



Peer Support for Older Adults with Substance Use Disorders: Best Practices Curriculum

The Regional Facilitation Center

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Qualitative Review

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Preface

The provision of non-clinical peer recovery support services is growing exponentially within the addiction and mental health fields and within allied service systems. Such services have been defined as follows:

Peer-based recovery support is the process of giving and receiving nonprofessional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery. (White, 2009, p. 16)

Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012, p.6)

Historically, non-clinical peer recovery support services span the growth of secular, spiritual, and religious recovery mutual aid societies; the growth of new recovery support institutions (e.g., recovery community organizations, recovery community centers, recovery residences, high school and collegiate recovery programs, recovery industries, recovery ministries, recovery cafes, etc.); and the emergence of new service roles (e.g., peer recovery support specialists, recovery coaches) (White, 2014). Peer recovery support services flow from theoretical concepts different from those of the delivery of professional services, including the following:

- *Experiential knowledge*: the legitimacy of common-sense knowledge gained by directly experiencing and recovering from an illness or traumatic event (Borkman, 1976),
- *Wounded healer*: the ability of people who have survived an experience or traumatic event to aid others in similar circumstances (Jackson, 2001),
- *Helper principle*: the helping process is reciprocally beneficial; both helpee and helper benefit from the helping process (Riessman, 1965),
- *Recovery is contagious*: the social transmission of recovery via recovery carriers—people with lived experience of recovery who offer living proof of the transformative power of recovery (White, 2010).

Scientific evaluations of the effects of peer recovery support services on long-term recovery outcomes are at an early stage but the number and quality of such studies have increased. Recently published systematic reviews of these research studies note the value and future potential of such services.

“Studies [of peer recovery support for individuals with substance use disorders] demonstrate improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment. It is clear that peer support services can provide a

valuable approach to guiding consumers as they strive to achieve and maintain recovery.” (Rief et al., 2014)

“...the general conclusion from the body of evidence is that participation of peers in recovery support interventions appears to have a salutary effect on participants and makes a positive contribution to substance use outcomes. The individuals studied generally had complex needs in addition to substance use issues and benefitted from the support of peers across diverse types of interventions.” (Bassuk, Hanson, Greene, Richard, & Laudet, 2016)

Research to date on the value of peer support in the resolution of substance-related problems among older adults is strengthened by parallel research on the value of peer support among older adults in the prevention (Burton et al., 2018; Dorgoa, King, Bader, & Limon, 2013) and management of other medical conditions, e.g., breast cancer, spinal cord injury, stroke, heart disease, diabetes, tuberculosis, chronic pain, depression, and other psychiatric illness (Cooper, Schofield, Klein, Smith, & Jehu, 2017; Crane-Okada, Freeman, Ross, Kiger, & Giuliano, 2010; Hirsch-Moverman, Colson, Bethel, Franks, & El-Sadr, 2013; Landers & McDuffe, 2005; Ljungberg, Kroll, Libian, & Gordon, 2011; Clark et al., 2012; Sadler, Sarre, Tinker, Bhalla, & McKeivitt, 2017; Shen, Edwards, Courtney, McDowell, & Wu, 2012; Solomon, 2004; Wurzer, Waters, Hale, & Leon de la Barra, 2014).

From a systems perspective, peer recovery support services remain at an early stage of development. Considerable work needs to be done in both defining these services and elevating their ability to support long-term personal and family recovery. The future of peer recovery support services will be shaped, not just through their scientific evaluation, but through testing the degree to which such services can be adapted for recovery support across the life cycle, across diverse populations, and across diverse cultural contexts. It is the intent of this latest product of the Portland Regional Facilitation Center to be an incremental step in achieving those goals. This is the third in a series of monographs produced by Portland Regional Facilitation Center, with earlier monographs addressing peer services for transition age youth (Martin, Vezina, et al., 2017) and the core competencies required for effective supervision of peer recovery support services (Martin, Jordan, et al., 2017). The present curriculum focuses on best practices in the delivery of peer recovery support services to older adults—an area of service need that has to date received little attention. This best practice analysis uses a series of investigative protocols, including: a systematic review of the literature, a DACUM (Developing A Curriculum) workgroup, a quantitative peer and supervisor validation survey, and a qualitative managerial and administrative validation review.

This best practice analysis is specifically designed for in-class training purposes. Best practices with specific Knowledge, Skills, and Attitudes (KSAs) are described in checkboxes for classroom participant self-assessment with the following recommended instructional steps:

1. Review and discuss a best practice.
2. Ask each participant to complete the associated self-assessment. The self-assessment checkbox can also be used as an “agency self-assessment” check box.
3. In groups, have participants discuss their strengths and areas needing improvement based on their self-assessment.
4. Facilitate a class discussion around the insights gained by individuals through self-assessment and group discussions.

5. Move on to the next best practice and repeat the process.

The above steps could also be adapted for use in group orientation and supervision of recovery support specialists serving older adults.

Methodology

The content for the curriculum was developed using the following steps:

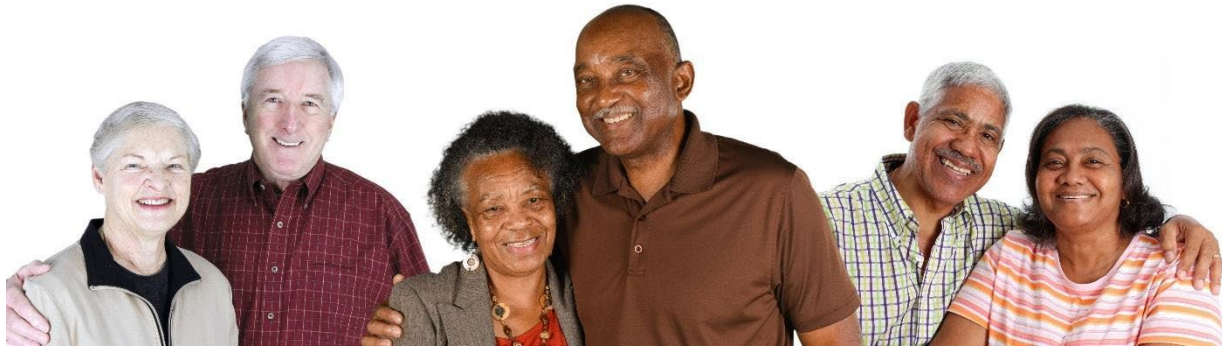
1. **Stage One: Systematic Review of the Literature.** We identified 25 relevant documents, manuals, credentialing standards, and curriculum outlines that were specific to, and related to peer services for older adults. We identified 17 common best practices which were then ranked by frequency of identification within the literature.
2. **Stage Two: DACUM Subject Matter Experts (SME).** The SME were assembled from experienced peers serving older adults (ages 50+) with all of the peers in long-term recovery from a substance use or gambling disorder. The workgroup analyzed the systematic review and generated concatenated best practices. They then edited language and developed organizational storyboard attributes to the best practice and task descriptions.
3. **Stage Three: Quantitative Peer & Supervisor Likert Validation Surveys.** The SME developed survey questions for peers serving older adults (n=18) regarding core competencies needed by peers serving this population. Eighteen peers serving older adults completed the Likert survey and feedback portion of the validation survey, with subsequent edits to competencies/tasks based on results (mean, median, variance, confidence intervals, margins of error, and standard deviation).
4. **Stage Four: Qualitative Managerial & Administrative Validation.** A draft document was distributed to administrators with peer/recovery experience for validation through managerial and administrative review, with subsequent edits to competencies based on results.
5. **Stage Five: DACUM Curriculum.** Final edits to the Older Adult Best Practices Curriculum were produced by the SME and the curriculum self-assessment grids were produced for training and self-evaluation.

