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Mobilizing resilience and recovery in response to adverse childhood experiences (ACE):
A Restorative Integral Support (RIS) case study

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Heather Larkin, PhD, LCSW-R
University at Albany School of Social Welfare

Brooke A. Beckos, MSW
St. Anne Institute

Joseph J. Shields, PhD
The Catholic University of America

Abstract

The Restorative Integral Support (RIS) model is a comprehensive, whole person approach to addressing adversity and trauma. The Adverse Childhood Experiences (ACE) Study conducted by the Centers for Disease Control (CDC) and Kaiser Permanente reveals a relationship between childhood trauma and adult health and social problems. The current empirical case study presents the Committee on the Shelterless (COTS), in Petaluma, CA, as an example of one social service agency employing RIS to break cycles of homelessness. By applying RIS, research-based programming is offered within a culture of recovery that mobilizes resilience through social affiliations. The authors recommend RIS model implementation and research in programs serving populations with ACE backgrounds.

108 words

Key Words: Restorative Integral Support (RIS), Adverse Childhood Experiences (ACE), homelessness, resilience, culture of recovery, social affiliations, “ACE-informed” programming

Author’s Notes

Address correspondence may be addressed to Heather Larkin at the School of Social Welfare, University at Albany (SUNY), 135 Western Ave, Albany, NY 12222: hlarkin@albany.edu.

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Introduction

Homelessness is increasing along with growing poverty and a shortage of affordable housing (National Coalition for the Homeless, 2009). Multiple problems associated with earlier adversity can make people more vulnerable to social conditions contributing to homelessness (Burt, 2001). The Centers for Disease Control (CDC) and Kaiser Permanente conducted a large scale epidemiologic study examining the relationship between “adverse childhood experiences” (ACE) and later-life health. ACE Scores, based on the number of “yes” responses to ten ACE categories, were strongly correlated with health risk behaviors and serious health problems (Anda et al, 2006; Felitti et al, 1998). Homeless service providers are challenged to facilitate healing social conditions that take adversity into account when helping people who are experiencing multiple problems, such as co-occurring mental health and health risk behaviors. In an effort to improve outcomes for those served, movements toward both evidence-based practice and recovery orientations have gained momentum among human service providers (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008; Starnino, 2009).

Bledsoe et al (2008) call for policies that promote recovery-facilitating evidence supported interventions (ESI) and the integration of recovery supporting systems within ESIs. The Substance Abuse and Mental Health Services Administration (SAMHSA) has placed a priority on developing “recovery-oriented systems of care” (Sheedy & Whitter, 2009). Sheedy & Whitter (2009) define recovery-oriented systems of care in the substance abuse treatment field as “networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders” (p.3). Jacobson & Greenley (2001) argue that recovery-oriented systems of mental health care

include “...services directed at symptom relief, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, and self-help” (p.484).

We present the Committee on the Shelterless (COTS), a homeless services agency in Petaluma, California, as a case example of one organization using the “Restorative Integral Support” (RIS) model to integrate research knowledge for a comprehensive, whole person approach to recovery from ACE consequences. Following a brief overview of the RIS model, this article will describe how COTS employs RIS to integrate best practices within “ACE-informed” programs to break cycles of homelessness.

Restorative Integral Support

The RIS model was developed for social service agencies helping high ACE Score populations experiencing multiple problems. RIS acknowledges the role of earlier adversity, including developmental impact, to mobilize resilience and recovery (Larkin & Records, 2007). Leadership and policies work together to develop a culture of recovery that fosters social affiliations among those served. A culture of recovery builds on individual strength and resilience, empowering people and supporting self-determination, autonomy, and healing through community integration (Jacobson & Greenley 2001). Social affiliation shapes healthy interdependence within a person’s community and culture, strengthening individuals through inclusion and group connectedness. Within social affiliations, people gain resources and opportunities for personal efficacy (Zlotnick, Tam, & Robertson, 2003).

