that maximize their well-being … within the conﬁnes and deﬁnitions of their respective cultures.”

—H. H. Fung (2013), p. 375255

**The consensus panel recommends that you maintain awareness of older adults’ racial, ethnic, gender, and LGBTQ diversity when addressing late-life substance misuse, health disparities,**

**and barriers to access to care.** Provide culturally responsive screening, assessment, and treatment for clients across settings.

## Recognize the Difference Between Early- and Late-Onset Substance Misuse

**Diagnosis and treatment planning differ for older adults who have a history of substance misuse (early onset) and those who develop problems only later in life (late onset).** For example, older adults who begin to drink because of late-life stressors (e.g., loss of a signiﬁcant other) may

not have the same chronic, co-occurring medical conditions or mental disorders that older adults who have been drinking since adolescence or early adulthood have. Late-onset substance misuse

may respond well to brief interventions. Older adults who exhibit chronic misuse may need more intensive SUD treatment.256

**The consensus panel recommends that, as part of regular screening and assessment, you determine whether clients have a history of substance misuse or are using in response to more recent stressors. Use this information to**

**identify appropriate treatment options. Discuss these options with clients.**

## Emphasize Client Education, Early Identification, Screening, and Brief Treatment

Substance misuse in older adults is often unrecognized by older adults themselves, as well as by their family members, friends, and healthcare and social service providers. To ensure that older adults receive education, screening, assessment, and treatment, all who have regular contact

with them—whether in the home, at healthcare visits, at community-based senior services, or in long-term care facilities—must recognize the signs of substance misuse (including prescription drug misuse) in older adults.

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) TIP 59, *Improving Cultural Competence* (https://store.samhsa.gov/ product/TIP-59-Improving-Cultural-Competence/ SMA15-4849), helps providers and administrators understand the role of culture in the delivery of mental health services and SUD treatment.

**RESOURCE ALERT: IMPROVING CULTURAL COMPETENCE**

**Older adults are less likely to get referrals to specialized SUD treatment from healthcare providers** than other sources (e.g., self-referral, referrals from legal incidents related to driving and substance misuse).257 **Yet healthcare providers are well positioned to identify and screen for substance misuse** in older adults.

**Older adults are more likely than younger adults to see their healthcare providers** to discuss

and receive treatment for numerous medical and health-related concerns. **Healthcare visits are opportunities to discuss substance use and related health risks and consequences.** Healthcare providers can also take these opportunities to talk with older clients about drug–drug interactions with alcohol, prescription medications, and other substances in the context of routine medical care.258

If you are a healthcare or social service provider who has contact with older adults in home-care situations, residential care facilities, community- based programs, or emergency departments, you should **be aware of the signs of substance misuse among this population. Within your**

**scope of practice, you should engage in routine screening of older adults for substance misuse** in accordance with your program’s policies and procedures.

A home healthcare nurse noticed empty beer bottles and the smell of alcohol on Joe’s breath during one of her regularly scheduled home visits to monitor Joe’s management of his diabetes. Joe also seemed unsteady on his feet. She recognized the signs of a potential problem and had a

friendly conversation with him about his health in which she embedded screening questions about his drinking. Joe agreed to let her call his daughter to arrange for a ride for him to see his healthcare provider for an assessment.

A growing body of research demonstrates that different kinds of **brief interventions delivered in a variety of healthcare and social service settings can effectively reduce alcohol consumption and substance misuse** and lower health-related risk among older adults.259,260,261,262,263 Brief interventions can also facilitate entry into more intensive treatment.264

**The consensus panel recommends that providers across settings in which older adults may seek care:**

* Promote early identiﬁcation, education, outreach, and prevention in their programs/ communities.
* Promote universal screening for alcohol misuse, drug use, and prescription medication misuse for older adults.
* Develop and expand brief interventions for older adults who misuse substances.

## Engage in Health Risk Reduction Practices

**Older adults who misuse substances may not want to set abstinence as their goal.**

**Engaging in health risk reduction practices is an important and viable option** for older adults and is consistent with age-sensitive treatment practices.265 For example, medical providers can slowly taper older adults to the lowest possible doses of benzodiazepines without withdrawing them completely. Another health risk reduction approach speciﬁcally designed for older adults is

the BRITE project, an adaptation of screening, brief intervention, and referral to treatment (SBIRT). It has demonstrated lowered alcohol severity and depression in older adults and improvements in medication misuse.266 (See Chapter 3 of this TIP for more information on screening and assessment.)

**Risk reduction strategies lower health-related risk for older adults and can boost functioning.** Risk reduction can also be a ﬁrst step toward abstinence. For example, once older adults who misuse alcohol begin to experience the health beneﬁts of less drinking, they may be more willing to stop completely.