This Competency Analysis was funded through The Regional Facilitation Center Grant from the Oregon Health Authority, Health Services Division.

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Introduction



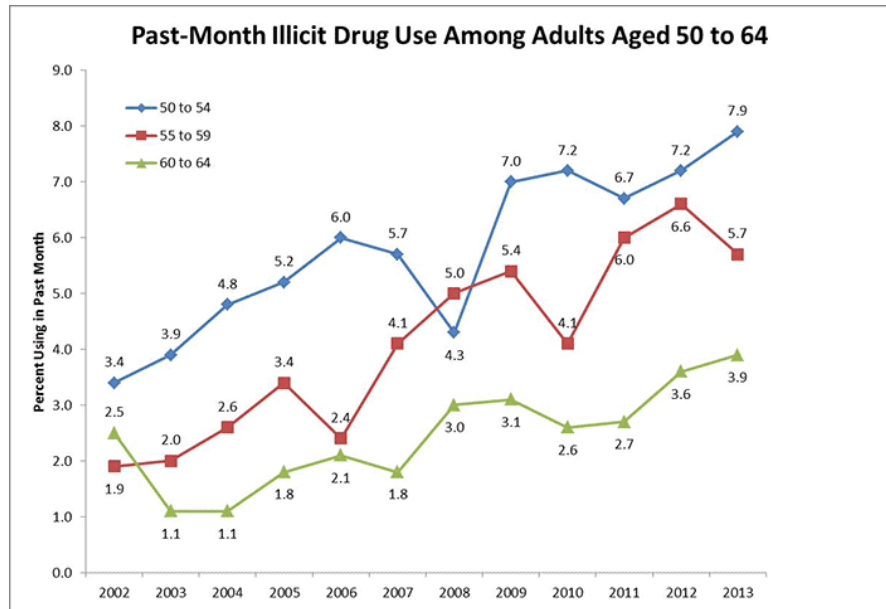
The age demographics in the United States are changing. Due to the aging of the “baby boomer” generation and rapid medical advances that are prolonging life expectancies, we are witnessing a rapid increase in the older adult population. Between 2010 and 2030, the population of individuals age 65 and older is expected to increase from 40.3 million to 72.1 million (Eden, Maslow, Le, & Blazer (Eds.), 2012). A growing percentage of those individuals will experience problems in their relationships with alcohol, prescribed psychoactive medications, and other drugs.

According to the National Council on Alcoholism and Drug Dependence (2015), as many as 2.5 million older adults experience an alcohol or other drug problem in the United States. The prevalence of older adults seeking help for a substance use disorder has increased (Arndt, Clayton, & Schultz, 2013) and is projected to rise to 5.7 million older adults by 2020 (Wu & Blazer, 2011). There are several populations of concern: 1) individuals with chronic substance-related problems who have survived into older adulthood, 2) older adults who did not experience substance-related problems during their youth and adult years but develop such problems within the aging process, and 3) older adults within the more than 22 million Americans in long-term recovery from a substance use disorder who will face challenges sustaining and redefining such recovery within the process of aging (Kelly, Bergman, Hoepfner, Vilsaint, & White, 2017).

Alcohol and other drug use can impact the vulnerability for and the severity of other health conditions in older adults. Substance-related health problems are usually more severe in older adults than younger adults, leading to emergency room visits, hospitalizations, and overdose fatalities. Moreover, the National Survey on Drug Use and Health reports an increase in illegal drug use among adults age 50-64 (Johnston, O’Malley, Bachman, Schulenberg, & Miech, 2016). Problem gambling is also on the rise. Like substance-related problems, life stressors associated with aging can increase the risk of developing gambling problems later in life. Older gamblers

are vulnerable to financial loss and are at higher risk of other behavioral health problems (Tse, Hong, Wang, & Cunningham-Williams, 2012).

There is a need for the addictions fields, including both the substance recovery and gambling recovery support workforces, to expand their knowledge and competencies in addressing the needs of



older clients. Peer support specialists play a vital role in this workforce (Eden et al., 2012). Older adults are more hesitant to seek addiction treatment and age-specific recovery services could potentially play a role in enhancing long-term recovery and health outcomes (SAMHSA, 2002). Peers serving older adults can help reduce the stigma associated with alcohol- and other drug-related problems and the process of aging.

It is important for peer support specialists to recognize the conditions that contribute to the development of substance use and gambling problems and related disorders in older adults (Eden (Eds.) et al., 2012). A recent review (White & Webber, 2017) suggests four major factors that can increase vulnerability for such problems and pose challenges within the recovery process:

1. **Physiological factors:** Changes in drug metabolism (e.g. decreased tissue tolerance, atypical drug actions, and interactions), co-occurring medical/psychiatric conditions, and the use of multiple medications have the potential to amplify untoward effects of alcohol and other drug consumption in older adults. These same factors may escalate the speed and severity of addiction reinstatement in the older adult who resumes alcohol and other drug (AOD) use after prolonged sobriety. Sleep disturbances and the onset of acute and chronic pain increase the vulnerability of both groups for patterns of self-medication. Age-related cognitive impairments increase AOD vulnerability due to age- and AOD-related effects on memory and judgment. Some older adults who have used medications to support their recovery—medications such as *camprosate (Campral)* or *disulfiram (Antabuse)*—may no longer be able to take these medications due to problems with liver or kidney functioning, leaving them at increased vulnerability for recurrent alcohol-related problems.
2. **Emotional Factors:** Aging requires the management of multiple losses: the loss of functional capabilities; the loss of family members and friends due to death and

relocations; the loss of meaningful roles, activities, power, and status; and the potential decline in one's standard of living. We have witnessed AOD problems developing among older adults in the context of such losses. These grief response sometimes morph into the clinical conditions of depression or anxiety and increase the propensity for and risks of self-medication with alcohol and other drugs.

3. Social Factors: The disruption of long-standing social networks in older adults due to retirement, relocation, and deaths can heighten vulnerability for AOD problems. We have also witnessed older adults falling prey to such problems when they enter new social groups (e.g., retirement communities) in which heavy alcohol or other drug use is the norm. Losing a sponsor to relocation, sickness, or death is also a potential source of recovery destabilization.
4. Spiritual Factors: Although growing older can result in a strong desire for connection to a greater being, for some older adults, aging is accompanied by a lost connection with their religious or spiritual roots. The resulting loss of meaning and purpose and a sense of hopelessness can increase vulnerability for a wide range of excessive behaviors, including AOD use. We have seen some older adults, fearing they are running out of time, commence risk-taking behavior similar to that seen in adolescence. We have also witnessed aging adults who, feeling they have fallen far short of their life goals, simply give up and commence drinking themselves into oblivion or death—until some event or new relationship rekindles a zest for living.

