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RESTORATIVE INTEGRAL SUPPORT (RIS) FOR OLDER ADULTS EXPERIENCING CO-OCCURRING DISORDERS

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ABSTRACT

The Restorative Integral Support (RIS) model is a whole person response that assists people to overcome adversity. The Adverse Childhood Experiences (ACE) Study conducted by Kaiser Permanente and the Centers for Disease Control and Prevention shows the association between stressors in childhood and multiple later-life health and social problems. Older adults experiencing co-occurring disorders are an under-served and vulnerable population where gaps in both practice models and research to inform effective service provision exist. The current empirical case study presents Senior Hope as one social service agency employing RIS to intervene on the linkage between ACEs and co-occurring disorders to assist older adults. RIS usefully articulates the way in which Senior Hope is developing ACE-informed programs that mobilize resilience and recovery to help older adults achieve positive mental health outcomes. Implementation and research on the RIS model is recommended to enhance services for groups with ACE characteristics.

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INTRODUCTION

Older adults experiencing co-occurring disorders are an under-served and vulnerable population where gaps in both practice models and research to inform effective service provisions exist. A vast amount of research carried out by Kaiser Permenente and the Centers for Disease Control and Prevention demonstrated a strong association between adverse childhood experiences (ACE) and later-life health risk behaviors, including substance abuse, as well as health and mental health outcomes (Anda, Felitti, Bremner, Walker, Whitfield, Perry, et al., 2006; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, et al., 1998). Senior Hope Counseling, Inc. is an agency intervening on the linkage between ACEs and co-occurring disorders to assist older adults. Both evidence-based practice and recovery movements aim to improve services (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008; Starnino, 2009), and the Substance Abuse and Mental Health Services Administration emphasizes "recovery-oriented systems of care" (Sheedy & Whitter, 2009). A movement toward integration is reflected by Bledsoe et al.'s (2008) call to include systems that facilitate recovery within evidence supported interventions and create policies that endorse evidence-supported interventions mobilizing recovery. Thus, a recovery orientation complements evidence-supported interventions (Starnino, 2009). Senior Hope illustrates use of the Restorative Integral Support (RIS) model as a best practice relevant to healthy aging that integrates research knowledge within a culture of recovery. We first describe the RIS model to then demonstrate how RIS articulates Senior Hope's ACE-informed program response to achieve substance abuse recovery and positive mental health outcomes.

RESTORATIVE INTEGRAL SUPPORT

The RIS model was designed as a whole person service approach for populations characterized by earlier adversity and complex problems. In this way, RIS connects evidence-supported interventions and emerging practices to client characteristics and combines them within a culture of recovery supporting resilience through social affiliations (Larkin, Beckos, & Shields, in press). Inclusion and group connectedness strengthen self-efficacy through the provision of resources and opportunities (Zlotnick, Tam, & Robertson, 2003). Individual resilience is enhanced within a culture of recovery that empowers people and facilitates healing through community integration (Jacobson & Greenley, 2001). Leadership and policies are key to supporting the staff that create this milieu through role modeling and relationship-building with clients. RIS involves staff in a process of identifying values and principles that will pervade the culture and inform programming as well as clarifying how best practices offered within programs address ACEs or their later-life consequences (Larkin et al., 2012). RIS sets forth the following practical steps for agency leaders:

- raise awareness of client characteristics among staff, including the role of earlier adversity in current problems;
- provide education on adversity, trauma, resilience, and recovery to inform comprehensive response that brings together multiple services within healing social networks;
- create restorative cultures that provide self-care resources for staff, recognizing that leaders set an example and tone through role modeling and relationship-building;
- engage staff in identifying agency values and principles that will pervade the culture;
- create policies that facilitate social affiliations and support recovery activities;
- identify how each service within programs responds to client characteristics; and
- build community partnerships to expand services and carry out research (Larkin et al., 2012).

Senior Hope began to articulate its approach through RIS as agency leadership sought real-world application of ACE research. Staff persons had made connections between ACEs and the co-occurring conditions faced by the older adults served and now examine ACEs during early treatment processes and group work. Since ACE research has led providers to RIS through their interest in an ACE Response that includes resilience and recovery, we will first discuss these areas of research. We will then describe Senior Hope and the way in which RIS articulates and develops the agency's ability to intervene on the linkage between ACEs and co-occurring disorders, restoring healthy aging.