RIS engages staff to integrate ESIs and research-informed emerging practices addressing client needs within this context. Consistent with an evidence-based behavioral practice (EBBP) process described by the National Institutes of Health (NIH, 2008), decision-making is made in light of resources, including practitioner skills, within the local culture. While the emphasis on

research supports provider competence in ESIs, the recovery focus on social connectedness, hope, and self-efficacy emphasize empowerment and attention to human relationships and the social context (Carpenter, 2002). To combine these elements, agency leaders employ the following practical steps to implement the RIS model:

- Raise staff awareness of ACE Score characteristics among those served
- Draw upon knowledge of resilience and recovery to inform ACE response
- Set a compassionate example and offer self-care support for staff who provide

relationship-building and role modeling for clients to create a culture of recovery

- Involve staff to clarify the values and principles behind “ACE-informed” programs
- Implement policies that facilitate a recovery-oriented system and culture
- Bring ESIs and emerging practices on-site to address challenges faced by clients
- Engage the community, tapping local resources while addressing local needs
- Build partnerships for comprehensive research of whole person service delivery

COTS began RIS implementation as staff persons made connections between ACE research and the substance abuse and other health risk behaviors of those served. Through this process, COTS programs became “ACE-informed” and intentionally focused on mobilizing resilience and recovery. Because awareness of this research was key to RIS implementation at COTS, an overview of ACEs, resilience, and recovery is presented next. We will then describe the history and background of COTS, followed by the next steps in RIS implementation.

Adversity, Resilience, and Recovery

The ACE Study, which began in 1994, collected two waves of data that resulted in a sample of 17,337 (response rate 68%). ACEs were defined as experiencing any of the following events prior to age eighteen: physical or emotional abuse by a parent, sexual abuse by anyone,

domestic violence, living with a substance abusing household member, living with a mentally ill or suicidal household member, incarceration of a household member, loss of a parent, and emotional or physical neglect by a parent. Respondents were given a score of one for each category they experienced. The ACE Score, ranging from 0 - 10, was analyzed in relationship to a number of adult risks (Felitti et al, 1998; Anda et al, 2006).

Felitti et al (1998) pointed out that people often employ health risk behaviors, such as overeating, smoking, and alcohol or other drug abuse, as coping strategies for short-term relief from the emotional distress created by ACEs. Higher ACE Scores were associated with leading causes of death, such as heart and lung disease (Anda et al, 2006; Dong et al, 2004; Felitti et al, 1998). A vast amount of research shows that a direct link exists between ACEs and smoking, alcoholism, other addictions (Felitti et al, 1998), and mental health problems (Edwards, Holden, Felitti, & Anda, 2003). ACEs also represent a high risk for impaired job functioning (Anda et al, 2004), homelessness (Burt, 2001), and criminal justice involvement (Messina & Grella, 2006).

Given the many human, social, and economic costs of ACEs, an understanding of how to interrupt these pathways is extremely important (Larkin & Records, 2007; Larkin, Felitti, & Anda, in press). Research on resilience, for example, has focused on human strengths and resources that help fend off depression, substance use, and other health and mental health related problems. This knowledge demonstrates that individual and community qualities work together to empower a person to move forward in life with a sense of hope, capability, mastery, and expectation. Resilient individuals accept reality, believe that life is meaningful and worth living, manage adversity, and push through hardship to overcome obstacles (Goldstein & Brooks, 2005; Henderson, 2003; Smith & Carlson, 1997). Emerging from hope, and supported by peers,

communities, and the larger society, the recovery process involves healing and a new sense of self, attitude, values, and goals (Gardner, Lehman, Brown, & Brooks, 2000; Starnino, 2009).