In short, aging increased the risk for substance-related problems and gambling problems. At the same time, substance-related problems also accelerated the aging process and related mortality risks (Bachi et al., 2017). Reviewing the above sources of vulnerability is not to suggest that aging is itself a pathological process. Aging can involve other dimensions that enhance resiliency and quality of life: increased time for self-care, shedding toxic habits, lifestyle changes that improve physical and emotional health, a shift from doing to being, acceptance of imperfection and limitation, letting go of past resentments, seeking forgiveness and forgiving, deepening gratitude for one's blessings, more meaningful personal and family relationships, discovering previously hidden resources within and beyond the self, time for pleasurable pursuits and quiet reflection, and exploration of new forms of service to others (White & Webber, 2017). Peers serving older adults assist individuals and families to rise above such vulnerabilities to achieve remission of substance-related problems, increased physical and emotional health, and enhanced connection to community. Peers capitalize on developmental windows of opportunity that can serve as a catalyst of recovery initiation and maintenance, e.g., reconciliations with children, parenting an adult child, grand-parenting, and assuming a caretaking role (Jessup et al., 2014).

This curriculum aims to provide peers serving older adults with training on best service practices and to help peers expand recovery support services to older adults within their communities.

For the purposes of this curriculum, we are defining “older adult” as age 50 and over. This curriculum is the product of a systematic review of the limited available literature (Rosen et al., 2013) and validation by peers and professionals in the recovery field and the subsequent identification of validated best practices. All those who participated are self-identified older adults with lived experience in recovery from addiction.

The reader will find two lists of best practices within the curriculum. The first, and most detailed, is the result of this DACUM analysis and the best practices to be used with this curriculum. The second list, presented in the Appendix One, provides the reader with the Likert validation survey of the ten global best practices, originally identified by the DACUM Workgroup of peer support professionals, and the methodology used to aggregate and prioritize the final list.

Best Practice #1: Provide Person-centered, Recovery-focused, Trauma-informed, and Culturally Competent Care

Peers respect older adults and their diverse communication styles and demonstrate that respect first and foremost by listening attentively to individuals. Such close attending is critical to rapport-building and service engagement. Peers also understand the perceptual challenges (hearing, vision, etc.) experienced by many older adults and how that impacts communication. Moreover, peers do not talk down to or patronize seniors in overly directive forms of communication. Peers address age-related trauma, including grief and loss issues regarding the ongoing loss of loved ones and friends, loss of independence, historical trauma, and social injustice. Peers understand concepts of aging within different cultures. Peers understand services are non-linear and not acute care driven. Peers often work with seniors over a period of years.

| Self-assessment Checklist | |
|---------------------------|---|
| <input type="checkbox"/> | Peers serving older adults seek training and supervision related to: problems and opportunities within the aging process; the prevalence, pathways, stages, and styles of recovery among older adults; the core competencies of recovery coaching, including role delineation between peers, other indigenous helpers (e.g., mutual aid sponsors), and allied professional roles (e.g., physicians, addiction counselors, and pastoral counselors); and the delivery of peer recovery support services across diverse populations of older adults and within diverse geographical and cultural contexts. |
| <input type="checkbox"/> | Peers serving older adults demonstrate respect for seniors and their diverse communication styles by listening attentively to individuals, most especially during engagement and rapport building. Peers serving older adult use styles and forms of communication that are culturally respectful and appropriate to the individual. Peers understand the wealth of life experience that seniors possess and do not dismiss their conversations or communication style as “rambling” or “pointless.” Peers do not “cut-off” seniors, or push them to “get to the point.” Peers do not use directive forms of communication to control seniors, or persuade them into a specific course of action. Peers avoid non-verbal behaviors that convey impatience, like repeatedly looking at their watch, looking or sounding impatient, etc. Peers practice what David Brooks (2015) has christened a “ministry of presence.” |

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| <input type="checkbox"/> | <p>Peers serving older adults understand the historical context of seniors and their diverse life experiences. Peers serving older adults are aware of issues facing older adults and how generational and cultural experiences influence an individual's perspective. Peers acknowledge histories of trauma, discrimination and social injustice experienced by some individuals. Peers understand how trauma, discrimination, and ageism impact and intersect with behavioral health issues and late life stressors. Peers are cognizant of grief and loss issues regarding the ongoing loss of loved ones and friends and the loss of health, mobility, independence, freedom, etc. experienced by many seniors. Peers accept and honor the life choices individuals have made in the past, in the context of history. For example, a peer may work with an elderly gay man or lesbian who was previously married with children, and is now estranged from their spouse and children, understanding that many decades ago many gay men and lesbians married and had families due to social pressure and social oppression.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults respect seniors as individuals. They do not make ageist assumptions regarding those older adults with whom they work. Peers do not stereotype older adults as having diminished abilities, simply due to their age. For example, peers do not speak loudly and slowly when meeting new seniors, assuming all seniors are deaf and have impaired cognition. Peers view each senior as an individual, recognizing their individual assets and challenges. Peers recognize perceptual challenges (vision, hearing, etc.) and make accommodations as warranted, linking individuals to resources that assist with perceptual challenges when appropriate. For example, when peers discover that an individual has hearing problems, they may raise the volume of their voice slightly without shouting, and they directly face the individual, so their lips are visible as they pronounce words. If an individual has hearing loss, peers insure that they have an environment free of background noise.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults convey empathy and warmth while avoiding disempowering and insulting "elderspeak." Peers avoid infantilizing seniors with language that equates to "baby talk."</p> |
| <input type="checkbox"/> | <p>Peers serving older adults instill hope through their shared lived experience. Peers share their experience of addiction recovery through the unique perspective of older adults. Such self-disclosures are strategic, brief, and appropriate to the person's stage of recovery and the stage of the helping relationship.</p> |

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| <input type="checkbox"/> | <p>Peers serving older adults understand the multiple factors that contribute to late-onset substance use and gambling problems and the experience of the threats these problems can pose to the person’s identity. Peers serving older adults use person-first language and avoid terms that may be perceived as labeling. Peers refrain from labeling individuals as “addict,” “alcoholic,” or “pathologic gambler.” Peers recognize the importance of self-determination. Individuals with early-onset substance use disorders are far more likely to find utility in self-identification as “addict” or “alcoholic.” It serves as a constant reminder to individuals to be vigilant in avoiding substance use or gambling, risky environments, or risky emotional states. Individuals with late-onset substance use disorders find less utility in self-identifying as “addict” or “alcoholic,” and may find shame associated with those labels from their historical life experiences. Similarly, older adults may prefer a different language of problem resolution, e.g., words such as quitting, ceasing, resolving, or redeemed may be preferred over recovery. Peers working with older adults are multilingual in discussing how substance use and gambling problems are ameliorated—using any language an older adult finds helpful in reconstructing their health, identity, and daily lifestyle.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults utilize empathic communication skills (reflective listening, identifying feelings, etc.) and strategies of Motivational Interviewing (identifying motivation for change, acknowledging and normalizing ambivalence, weighing pros and cons, etc.). Peers understand from research that older adults, in general, have lower motivation for change for intrapersonal reasons, and significantly more motivation for change on behalf of their children and grandchildren. In general, research reveals older adults are less interested in long-term plans to make more money or making large purchases (bigger houses, better cars, more expensive clothing, etc.) and tend to be more interested in the well-being and success of their children, grandchildren, other friends, family, or significant others. Some behavioral health professionals may see older adults as “defocusing” or “deflecting” by frequently talking about their children/grandchildren versus themselves, not realizing this is a natural part of the aging process. Peers identify that external motivation for change and engage older adults in “change talk” or “developing discrepancy” that includes their well wishes for their children and grandchildren. For example, “It sounds like you want to be able to support your daughter by being able to babysit your grandkids, but it’s hard for you to get to her house and see your grandkids because of all the pain medication you are taking.”</p> |
| <input type="checkbox"/> | <p>Peers serving older adults develop enduring relationships with older adults, recognizing that services are non-linear, and are not driven by acute care. Peers meet the client where they are at in their stage of change and support clients in their stage of life and each individual’s pace of change. Peer recovery support emphasizes continuity of relation-building over time, in contrast to the usual</p> |

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| | brief interventions and repeated professional disengagements to which older adults have become accustomed. |
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Resources: Brooks, 2015. Harwood, 2012. Southard, 2013.