ADVERSITY, RESILIENCE, AND RECOVERY

Beginning in 1994 and following two waves of data collection, the ACE Study included a combined sample of 17,337 adults who used Kaiser Permanente health clinic services (Anda et al., 2006; Felitti et al., 1998). ACEs include physical, emotional, and sexual abuse, domestic violence, living with substance abusing, mentally ill or incarcerated household members, loss of a parent, and emotional or physical neglect. ACE Score is calculated by adding the number of "yes" responses to each of the categories (0-10). The research shows that these categories are inter-related and connected to health risk behaviors and serious health problems (Anda et al., 2006; Felitti et al., 1998; Larkin, Felitti, & Anda, in press).

ACE Score, or the number of categories of adverse childhood experiences, was found to be strongly associated with health risks such as the following: substance abuse, including alcoholism and smoking; sexual risk-taking; physical inactivity; and severe obesity. ACEs are associated with depression, prescribed psychotropic medications, hallucinations, and suicide risk as well as poor self-rated health and a range of serious health problems including lung, heart, and liver

disease; multiple types of cancer; and broken bones. In fact, these were referred to as dose-response relationships in which the increase in ACE Score (dose) was powerfully correlated to later-life health risks (response) (Anda et al., 2006; Felitti et al., 1998; Larkin et al., in press).

Given the many costs associated with earlier adversity and serious subsequent health and mental health challenges, an understanding of how to interrupt a path from ACEs to negative consequences is valuable (Larkin et al., in press; Larkin & Records, 2007). The literature states that people who find life worthwhile, focus on overcoming obstacles, and face reality to manage adversity are resilient. Communities can support resilience by offering relationships that foster hope, opportunities to build skills, and a sense of expectation. In these ways, individual strengths and community resources merge to help people deflect depression, substance use, and other health issues (Gardner, Lehman, Brown, & Brooks, 2000; Henderson, 2003; Smith & Carlson, 1997). Peer, community, and societal support also help to instill hope and facilitate recovery, which involves the individual's development of new attitudes, goals, values, and sense of self (Jacobson & Greenley, 2001; Starnino, 2009). RIS, as presented, specifically draws on this research to inform the intentional development of a culture of recovery that strengthens resilience through social affiliations (Larkin et al., 2012).

SENIOR HOPE

As the baby boomers (born between 1946-1964) age, an unprecedented number of older adults requiring substance abuse treatment is anticipated (Han, Gfroerer, & Colliver, 2009). Mental health disorders are estimated to affect one in four older adults and expected to double by 2030 (Bartels, Blow, Brockmann, & Van Citters, 2005). Co-occurring mental health and substance abuse problems were connected to increased suicidality and service use among older adults (Bartels, Blow, Van Citters, & Brockman, 2006). Yet, a gap exists in research on the prevalence and treatment of co-occurring mental health and substance abuse problems for this group (Grella, 2009). Senior Hope seized an opportunity to develop an age-specific best practice through the real-world application of ACE data, employing RIS for a coherent set of interventions mobilizing resilience and recovery.

While the need for older adult alcohol treatment services increases, less than one in five programs provide age-specific services (Schultz, Arndt, & Liesveld, 2003). Increasing treatment availability and providing integrated approaches to meet the growing needs of our aging addicted population will become increasingly important over the next decade (Han, Gfroerer, & Colliver, 2009; Han, Gfroerer, Colliver, & Penne, 2009). Senior Hope is the only freestanding, outpatient, non-intensive clinic licensed by the New York State Office of Alcoholism and Substance Abuse Services exclusively serving seniors 50 and older. Ranging

in age from 50 to 75 years, over half of those served experience co-occurring disorders. Thus, Senior Hope is an example of one agency applying ACE research to strengthen comprehensive, recovery-oriented service provision to resolve gaps and achieve positive mental health outcomes for older adults.