The Committee on the Shelterless (COTS)

The Committee on the Shelterless (COTS) was founded in 1988 when two local women, alarmed to find both adults and children sleeping in outdoor dumpsters and drains, raised awareness and sought private donor funding to develop homeless services in the town of Petaluma, CA. COTS began by providing safe shelter in a bookstore basement, two local churches, and one house. While educating the community and monitoring local temporary shelters, ongoing city council support was established and led to the development of reliable local and county funding sources. COTS' leadership sought to expand from temporary shelter services to develop programs that could help people with challenges that contributed to homelessness and reasonably offer people hope for a more stable life. Over time, COTS has developed into a multi-service, recovery-oriented agency.

In 2002, COTS secured private donor funding for a “Program Development, Evaluation, Training and Export” (PDETE) project. COTS leadership drew staff together to reflect on organizational values and program offerings. Each staff person investigated a best practice developed to address one or more of the multiple problems associated with homelessness (i.e. substance abuse, trauma, coping skills, etc) and considered ways to expand research-informed services to help homeless people. Today, the multiple services offered by COTS include:

- The Petaluma Kitchen, offering food and outreach services
- Case management, a core element serving people across programs
- The “Mary Isaak Center” emergency shelter and transformative programming
- Transitional Housing modeled after Oxford House

- Skill-building programs and specialized support services (such as Rent Right, Work Right, Kids First)
- On-site health, dental care, and mental health/crisis consultation
- A “Somatic Experiencing” (SE) clinic
- “At Home Within” programming (includes yoga, Qi Gung, mindfulness meditation, drumming, visualization, and integrative restoration/iREST)
- The Family Connection Program -- teams of volunteers support families exiting homeless situations to establish healthy social affiliations in the community
- Permanent housing (www.cots-homeless.org).

Consistent with research demonstrating the effectiveness of therapeutic communities (NIDA, 2002), COTS includes staff and recovering community members as change agents within social networks mobilizing peer influence in the development of social and recovery skills. Clients begin with an action plan and immediately join a culture of positive change. Greater degrees of personal and social responsibility are developed as those served graduate from one COTS program to the next. For example, COTS’ programming leads into transitional housing modeled after the self-run, democratic recovery homes known as Oxford House, which have been found to promote adjustment through community-based social support (Ferrari, Jason, Sasser, Davis, & Olson, 2006). Within this therapeutic community context, the Committee on the Shelterless (COTS) combines elements of emergency shelter, continuum of care, housing, service integration, and outreach in a way that is informed by an understanding of the developmental impact of early adversity as well as resiliency and the potential for recovery. The response focuses on breaking the cycle of risk behaviors associated with homelessness by helping people to recover and transform their lives, saving the cost of future ACE consequences

for the next generation. This recovery approach could be overlaid upon other service models (Larkin & Records, 2007; Larkin, Beckos, & Martin, 2012).

“ACE-informed” programming

The ACE Study, introduced to COTS by the United Way in 2004, helped explain what COTS staff saw in the shattered lives of people served. Many homeless people had survived significant past adversity, in addition to the stressful experience of homelessness. Risk behaviors, such as substance abuse, seemed to contribute to people’s homeless situation. ACEs were recognized as underlying many of the multiple problems with which homeless people presented. Employing RIS, COTS’ leadership facilitated an organizational development process in which staff learned about ACE research and considered ways to integrate this knowledge through RIS.

The integration of ACE research provided a foundation from which programs at COTS have become “ACE-informed.” This process began by building ACE awareness among staff. ACE knowledge was incorporated to enhance existing programs such as Kids First, Support Groups, Case Management, Anger Management, and the Four Agreements Seminars. Other programs and classes were initiated as ACE research was included in program design: ACE Awareness Education Presentations, Emotional Hijacking Coping Strategies Seminars, Somatic Experiencing (SE), At Home Within, Stress and Coping classes, Relationship Skills classes, and Domestic Violence awareness classes were introduced to further support people recovering from ACE consequences. All program staff received education on ACE findings, and staff specified how each program intervention sought to prevent and address ACEs or ACE consequences within logic models. RIS usefully articulates how programs were unified so that all services

work together for a comprehensive, whole person response that takes underlying ACEs into account to enhance resilience and support recovery.