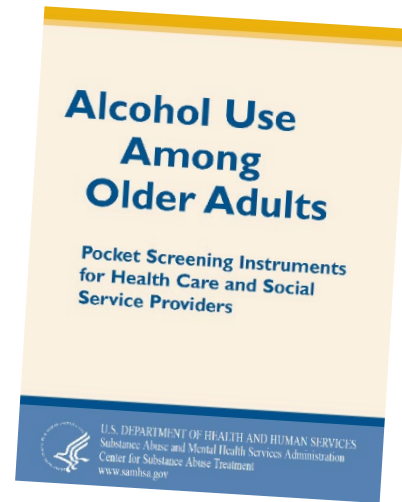
Best Practice #2: Screen and Refer for SUDs, Gambling, Mental Health, Self-Harm, and Elder Abuse

Peers serving older adults recognize and understand symptoms and risk factors associated with substance use, gambling, mental health problems, and signs of self-neglect, self-harm, and elder abuse. Peers are familiar with screening tools used with older adults. Peers are sensitive to the potential reluctance to be labelled with a substance use disorder, mental health disorder, or elder abuse issues. Peers serving older adults know when to refer to professional services and how to make referrals to appropriate providers and community supports.

| Self-assessment Checklist | |
|----------------------------------|--|
| <input type="checkbox"/> | Peers serving older adults are familiar with problems that can result from the use of psychoactive medications. They can recognize signs, symptoms and risk factors of substance use disorders and problem gambling that are significant and specific to older individuals. Peers are familiar with changes in physiological tolerance in older adults and are aware of revised recommended drinking guidelines for older adults. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) recommends that alcohol consumption for adults age 65 and older be limited to 1 standard drink (12 ounces of beer, 4-5 ounces of wine or 1½ ounces of distilled spirits) per day or 7 standard drinks per week and no more than 3 drinks on one occasion. |
| <input type="checkbox"/> | Peers are familiar with screening tools and methods that are valid and reliable with older adults. Peers serving older adults know how to utilize these tools and methods within their scope of practice. The AUDIT-C, CAGE, the ORT, Lie/Bet, |

and the Short Michigan Alcoholism Screening Instrument – Geriatric Version (SMAST-G) are all recommended screening tools.

What is validity and reliability? The MAST-G, the original instrument from which this measure was derived, has a sensitivity of 93.9%, specificity of 78.1%, a positive predictive value of 87.2% (meaning the individual has an alcohol problem), and a negative predictive value of 88.9% (meaning the individual does not have an alcohol problem).




The SAMHSA guide, Alcohol Use Among Older Adults contains a screening tool that peers can informally use in their supportive communications with older adults.

Peers are familiar with psychoactive medications and their side effects, and are familiar with statistics regarding late-onset gambling addiction and aging. Peers are familiar with “action” and “escape” gambling, and the signs and symptoms of gambling disorders.

Peers serving older adults are cognizant of state and federal laws regarding elder abuse and exploitation and monitor for possible signs of abuse. Peers are knowledgeable regarding the signs and symptoms of elder abuse and the fact that older adults with substance use disorders have a higher likelihood of being victims of neglect, abuse, and financial exploitation. Potential signs of elder abuse include but are not limited to:

- *Unusually messy or unclean environment or clothes out of character for the senior.*
- *Loss of weight with signs of malnutrition and is unable to describe their recent eating habits. Or they may describe eating very little and having very little food available to them within the home.*
- *Consistent ongoing injuries versus one time injury associated with an accident.*
- *Bruises or injuries on both sides of the body which can't be explained by a single accident. Bruises on both arms might be inconsistent with a fall or other similar accident.*
- *Injuries to the genitalia or breast.*
- *Contraction of a sexually transmitted disease, especially if there is no known sexual partner.*
- *Unexplained bank withdrawals.*

| | |
|--------------------------|--|
| | <ul style="list-style-type: none"> ● <i>Legal documents that have changed or disappeared.</i> ● <i>Missing financial statements, checkbooks, or debit/credit cards.</i> ● <i>Unpaid bills, utilities shut off, or notices of eviction.</i> ● <i>New friends/associates that are unknown to the family of the senior.</i> <p>Communicating with older adults about sensitive topics, like substance-related problems, gambling, physical abuse, financial exploitation, etc. can be uncomfortable for peers. The Gerontological Society of America has a helpful guide regarding evidence-based skills for communicating with older adults that addresses sensitivity to issues many would find embarrassing to discuss.</p>  |
| <input type="checkbox"/> | <p>Peers serving older adults engage individuals using language that is non-labeling and is sensitive to generational differences in attitudes regarding substance- and gambling-related problems. Peers promote self-determination, by describing the signs and symptoms of substance/gambling problems using their own lived experience without diagnosing these problems in others.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults are knowledgeable of treatment programs and referral processes of local treatment agencies and are aware of any programs and recovery support services that provide elder specific care. Peers are sensitive to the needs of a senior’s family and attempt to include family, friends, and allies in the treatment referral process.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults use assertive rather than passive linkage to needed resources. Where the latter might consist of providing a name and phone number of a referral resource, the latter involves facilitating the linkage to a particular person, arranging appointments, transportation support (if needed), and debriefing the older adult and his/her family regarding their experience with the resource to which he or she was referred.</p> |

Resources: NIAAA, Screening Tools. SAMHSA, 2002. Zubritsky, Keogh, Mastrine, Deppen, & Boyer, 2015. Zubritsky, Keogh, & Cantiello, 2016, Bartels & Naslund, 2013. Gallo et al., 2004. Barrick & Conners, 2002. White, 2006. Harwood, 2012. The Gerontological Society of America, 2012.

Best Practice #3: Include Family, Supporters, Caregivers, and Allies

Peers serving older adults provide education and support to families, supporters, and allies regarding aging and older adult behavioral health disorders including, but not limited to: substance use, gambling, and hoarding. Peers serving older adults provide information to seniors, family, and allies regarding formal senior services, informal senior resources, elder abuse, and mandatory reporting. Peers support older adults in addressing their issues within family systems that support and/or perpetuate substance- or gambling-related problems.