**The consensus panel recommends engaging in health risk reduction practices to lessen the**

**impact of substance misuse on the physical and mental health of older adults.**

## Provide Person-Centered Care

Based on a literature review and qualitative research, a consensus panel convened by the American Geriatrics Society determined that **a**

**person-centered approach to care for older adults puts older adults’ values and preferences at the center of the decision-making process regarding healthcare** options and treatment goals.267

‘Person-centered care’ means that individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals.

Person-centered care is achieved through a dynamic relationship among individuals, others

who are important to them, and all relevant providers. This collaboration informs decision- making to the extent that the individual desires.”

—American Geriatrics Society (2015), p. 16268

**Consider client needs and preferences** when deciding treatment intensity (e.g., inpatient or outpatient), method (i.e., group or individual treatment), and goal choice (i.e., abstinence or reduction in use).

**Collaborating with clients to develop treatment goals enhances positive outcomes.**269 Offer clients a menu of treatment options that ﬁt their needs and preferences. Options should include the least intensive treatment approaches that are medically appropriate as well as more intensive alternatives.

**More treatment leads to better outcomes,** regardless of the level of care (e.g., residential versus outpatient treatment) or whether treatment is greater in intensity or greater in length of overall treatment. The more attention older clients receive, the more likely they are to improve.270

**Continually reassess older clients’ needs, treatment goals, priorities, and intensity of care** throughout treatment. Maintaining clients at the center of the conversation is essential to this process.

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**The consensus panel recommends that you engage older clients in a comprehensive, person- centered, trauma-informed approach to SUD treatment that emphasizes their values, needs, and preferences. Offer a menu of care options, including the least intensive treatment approach.**

## Build Alliances With Age-Sensitive Engagement and Retention Strategies

**Building a strong treatment alliance with each client fosters engagement and retention in treatment.** The treatment alliance is a collaborative process based on agreement on treatment

goals and tasks and a bond between you and your client.271 A large body of research shows the alliance as signiﬁcant in all kinds of helping

relationships across a variety of treatment methods, including SUD treatment.272

**Retention in SUD treatment predicts good outcomes for older adults** regardless of treatment approach.273 Retention refers to a client’s length of time in treatment and adherence to treatment.

**To engage and retain older adults in treatment,**

the following practices are helpful:

* **Recognize the importance of establishing a collaborative relationship** as the primary mechanism for engaging clients in treatment

and supporting behavior change.

* **Create a culture of respect,** which is nonconfrontational, focuses on building older clients’ sense of value and worth, acknowledges

the wisdom of their own lived experience, and expresses conﬁdence in their ability to participate in treatment and accomplish their treatment and recovery goals. Respect the customary social conventions of older adults’

age cohort (e.g., refrain from swearing or using slang) and ask clients how they would like to be addressed and introduced to others.

* **Use proven treatment approaches** that have demonstrated effectiveness or shown promise with older adults in addressing substance misuse

across a variety of settings. Such approaches include brief advice and brief interventions, SBIRT, motivational interviewing, supportive therapy, problem-solving therapy, individual therapy, and cognitive–behavioral therapy.274,275

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* Match treatment to older adults’ needs and levels of functioning.
* Outpatient programs should provide services during daytime hours and assist clients with transportation. Offer in-home or telehealth support services to homebound older adults.
* Inpatient and residential treatment programs

should create an environment that is easy for older adults to navigate. Facilities should be well lighted and accessible to individuals with disabilities, and should have other

accommodations as needed for older clients.

* Programs should modify design and delivery of services to accommodate vision, hearing,

and mild cognitive problems that develop or increase in later life.

* A slower program pace, repetition of

information and instructions, and allowing time for clients to integrate and respond to information and questions can enhance their learning and participation in program activities.

* **Implement age-sensitive group treatment approaches to meet older adults’ needs and preferences.** Older adults, regardless of

gender, tend to be more private and concerned about how much personal information they will share in a mixed-age group setting. They may not relate to or feel comfortable sharing their problems with younger adults.276

* **Use age-sensitive adaptions if your program only has mixed-age groups:** Emphasize privacy/ conﬁdentiality, accommodate physical needs,

establish group norms for respect, and ensure older adults’ voices are heard by creating opportunities to share without pressure to disclose.

* **Work with older clients to explore pros and cons of age-speciﬁc and mixed-age groups, and honor their preferences** if possible in your

program. Age-speciﬁc groups for older adults should focus on topics such as grief and loss, trauma, social isolation, social pressure to drink, life-stage and role transitions, and coping skills speciﬁc to older adults (e.g., strategies for coping with loneliness).

* **Match older adults to groups** based on availability, primary substance use concerns, age-related issues, and client preference.

If possible, match older adults who have experienced trauma to gender-speciﬁc groups and those with chronic pain to groups that address pain and medication misuse.