Client and Service Characteristics

As an agency licensed by the New York State Office of Alcoholism and Substance Abuse Services, Senior Hope completes and electronically delivers required Client Admission and Client Discharge Reports. The data in these reports are then used in the Integrated Program Monitoring and Evaluation System, which allows for the evaluation of program performance by reviewing patient-level summary of achievement such as length of stay and completion of treatment. Outcome variables also include reduced use, abstinence, and goal attainment for each patient. Approximately 65.8% of the patients are male and 34.2% are female. These clients come from diverse socio-economic backgrounds and many use Medicare and/or Medicaid. Several of the clients are widowed (12.0%) or divorced (26.8%), and most have primary diagnoses of alcohol abuse or dependence (73.2%). Over half (52.2%) have a diagnosed mental health condition (NYS OASAS, 2011a). Current Senior Hope services include screening and evaluation, individual and group counseling, and family interventions that incorporate support for Adult Children of Alcoholics. The results of New York State Office of Alcoholism and Substance Abuse Services (2011b) program evaluation data for the year 2010 offers some support for the important role of age-specific substance abuse treatment for older adults. Senior Hope has demonstrated the following outcomes: 73% retention rate at 3 months, 58% retention rate at 6 months, and a discontinued use rate of 68% among those completing the program.

ACE-Informed Programming

In light of current mental health and substance abuse service delivery gaps, an integrated approach may be especially important to meet the unique biopsychosocial needs of older patients (Grella, 2009; Oslin, 2004; Rinfrette, 2009). We propose that RIS offers a useful guide to agency leaders seeking to fill this service gap. Within RIS, leadership and policy play key roles in order to successfully incorporate research-informed services within a culture of recovery. In addition to setting a tone and example, leaders authorize policies that influence the culture. Policies, for example, can help create recovery-oriented systems that aid the development of social networks through procedures involving program graduations and mentoring. Systems can also be designed to ease community relationships that bring services on-site (Larkin et al., 2012).

The National Institutes of Health (2008) Council for Training in Evidence-Based Behavioral Practice describes evidence-based practice as an integrative process that takes into account client characteristics, needs, and values along with practitioner skill and research within the local context. RIS designs ACE-informed programming, which can be applied to enhance current Senior Hope services in a way that is consistent with the evidence-based practice process described by the National Institutes of Health (2008). Senior Hope now takes ACE histories into account during the first 45 days of treatment to better understand client characteristics and address needs, recognizing the role of earlier adversity in co-occurring later-life mental health, substance abuse, and health problems. The ACE language joins services designed to address ACE consequences and empowers clients to engage in programming. RIS unites evidence-supported interventions and emerging practices consistent with practitioner skills and client needs within the context of healthy social networks supported by recovery-oriented systems of care (Larkin et al., 2012). This facilitates integrative research to further inform comprehensive service provision (Larkin, Beckos, & Martin, 2012).

Evidence-Supported Interventions

Screening for ACE backgrounds further reveals client characteristics and needs as called for in the evidence-based practice process (NIH, 2008). RIS then engages agency staff to assess the extent to which current evidence-supported interventions and emerging practices address ACE consequences (Larkin et al., in press). Senior Hope assesses substance abuse using the Cut down, Annoyed, Feeling Guilty, and Use of an Eye opener (CAGE; Ewing, 1984). Yet, there is a gap in evidence-supported interventions for older adults with substance abuse problems (Beechem, 2004; Blow, Walton, Chermack, Mudd, & Brower, 2000; Cummings, Bride, & Rawlins-Shaw, 2006; Oslin, Pettinati, & Volpicelli, 2002). In light of this shortage, there are opportunities to incorporate emerging practices that can then be studied through practice-based research. One homeless organization implementing RIS offered a Somatic Experiencing clinic, staffed by certified practitioners from the community. Thus, decision-making brought together client needs for trauma treatment with an emerging neuroscience-based practice that was consistent with practitioner skills (Larkin et al., 2012). The Emotional Freedom Technique, a trauma treatment using acupressure, can also be combined with evidence-supported interventions within the RIS model if it is consistent with practitioner skills (Larkin & Records, 2007). Moving toward program integration, services are brought on-site through inter-agency agreements. Thus, RIS supports the evidence-based practice process by integrating research knowledge with practitioner skills and locally available services in light of client needs within the local culture (Larkin, Beckos, & Martin, 2012).