| Self-assessment Checklist | |
|---------------------------|---|
| <input type="checkbox"/> | Peers serving older adults are inclusive of family members, spouses, loved ones, friends, supporters, allies, and caregivers. When talking to older adults, family members, or caregivers, peers never exclude older adults from the conversation. Peers do not assume that a family member or caregiver “speaks for” the older adult. While it is important for family members, friends, allies, and caregivers to contribute to conversations, it should never replace direct communication with the older adults with whom we work. Peers maintain confidentiality and do not share private information with family, friends, supporters, or caregivers without proper consent. Peers do not converse with family, friends, or caregivers “as if” they are the “legal guardians” of older adults, unless such legal documents actually exist. |
| <input type="checkbox"/> | Peers serving older adults appreciate the importance of family and social relationships and how those relationships and roles may shift in the process of aging and in recovery. Peers provide age-related education to individuals, families, loved ones, etc. regarding aging and behavioral health disorders and risk and resiliency factors. This education may include information regarding how loved ones can support recovery and avoid behaviors that perpetuate or enable recovery. For example, a family member may say, “They’re old, if they want to get drunk, smoke, and gamble – let them. They’re really old now, they should be able to do what they want. They’re going to die soon anyway, so who cares. We should just let them be happy in the short time they have left.” Peers educate families about hope for recovery and the benefits to individuals, families, and the community that can result from recovery among older adults. Such hope is grounded in their own lived experience of recovery and in research studies concluding that older adults with substance use disorders experience high rates of sustained recovery when provided the proper treatment and recovery support (Schutte, Nichols, Brennan, & Moos, 2003). |

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| <input type="checkbox"/> | <p>Peers serving older adults provide resources and referrals to family members, supporters, allies, and caregivers. Peers provide information regarding withdrawal management and addiction treatment services serving older adults. Peers are familiar with programs and individual professionals within programs that serve older adult clients.</p> |
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Resources: LaCoursiere, 2013. Harwood, 2012.

Best Practice #4: Knowledge of Aging and Disability Systems, Older Adult Resources, and Transportation

Many older adults have a significant need for transportation accommodating those with disabilities. Peers serving older adults must have specific knowledge of older adult service systems and informal resources within their community.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | <p>Peers serving older adults work toward eliminating barriers to accessing needed services that support social determinants of health. These barriers may include, but are not limited to, isolation, lack of or limited access to services, and lack of knowledge of available resources. Peers are knowledgeable of available resources, particularly the aging and disability service systems that serve older adults, veterans, and people with disabilities and how to access them.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults understand and recognize health issues and disabilities associated with the aging process and how these impact mobility, independence, and individual transportation needs. Peers recognize that some older individuals may be reluctant to ask for help in these areas.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults are sensitive and supportive of older adult needs and desires to maintain independence. Peers engage individuals in accessing support services in a manner which promotes dignity and respect. Peers do not make assumptions about individuals' capabilities and level of functioning based on age or disability.</p> |

Resources: LaCoursiere, 2013. SAMHSA, 2002. American Council on Education, 2007. Zubritsky et al., 2015.

Best Practice #5: Advocate for Consumer Choice and Independent Living when Appropriate

Peers serving older adults honor and advocate for consumer choice, which may include non-restrictive independent living.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | Peers serving older adults utilize person-centered consumer choice regarding independent living, assisted living, or other geriatric care. When talking to older adults, family members, or caregivers, peers never exclude older adults from the conversations. Peers do not assume that a family member or caregiver “speaks for” the older adult. While it is important for family members, friends, allies, and caregivers to contribute to conversations, it should never replace direct communication with the older adults with whom we work. |
| <input type="checkbox"/> | Peers serving older adults honor and accept consumer choice and assist individuals in assessing the pros and cons of their choices in an objective and non-directive manner. Peers facilitate genuine and honest communication regarding independent living and “relapse potential” associated with independent living situations. Peers are aware that recovery residences may provide an alternative to other institutional care for older adults recovering from substance-related problems. |
| <input type="checkbox"/> | Peers serving older adults assist individuals in overcoming barriers to independent living. Peers assist individuals in obtaining requisite resources for independent living. |
| <input type="checkbox"/> | Peers serving older adults operate within their scope of practice and do not give medical advice regarding independent, assisted, or dependent living circumstances that involve medical care. |

Resources: LaCoursiere, 2013. SAMHSA, 2002. American Council on Education, 2007. Zubritsky et al., 2015. Harwood, 2012.

Best Practice #6: Facilitate Social Connectedness through In-person Affiliation and Emotional Support

Results from multiple research studies reveal that lack of social connection increases risk of mortality. Lack of social connection is comparable to other risk factors such as obesity, physical

inactivity, and smoking in reducing longevity. Studies show the efficacy of peer facilitated social contact, demonstrating reductions in symptoms of depression and improvement in overall health.

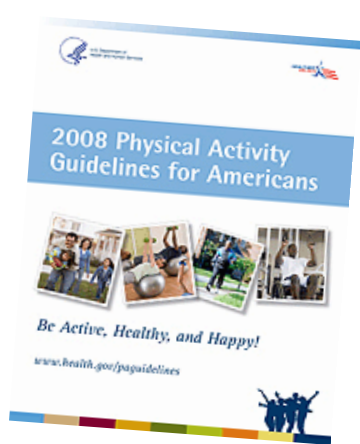
| Self-assessment Checklist | |
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| <input type="checkbox"/> | Peers serving older adults facilitate affiliation and provide emotional support. In 1997, Salzer and the Mental Health Association of Southeastern Pennsylvania Best Practices Team identified four key domains to peer services; 1) emotional, 2) informational, 3) instrumental, and 4) affiliational. The domain of affiliation suggests peers should help individuals develop a greater reliance on others through multiple social connections. Peers should not foster dependence on a peer supporter. Rather, peers should foster independence and reliance on the greater community of seniors and seniors in recovery from substance use and gambling disorders. Peers encourage involvement of older adults in recovery advocacy activities and various recovery support venues when available, e.g., recovery celebration events, recovery community centers, recovery-focused social events, and recovery cafés. |
| <input type="checkbox"/> | Peers serving older adults are familiar with the older adult recovery community and other senior social groups and activities. Peers are familiar with 12-Step meetings, Celebrate Recovery meetings, Wellbriety meetings, SMART Recovery meetings, etc. that cater to older adults and/or have significant representation of older adults. Peers provide the option of linking older adults with late-onset substance use disorders to recovery support meetings with high representation of older adults in recognition that older adults may not be comfortable in community recovery meetings heavily attended by younger people in recovery. |
| <input type="checkbox"/> | Peers serving older adults provide emotional support through basic communication skills and expressing empathy and encouragement while linking older adults to the greater community and older adult recovery community. |

Resources: Holt-Lundstad, Smith, & Layton, 2010. Zubritsky et al., 2015. Chapin et al., 2013. Stronge, Rogers, & Fisk, 2007. Heller, Thompson, Trueba, Hogg, & Vlachos-Weber, 1991. Salzer & the Mental Health Association of Southeastern Pennsylvania Best Practices Team, 1997.