**The consensus panel recommends incorporating into your program age-sensitive and age-speciﬁc treatment practices that engage clients and improve retention in treatment.** (See Chapters 4 and 5 for additional information on treatment of older adults for AUD and other SUDs, respectively.)

## Help Older Clients Use Social Networks and Community-Based Services

**Older adults in long-term recovery from SUDs demonstrate better outcomes when they have social supports that promote abstinence.**277,278 Social networks for older adults in recovery include caregivers, family, friends, faith-based communities, peer recovery support services, and mutual-help groups.

**Older adults’ social networks frequently narrow** because of retirement, loss of spouses or friends, or reduced ability to engage in activities outside the home. This can increase some older adults’ isolation and contribute to substance misuse.279

**Assess older adults’ current social networks.** Help them improve and use social supports to reduce isolation and support recovery from substance misuse.

**CASE MANAGEMENT SERVICES**

Case and care management (CCM) services are often the keys to better outcomes, particularly for older adults with SUDs or co-occurring medical conditions or mental disorders.280 The CCM provider helps clients gain access to healthcare, addiction treatment, mental health, social, ﬁnancial, education, employment, and other community-based services. CCM services can be provided by a nurse care manager, social worker, addiction treatment or mental health counselor, or a peer recovery support specialist. Programs serving older adults should either provide CCM or actively link clients to a CCM provider who

can connect older adults and their families to community-based resources and services.

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**The consensus panel recommends that SUD treatment programs help older clients connect with social networks that promote recovery.**

**Use a CCM approach to link clients actively to community services.**

## Encourage Family and Caregiver Involvement

**Involving caregivers throughout treatment and ongoing recovery enhances retention and improves treatment outcomes for people with**

**SUDs.281** Include caregivers (e.g., family members or guardians) in the entire treatment and recovery process, with the permission of the older client.

Caregivers and family members can be essential partners in helping older adults participate fully in treatment and recovery activities. For example, they can assist older adults who have mobility challenges and cognitive impairments that make it difﬁcult to follow treatment and recovery plans without support.

**Educate caregivers about how substance misuse can affect older adults’ physical and mental health, as well as their relationships.** Include them in counseling sessions that focus on recognizing relapse triggers, improving communication, and teaching constructive problem-solving skills. This knowledge will help them more effectively support the recovery of your older clients.

Family members are often both caregivers and case managers for older adults with SUDs. The stress of this responsibility and resulting neglect of their self-care can put them at risk for developing SUDs, worsening chronic medical conditions, or increasing vulnerability to stress-related illnesses.282 Help caregivers reduce their stress levels and maintain their own mental, emotional, and physical health.283 Encourage family members to take care of their own emotional, mental, and health needs and participate in community-based supports such as caregiver groups.

SAMHSA’s Toolkit *GET CONNECTED: Linking Older Adults With Resources on Medication, Alcohol, and Mental Health* (https://store.samhsa. gov/product/Get-Connected-Linking-Older- Adults-with-Resources-on-Medication-Alcohol- and-Mental-Health-2019-Edition/SMA03-3824) addresses developing and actively linking to referral resources for alcohol misuse prevention and treatment among older adults.

**RESOURCE ALERT: DEVELOPING REFERRAL RESOURCES**

**The consensus panel recommends that, with older clients’ consent, providers across service settings involve caregivers in all aspects of older clients’ treatment and recovery.**

## Coordinate Care and Develop Service Linkages

**Develop linkages to appropriate services and maintain ongoing relationships with other providers to coordinate care across settings for older adults with SUDs.** Doing so will increase successful referral outcomes.284 Coordinated care involves establishing and strengthening referral streams and partnering with community-based resources serving older adults (e.g., local Area Agencies on Aging).

**Referring older clients to other services is not a once-and-done event.** It requires actively connecting clients to appropriate providers or services (e.g., a “warm handoff” in which you

make a referral to another agency in person with the client present) and following up with clients to ensure that referral was successful.

**Care coordination and management are especially important for older adults with**

**co-occurring medical or mental disorders.** For example, a client with an SUD in a healthcare setting who screens positive for anxiety or depression should receive a referral for further assessment and treatment to a mental health service clinician experienced in working with older adults who have co-occurring disorders. Consider availability, accessibility, and client preferences when making referrals to other providers or community-based services. In addition, stay informed of available services. Treatment options within a given agency may change frequently.