A Culture of Recovery

The RIS model includes current Senior Hope interventions and enhances services by offering a cohesive framework guiding provision of both individual and community supports in a way that takes ACEs and other trauma into account. RIS highlights an opportunity to intentionally develop social networks. Evidence-supported interventions and other services are integrated within a culture of recovery for a more powerful combined influence. Thus, the first step in RIS implementation involves clarifying the organizational mission, values, and principles that will pervade the culture. The mission of Senior Hope is "to provide high quality, science-based, compassionate, and comprehensive services to mature members of our community, 50 years and older, and their families." Stated values of the organization include a strengths perspective and appreciation of the contributions senior citizens make to the community, respect for unique individuals, partnership among professionals within and across agencies, and integrity. The agency operates on the principle that recovery is a journey that includes the whole person, mind-body-spirit, and can be supported by the community. The principle of recovery and stated values permeate all Senior Hope programs to support the mission and development of a compassionate culture (www.seniorhope.org).

Next, RIS focuses on the important contribution of each individual staff member's attitudes and actions in creating healing social networks that mobilize resilience and recovery. Leadership and policies can facilitate self-care and development of staff members, which is key to their ability to contribute to a compassionate culture through relationship-building and role modeling for clients. This is consistent with literature emphasizing the importance of self-care by helping professionals (Brenner & Homonoff, 2004; Christopher, Christopher, Dunnagan, & Schure, 2006) and prevention of vicarious traumatization (Badger, Royse, & Craig, 2008). Thus, RIS emphasizes the power of social networks, which is bolstered by research showing that health-related behaviors are contagious within social networks (Christakis & Fowler, 2007) as well as by research on substance abuse among older adults demonstrating advantages of group intervention with same-age peers (Cummings et al., 2006; Kashner, Rodell, Ogden, Guggenheim, & Karson, 1992; Kofoed, Tolson, Atkinson, Toth, & Turner, 1987). In fact, it is suggested that both family and group interventions can help counteract the lack of social support and loneliness often reported as important issues for older adults (Barrick & Connors, 2002). Peer support therefore holds an opportunity to assist older adults' recovery. Within a compassionate culture that promotes recovery, screening for ACEs and trauma can help people discover their strengths and supports. Within RIS, and consistent with Senior Hope values, older adults are appreciated for their ability to work through adversity and capacity to open themselves up to therapeutic relationships holding hope for new possibilities. This empowers older adults to use services available within programs as well as the community at large.

Research-Practice Integration

Through RIS implementation, Senior Hope serves as an example of an agency combining the intentional development of social networks with diverse agency services for a whole person response to assist older people. Thus, Senior Hope builds upon and enhances existing models, poising the agency for an integrated approach to research and evaluation of whole person service delivery. RIS promotes and extends a team-based research process known as Service Outcomes Action Research (Duffee, 2010) to explore effectiveness of incorporated evidence-supported interventions while engaging in practice-based research (Larkin, Beckos, & Martin, 2012). In this way, Senior Hope can help determine the overall effectiveness of RIS as a best practice to restore healthy aging.

CONCLUSION

Adverse childhood experiences (ACEs) are strongly correlated with serious high cost health and social problems (Larkin et al., in press). At the same time, older adults with ACE backgrounds have been incredibly resilient, and recovery is possible. Senior Hope is the first clinic serving older adults through the development of ACE-informed programming. Consistent with an evidence-based practice process (NIH, 2008), RIS takes ACEs and other client characteristics into account, integrating research-based services (consistent with client needs and practitioner skills) within the context of intentionally developed social networks to support recovery (Larkin et al., 2012). With an economic crisis re-shaping social service delivery, Senior Hope is a beacon in integrated programming that serves the whole person to restore healthy aging. ACE research provides a compelling foundation for addressing core issues to prevent costly health outcomes of concern to national policy (Larkin et al., in press). ACE-informed programming can help to achieve national health goals in a cost-effective way. Replication of the RIS model in other settings could transform our service delivery system by streamlining care to restore healthy development across the lifespan. Team-based research is proposed to determine RIS effectiveness (Larkin, Beckos, & Martin, 2012).

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