Best Practice #7: Promote Physical Health, Wellness, and Resiliency through Physical Activity and Health Education

Peers serving older adults (55+) enhance motivation and resiliency through their optimism and sharing their lived experience of recovery. Research reveals that peers serving older adults who facilitate physical activity produce superior outcomes when compared with younger adult peers and professionals. Peers serving older adults are effective health educators and commonly provide information regarding: anxiety, depression, arthritis, pain management, heart disease, substance use, gambling, hoarding, exercise, etc.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | Peers serving older adults provide information on a variety of health and wellness concerns that are pertinent to older adults, including, but not limited to: falls prevention, nutrition, the benefits of exercise, regular medical checkups, and age-related physiological changes (including metabolic changes that affect tolerance and sensitivity to alcohol, drugs, and prescription medications). Peers do not prescribe or recommend specific health and wellness regimes but do provide education and encourage individuals to choose the health and wellness method, program, or activity that is right for them. |
| <input type="checkbox"/> | Peers serving older adults understand how substance use and problem gambling can exacerbate other physical and behavioral health problems, especially among older adults. Older adults tend to have more health-related problems than younger adults and a growing number of older adults are also experiencing behavioral health problems. Peers understand the importance of social connectedness in promoting resiliency and healthy lifestyle choices. |
| <input type="checkbox"/> | Peers serving older adults recognize the importance that personal health, wellness, and independence hold for older adults as well as the barriers they face in initiating changes to their current lifestyle. Encouragement to change is given from a strengths-based perspective, respecting the individual's personal motivation to make improvements to their health. Such encouragement should never be coercive. Peers may assist individuals in developing a wellness plan that is reasonable and achievable and based on the individual's health priorities. Peers take a holistic view of recovery from a bio-psychosocial perspective and provide education to individuals, their family, and caregivers on how overall health and wellness supports addiction recovery, reduces risk of problem recurrence, and improves quality of life. |

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| <input type="checkbox"/> | <p>Peers serving older adults are aware of the recommended guidelines for physical activity appropriate for older adults. The U.S. Department of Health and Human Services' <i>2008 Physical Activity Guidelines for Americans</i> includes information for older adults. Older adults should engage in physical activities that are appropriate to their level of fitness. Activities that improve balance can reduce risk of falls and other injuries. Studies show that peers serving older adults contribute to positive outcomes regarding improved fitness and level of activity among older adults. Peer-supported physical fitness programs correlate with improved emotional wellbeing and social functioning in addition to physical benefits.</p> |  |
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Resources: Buman et al., 2011. Dorgo et al., 2009. Dorgo, King, Bader, & Limon, 2011. Sourtzi, Amanatidou, & Velonakis, 1998, 2003. Elder Network, 2018. Zubritsky et al., 2015. Daniels et al., 2012. U.S. Department of Health and Human Services, 2008. [Need complete citation for Ref. List]

Best Practice #8: Cooperate with Medical and Behavioral Health Experts in Primary Care

Peers serving older adults work within primary care settings. Peers and health care professionals work cooperatively to promote individual empowerment and self-advocacy. Peers have a basic awareness of older adult health issues including, but not limited to, adverse reactions associated with misuse of medications and medications combined with alcohol.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | <p>Peers serving older adults act as both advocates and liaisons between individuals and medical and behavioral health professionals. Peers understand that older adults may feel more comfortable accessing primary care services compared to specialty behavioral health services in addiction treatment clinics. Older adults may experience enhanced feelings of stigma when discussing substance use and/or gambling problems. Although older adults tend to have a high respect for medical professionals, they may be less trusting of younger professionals. Peers help to bridge confidence and build trust when working with older adults in professional settings.</p> |

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| <input type="checkbox"/> | <p>Peers serving older adults have a general awareness of adverse complications associated with substance use, including misuse of medication and the risk of medications combined with alcohol and/or other drugs. Older adults tend to have more comorbid physical health issues and substance misuse exacerbates and complicates physical health issues more severely than with younger adults.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults understand how complex physical issues, which can be more prevalent in later life, require clear delineation of scope of practice and coordinated care with physical health professionals. Peers do not recommend any specific medical treatments, medications, or choices for primary care and/or behavioral health providers. They support the individual’s right to be part of the decision-making process when it comes to their healthcare and defer to medical professionals when individuals are in need of direct medical advice, recommendations, and treatment planning.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults respect the limits of confidentiality regarding substance use disorders and Code of Federal Confidentiality Regulations 42 part 2 (2018). Peers understand the importance of sharing information through valid exceptions to confidentiality, releases of information, and limits of information being shared. Conversely, peers do not obstruct sharing crucial substance use disorder information with medical providers when valid releases and exceptions are in effect.</p> |

Resources: SAMHSA, 2002. LaCoursiere, 2013. CRF 42, Part 2, 2018

Best Practice #9: Support Volunteer Consumer Governance and Volunteer Peers

Peers serving older adults include senior input regarding the direction of services and programming. Peer support programs promote volunteerism. Peer-delivered services research reveals that seniors have the highest rate of volunteerism compared to all other age groups.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | <p>Peer programs serving older adults recognize the value and experience of older volunteers. High rates of volunteerism among older adults serving as peers are cost-effective methods for doing outreach to older adults.</p> |
| <input type="checkbox"/> | <p>Peers serving older adults understand the importance of senior volunteerism as a means of “feeling useful” and contributing later in life. Peers cultivate and create volunteer opportunities for older adults.</p> |

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| <input type="checkbox"/> | Peers serving older adults include seniors in the governance of peer services. This governance includes older adult consumer positions on boards of directors, older adult consumer advisory boards/councils, and other leadership opportunities. Peers promote Addiction P.R.O. programs. SAMHSA defines P.R.O.s as Peer Run Organizations, where 51% or more of the leadership is in recovery from substance use disorders or gambling. |
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Resources: Martin et al., 2016. Sourtzi et al., 1998, 2003. Dorgo et al., 2011. Center for Substance Abuse Treatment (CSAT), 2006. SAMHSA, 2013

Best Practice #10: Practice Established Competencies, Maintain Standards of Ethical Practice and Maintain Appropriate relationship Boundaries in Varied Work Settings with Older Adults

Peers serving older adults maintain confidentiality and accommodate seniors' preferred methods of communication. Peers demonstrate varied competencies depending on occupational settings in which they work. Peers uphold ethical, legal, and regulatory standards and advocate for the rights of individuals they serve.

| Self-assessment Checklist | |
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| <input type="checkbox"/> | Peers serving older adults provide support, education, assistance, and alliance while honoring the older individual to make decisions and choices about their health and behavioral healthcare, including advance directives. The individual needs of the older adults we work with take priority, and peer support services are delivered in a manner that is beneficial and does no harm. Peers seek consultation and supervision when faced with situations or circumstances beyond their scope (for instance, if an individual they are working with begins to exhibit symptoms of physical or cognitive decline or dementia) and will refer to the appropriate professionals when needed. |
| <input type="checkbox"/> | Peers serving older adults fully understand their role as recovery coaches, role models, and mentors and the value of experiential knowledge. Peers maintain authenticity and credibility in their shared experience as older adults in recovery. They foster the hope that recovery is possible at any age. Peers work within the context of their position and do not take on the role of 12-step sponsor, caretaker, professional counselor, or personal friend. Although peers acknowledge that their role is more egalitarian, for instance, than the individual's medical provider or therapist, they still hold a responsibility and |

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| | obligation to individuals who are in a more vulnerable position in their recovery process. |
| <input type="checkbox"/> | Peers serving older adults may be part of a multidisciplinary team and work with other providers in treatment and healthcare settings. Peers promote positive outcomes for the older adults they work with, abiding by state and federal laws regarding confidentiality when consulting with other care providers and professionals. Peers understand that not everyone is “health literate” and advocate, engage, and collaborate in ways that are clear, ethical, and informative of an individual’s rights within the context of their competencies. Older adults may be receiving services from multiple social service and health care providers. Peers help individuals navigate the systems they are involved in. Peers do not make promises they may not be able to keep, avoid staff splitting, and are knowledgeable of agency guidelines where they work and are able to convey these guidelines and support individuals in their understanding of them. |
| <input type="checkbox"/> | Peers serving older adults complete generally accepted training in research-based standardized competencies of peer-delivered services and pursue advanced and/or specialized training in older adult services. Currently, researched-based peer competencies include: <ul style="list-style-type: none"> ● <i>The Substance Abuse & Mental Health Services Administration: Core Competencies for Peer Workers in Behavioral Health Services (2015),</i> ● <i>The International Certification & Reciprocity Consortium: Peer Recovery Competency Domains (2013),</i> and ● <i>Mental Health America: National Certified Peer Specialist Role Delineation Study Report (2016).</i> |

White & PRO-ACT Ethics Workgroup, 2007. Schwiebert, Myers, & Dice, 2000. Daniels et al., 2012.