**The consensus panel recommends that you establish ongoing relationships with providers across services and community-based programs to ensure active linkage of clients to older adult services, healthcare professionals who specialize in geriatrics, addiction treatment services, mental health services, and recovery resources.**

**Make Programmatic Changes To Effectively Serve Older Adults With SUDS** Before administrators and clinical supervisors

can focus on workforce development, they

must establish their organizations’ vision and commitment to making programs more accessible to older clients and to creating new or adapting existing programs to accommodate older adults’ unique needs. **Start with an organizational self- assessment and change plan** that includes:

* A rationale for providing age-sensitive and age- speciﬁc services.
* An assessment of the organization’s strengths and needs for improving services for older adults.
* A review of priorities, goals, and tasks to help develop or augment existing services for older adults.
* A plan for adapting facilities and programs to accommodate the unique needs of older

adults throughout the continuum of care. This includes establishing age-sensitive and age- speciﬁc policies and practices for outreach, universal screening for substance misuse, and enhancing access and ﬂow of clients through the continuum of care from screening to brief intervention and referral or admission to SUD treatment and continuing care.

* A plan for identifying and developing linkages to community-based resources serving older adults.
* A plan for involving staff, older clients, and members of older adult programs and recovery- focused organizations in the planning and

implementation of services.

* Guidelines for implementing organizational change that describe roles, responsibilities,

timeframes, and speciﬁc activities for each step of the change process.285

In addition, administrators need to be aware of state-level variance in policies and practices, which can dictate the parameters and limitations of a program’s features and implementation process.

**The consensus panel recommends that you do an organizational self-assessment and have a plan**

**in place before implementing any organization- wide changes to policies and practices.**

## Invest in Age-Sensitive Workforce Development

To implement older adult-speciﬁc SUD treatment programs and services successfully, program administrators must **hire and retain highly motivated staff who are committed to serving older adults.** To ensure staff are knowledgeable and have the skills to care for older adults

with SUDs, **engage in ongoing workforce development practices:**286,287

* Develop staff recruitment, retention, and promotion strategies that engage clinical and

program staff who are knowledgeable about older adult health, mental health, and substance misuse and are motivated to work with this population.

* Recruit older peer recovery support providers and create a work environment that recognizes lived experience as a valuable source of

knowledge.

* Develop pathways for integrating older peer recovery support providers into service teams and provide them with ongoing supervision and

professional development opportunities.

* Create training plans and curriculums that address ageism, health disparities, and cultural diversity among older adults; the culture of

aging; physical and mental health needs of older adults; and treatment practices and evidence- based approaches that are effective with older adults.

* Provide ongoing clinical and administrative supervision that emphasizes the attitudes, knowledge, and skills required to care for older

adults.

* Evaluate staff performance on the attitudes, knowledge, and skills required to care for older adults.

**The consensus panel recommends that you implement workforce development strategies for building or improving age-sensitive and age- speciﬁc treatment for older adults with SUDs.**

# Summary

The principles of care this TIP describes will support efforts to develop and improve age- sensitive and age-speciﬁc services for older adults with SUDs. The key to implementing these principles is to work collaboratively with staff, older clients, other providers, and community

stakeholders to foster awareness and commitment to providing quality services to older adults and their families.

# Chapter 2 Resources

## Provider Resources

**American Psychological Association (APA)— *Guidelines for Psychological Practice With Older Adults*** ([www.apa.org/pubs/journals/features/older-](http://www.apa.org/pubs/journals/features/older-) adults.pdf): These guidelines provide information on evaluating psychologists’ readiness for working with older adults; this information is also applicable to other behavioral health service providers.

**APA—*Multicultural Competency in Geropsychology*** ([www.apa.org/pi/aging/](http://www.apa.org/pi/aging/) programs/pipeline/multicultural-competency.pdf): This report describes behavioral health service providers’ multicultural competencies for working with older adults.

**Council on Social Work Education—Gero-Ed Center** ([www.cswe.org/Centers-Initiatives/](http://www.cswe.org/Centers-Initiatives/)

CSWE-Gero-Ed-Center.aspx): The center’s website provides resources, educational materials, and a curriculum to enhance social work competencies, which apply to all behavioral health service providers caring for older adults.

**Institute of Medicine (IOM)—*The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*** ([www.nap.edu/download/13400;](http://www.nap.edu/download/13400%3B) download for free as a guest): The IOM provides this report as an overview of the eldercare workforce and workforce development barriers and needs. (IOM is now the National Academy of Medicine.)

**Ofﬁce of Minority Health—National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (https:// thinkculturalhealth.hhs.gov/clas): These standards describe principles of culturally appropriate services applicable to treating culturally diverse older adults in healthcare and behavioral health service settings.

***Understanding Issues Facing LGBT Older Adults*** ([www.lgbtmap.org/ﬁle/understanding-issues-](http://www.lgbtmap.org/%EF%AC%81le/understanding-issues-) facing-lgbt-older-adults.pdf): This report from the Movement Advancement Project and SAGE helps providers and others better understand the social isolation and health challenges that affect many LGBT older adults.