References

- American Council on Education. (2007, October). *Framing new terrain: Older adults and higher education*. Washington, DC: American Council on Education. 16.
- Arndt, S., Clayton, R. & Schultz, S.K. (2013). Trends in substance abuse treatment 1998-2008: Increasing older adult first-time admissions for illicit drugs. *American Journal of Geriatric Psychiatry*, 19(8), 704-11.
- Bachi, K., Sierra, S., Volkow, N. D., Goldstein, R. Z., & Alia-Klein, N. (2017). Is biological aging accelerated in drug addiction? Current opinion in behavioral sciences. *ScienceDirect*, 13, 34-39. Retrieved from <https://doi.org/10.1016/j.cobeha.2016.09.007> on January 24, 2018.
- Barrick, C., & Connors, G. J. (2002). Relapse prevention and maintaining abstinence in older adults with alcohol-use disorders. *Drugs & Aging*, 19(8), 583-594.
- Bartels, S. J., & Naslund, J. A. (2013). The underside of the silver tsunami: Older adults and mental health care. *The New England Journal of Medicine*, 368, 493-496. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMp1211456> on January 24, 2018.
- Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016, April). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, 63, 1-9. doi: 10.1016/j.jsat.2016.01.003
- Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50(3), 443-456.
- Brooks, D. (2015). *The Road to Character*. New York: Random House.
- Buman, M. P., Giacobbi, P. R., Jr., Dzierzewski, J. M., Aiken-Morgan, A., McCrae, C. S., Roberts, B. L., & Marsiske, M. (2011, September). Peer volunteers improve long-term maintenance of physical activity with older adults: A randomized controlled trial. *Journal of Physical Activity and Health*, 8(Suppl 2), S257-S266.
- Burton, E., Farrier, K., Hill, K. D., Codde, J., Airey, P., & Hill, A. M. (2018). Effectiveness of peers in delivering programs or motivating older people to increase their participation in physical activity: Systematic review and meta-analysis. *Journal of Sports Sciences*, 36(6), 666-678.

- Center for Substance Abuse Treatment (CSAT). (2005). Substance abuse relapse prevention for older adults: A group treatment approach. (DHHS Publication No. (SMA) 05-4053). Rockville, MD: Substance Abuse and Mental Health Services Administration. US Department of Health and Human Services.
- Center for Substance Abuse Services (CSAT). (2006). Emerging peer recovery support services and indicators of quality: An RCSP conference report. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Chapin, R. K., Sergeant, J. F., Landry, S., Leedahl, S. N., Rachlin, R., Koenig, T., & Graham, A. (2013, April). Reclaiming joy: pilot evaluation of a mental health peer support program for older adults who receive Medicaid. *Gerontologist*, *53*(2), 345-352.
- Clark, A. M., Munday, C., McLaughlin, D., Catto, S., McLaren, A., & Macintyre, P. D. (2012). Peer support to promote physical activity after completion of centre-based cardiac rehabilitation: evaluation of access and effects. *European Journal of Cardiovascular Nursing*, *11*(4), 388-395.
- Cooper, K., Schofield, P., Klein, S., Smith, B. H., & Jehu, M. (2017). Exploring peer-mentoring for community dwelling older adults with chronic low back pain: A qualitative study. *Physiotherapy*, *103*(2), 138-145.
- Crane-Okada, R., Freeman, E., Ross, M., Kiger, H., & Giuliano, A. E. (2010). Training senior peer counselors to provide telephone support for newly diagnosed breast cancer survivors. *Journal of Cancer Education*, *25*(2), 174-179.
- Daniels, A. S., Tunner, T. P., Ashenden, P., Bergeson, S., Fricks, L., & Powell, I. (2012). *Pillars of peer support- III: Whole health peer support services*. Retrieved from pillarsofpeersupport.org on January 24, 2018.
- Dorgo, S., Robinson, K., Bader, J. (2009). The effectiveness of a peer-mentored older adult fitness program on perceived physical, mental, and social function. *Journal of the American Academy of Nurse Practitioners*, *21*(2), 116-122.

- Dorgo, S., King, G. A., Bader, J. O., & Limon, J. S. (2011, May-June). Comparing the effectiveness of peer mentoring and student mentoring in a 35-week fitness program for older adults. *Archives of Gerontology and Geriatrics, 52*(3), 344-349.
- Dorgo, S., King, G. A., Bader, J. O., & Limon, J. S. (2013). Outcomes of a peer mentor implemented fitness program in older adults: a quasi-randomized controlled trial. *International Journal of Nursing Studies, 50*(9), 1156-1165.
- Dorgo, S., Robinson, K. M., & Bader, J. (2013, April). The effectiveness of a peer-mentored older adult fitness program on perceived physical, mental, and social function, *Journal of the American Academy of Nurse Practitioners, 53*(2), 345-352.
- Eden, J., Maslow, K., Le, M., & Blazer, D. (Eds.) Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Washington, DC: The National Academies Press.
- Elder Network website. (2018). Retrieved at elder-network.org on January 24, 2018.
- Gallo, J. J., Zubritsky, C., Maxwell, J., Nazar, M., Bogner, H. R., Quijano, L. M., . . . Levkoff, S. E. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (PRISM-E). *Annals of Family Medicine, 2*(4), 305-309.
- The Gerontological Society of America. (2012). *Communicating with older adults: An evidence-based review of what really works*. Retrieved from https://www.geron.org/component/hikashop/product/13-002_Communicating?Itemid=385 on January 24, 2018.
- Harwood, J. (2012). Certified Peer Specialist (CPS) Training. Philadelphia, PA. Training curriculum.
- Heller K., Thompson, M. G., Trueba, P. E., Hogg, J. R., & Vlachos-Weber, I. (1991). Peer support telephone dyads for elderly women: Was this the wrong intervention? *American Journal of Community Psychology, 19*(1), 53-74.
- Hirsch-Moverman, Y., Colson, P. W., Bethel, J., Franks, J., & El-Sadr, W. M. (2013). Can a peer-based intervention impact adherence to the treatment of latent tuberculous infection? *The International Journal of Tuberculosis and Lung Disease, 17*(9), 1178-1185.

- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010, July 27). Social relationships and mortality risk: A meta-analytic review. *Public Library of Science Medicine*, 7(7), e1000316. Retrieved at <https://doi.org/10.1371/journal.pmed.1000316> on January 23, 2018.
- International Certification & Reciprocity Consortium (IC & RC). (2013). *Peer Recovery Domains, Role Delineation Job Analysis*. Harrisburg, PA: International Certification & Reciprocity Consortium.
- Jackson, S. W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75(1), 1-36.
- Jessup, M. A., Ross, T. B., Jones, A. L., Satre, D. D., Weisner, C. M., Chi, F. W., & Mertens, J. R. (2014). Significant life events and their impact on alcohol and drug use: A qualitative study. *Journal of Psychoactive Drugs*, 46(5), 450-459.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Miech, R. A. (2016). *Monitoring the Future national survey results on drug use, 1975– 2015: Volume II, College students and adults ages 19–55*. Ann Arbor: Institute for Social Research, The University of Michigan. Retrieved from <http://monitoringthefuture.org/pubs.html#monographs> on January 26, 2018.
- Kelly, J. F., Bergman, B., Hoepfner, B., Vilsaint, C., & White, W. L. (2017). Prevalence, pathways, and predictors of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. *Drug and Alcohol Dependence*, 181, 162-169.
- LaCoursiere, L. (2013). *Older adults and substance abuse: A program evaluation*. Master of Social Work Thesis, Clinical Research Papers, St. Catherine University, Minneapolis/St. Paul, Minnesota.
- Landers, G. M., & McDuffe, E. (2005). *Feasibility study: Peer support for the elderly transitioning from nursing facility care to community care*. (Report/White paper). Georgia State University, Georgia Health Policy Center of the Andrew Young School of Policy Studies.
- Ljungberg, I., Kroll, T., Libin, A., & Gordon, S. (2011). Using peer mentoring for people with spinal cord injury to enhance self-efficacy beliefs and prevent medical complications. *Journal of Clinical Nursing*, 20(3-4), 351-358.
- Mental Health America: National Certified Peer Specialist Role Delineation Study Report (2016).

- Martin, et al. (2016). SUD Peer Supervision Competencies. MAAPP.org
- Martin, E., Jordan, A., Razavi, M., Burnham, V., IV, Linfoot, A., Knudson, M., . . . Dumas, L. (2017). *Substance Use Disorder Peer Supervision Competencies*. The Regional Facilitation Center, Portland, Oregon.
- Martin, E., Vezina, T., Gardiepy, D., Courtney, M., Roberts, C., & Parker, G. (2017). *Substance Use Disorder Transition Age Youth Peer Delivered Services Best Practice Curriculum*. The Regional Facilitation Center, Portland, Oregon. Retrieved from maapp.org on January 26, 2018.
- National Council on Alcoholism and Drug Dependence, Inc. (2015). *Alcohol, drug dependence and seniors*. Retrieved from <https://www.ncadd.org/about-addiction/seniors/alcohol-drug-dependence-and-seniors> on January 24, 2018.
- Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services, 65*(7), 853-861.
- Riessman, F. (1965). The "helper" therapy principle. *Social Work, 10*(2), 27-32.
- Rosen, D., Engel, R.J., Hunsaker, A.E., Engel, Y., Detlefsen, E.G. & Reynolds, C.F. (2013). Just say know: An examination of substance use disorders among older adults in gerontological and substance abuse journals. *Social Work & Public Health, 28*(3-4), 377-87.
- Sadler, E., Sarre, S., Tinker, A., Bhalla, A., & McKeivitt, C. (2017). Developing a novel peer support intervention to promote resilience after stroke. *Health and Social Care in the Community, 25*(5), 1590-1600.
- Salzer, M. and Mental Health Association of Southeastern Pennsylvania Best Practices Team. (1997). *Best practice guidelines for consumer-delivered services*. Peoria, Illinois: Behavioral Health Recovery Management Project.
- Schutte, K. K., Nichols, K. A., Brennan, P. L., & Moos, R. H. (2003). A ten-year follow-up of older former problem drinkers: Risk of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol, 64*(3), 367-374
- Schwiebert, V. S., Myers, J. E., & Dice, C. (2000). Ethical guidelines for counselors working with older people. *Journal of Counseling and Development, 78*(2), 123-129.

- Shen, H., Edwards, H., Courtney, M., McDowell, J., & Wu, M. (2012). Peer-led diabetes self-management programme for community-dwelling older people in China: study protocol for a quasi-experimental design. *Journal of Advanced Nursing*, 68(12), 2766-2777.
- Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401.
- Sourtzi P., Amanatidou, A., & Velonakis, E. G. (2003). The role of older volunteers in promoting healthy nutrition for the prevention of cardiovascular diseases. *Global Health Promotion*, 10(1), 11-16, 39, 47.
- Sourtzi, P., Amanatidou, A., & Velonakis, E. G. (2010). Health Promotion Programs for the Elderly in Greece, the "Health Pro Elderly" Project. *Hygiea Internationalis An Interdisciplinary Journal for the History of Public Health* 9(1)
- Southard, M. J. (2013). *Peer specialist training and core competencies: Summary of findings*. (Report). County of Los Angeles Department of Mental Health, Los Angeles, California.
- Stronge, A. J., Rogers, W. A., & Fisk, A. D. (2007). Human factors considerations in implementing telemedicine systems to accommodate older adults. *Journal of Telemedicine and Telecare*, 13(1), 1-3.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). SAMHSA's expert panel on strategies for peer-run/recovery community organizations to build collaboration & relationships with local, county & state-level governments. Retrieved from http://facesandvoicesofrecovery.org/file_download/inline/60150d12-9b4a-4ce2-9a67-e5b385aec4ad
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *Promoting older adult health: Aging network partnerships to address medication, alcohol, and mental health problems*. Retrieved from https://www.ncoa.org/wp-content/uploads/PromoteOAHealth_SAMHSA.pdf on January 24, 2018.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *Equipping behavioral health systems & authorities to promote peer specialist/peer recovery coaching services*. Expert Panel Meeting Report, March 21 – 22, 2012, Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS).

- Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Core competencies for peer workers in behavioral health services*. Bringing Recovery Supports to Scale Technical Assistance Center Strategy Project (BRSS TACS).
- Tse, S., Hong, S-L., Wang, C-W., & Cunningham-Williams, R. M. (2012, September). Gambling behavior and problems among older adults: A systematic review of empirical studies. *The Journals of Gerontology: Series B*, 67(5), 639-652. Retrieved from <https://doi.org/10.1093/geronb/gbs068> on January 24, 2018.
- U.S. Department of Health and Human Services. (2008). 2008 Physical Activity Guidelines for Americans [Needs complete citation-Best Practice #7 Table]
- White, W. (2006). Recovery across the life cycle. *Alcoholism Treatment Quarterly*, 24(1-2), 185-201.
- White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.
- White, W. (2010). *Recovery is contagious*. Accessed January 24, 2018 at <http://www.williamwhitepapers.com/pr/2010%20Recovery%20is%20Contagious.pdf>
- White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.
- White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R., & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.
- White, W., & Webber, R. (2017). *Recovery challenges among older adults*. Retrieved from <http://www.williamwhitepapers.com/blog/2017/11/recovery-challenges-among-older-adults-bill-white-and-randall-webber.html>
- Wurzer, B., Waters, D. L., Hale, L. A., & Leon de la Barra, S. (2014). Long-term participation in peer-led fall prevention classes predicts lower fall incidence. *Archives of Physical Medicine and Rehabilitation*, 95(6), 1060-1066.

Zubritsky, C., Keogh, B., & Cantiello, H. (2016, September). *Certified Older Adult Peer Specialist (COAPS) Program: A peer-based model addressing co-morbidities in older adults living in the community*. Paper presented at September 2016 Rehabilitation & Community Providers Association Conference held at the MLA Center for Mental Health Policy & Services Research, University of Pennsylvania, Hershey.

Zubritsky, C., Keogh, B., Mastrine, G., Deppen, B., & Boyer, B. (2015). *Certified Older Adult Peer Specialist Program: A peer-based model addressing co-morbidities in older adults living in the community*. University of Pennsylvania, Philadelphia.