Developing a culture of recovery

Researchers recognize that agency goals and processes are crucial to the way service providers within organizations carry out their work (Rosenheck, 2001). Within the RIS model, the self-care and workforce development of agency leadership and staff members is included as an aspect of intentionally-developed social networks that create a therapeutic community. The organizational development process, which engages organizational members, is therefore an important element of RIS implementation.

With the mission of breaking the cycle of homelessness, COTS' executive director engaged staff in reviewing best practices in light of ACE research and, in this context, articulating the values and principles guiding agency culture and program design. Identifying organizational values and principles is an aspect of implementing the RIS model because this helps to create the culture that intentionally shapes social networks for a therapeutic community supportive of resilience and recovery. It is within this context that ESIs and emerging practices are incorporated, with individual and community interventions working together to facilitate an ACE response that is comprehensive and serves the whole person. At COTS, the Four Pillars of Success were developed by staff and considered important principles for effective service. Staff persons also adopted the Four Agreements, developed by Ruiz (2001), as guidelines for conduct. This process involved regular meetings with staff and volunteers. The Four Pillars of Success and the Four Agreements, along with ACE information, now pervade agency culture and influence programmatic decisions.

The Four Pillars of Success, as developed by COTS, are Connection, Hope, Commitment, and Integrity (CHCI). Consistent with knowledge of resilience and protective factors (Smith & Carlson, 1997), the connection of a supportive and healthy relationship provides the basis from which hope can emerge. In order to develop such a relationship and gain the credibility needed to help people, COTS staff demonstrate that they are trustworthy and reliable. Hope becomes realistic through small life changes and can help people develop the commitment to bigger changes, and then set personal goals to improve their circumstances. CHCI represents how staff orient around the mission and serves as a basic framework for any program. COTS staff describe the culture as flowing from these values and the Code of Conduct based on Ruiz' (2001) "Four Agreements." These Four Agreements include:

- 1) Be Impeccable with Your Word, 2) Don't Take Anything Personally,
- 3) Don't Make Assumptions, and 4) Always Do Your Best (Ruiz, 2001).

These values and principles have guided the intentional development of a recovery-oriented culture that fosters resilience. This culture facilitates the personal development of staff, many of whom have identified their own ACE Scores, who then support the development of healing social networks for those served. Thus, the self-care of agency leadership and staff persons is actually an aspect of RIS. For example, the case management group conducts meetings on self-care, which is recognized as key to accomplishing relationship-building and role modeling. Somatic Experiencing (SE) volunteers worked with staff on secondary trauma and self-regulation for a full year. Rest, renewal, and development are viewed as crucial to meeting the demands of a life of service – working with traumatized people, sticking to principles, completing administrative tasks, combining disparate fields to serve people comprehensively, and operating as a leader in the community. This is in keeping with literature highlighting the importance of preventing vicarious traumatization (Badger, Royse, & Craig,

2008) and addressing self-care among helping professionals (Christopher, Christopher, Dunnagen, & Schure, 2006).

Within a culture of recovery, ACE research information plays an important role to help people discover how they have been able to survive and explore their own resiliency and supports. People served at COTS are viewed as heroes who have pulled through adversity and are still willing to open themselves up to relationships with staff and volunteers because they want to better their lives and their children's lives. At COTS, people experience a healthy relationship and see someone believing they can succeed. For example, when COTS helps a parent with an ACE Score of 8 along with their child who has an ACE Score of 4, it is crucial that the parent experience themselves as connected to reliable staff who offer hope and mobilize the parent's resiliency and recovery while teaching them new parenting skills and encouraging them to continue providing their children healthier experiences. This also helps to empower parents to utilize services available within the agency and community.

The culture created at COTS extends into the community. COTS involves the community in an ongoing series of programs designed to lift people up and give them hope for a better life. Community volunteers become invested in the success of the participants. COTS has relationships with town businesses and community organizations, viewing the support of the community as imperative in accomplishing the mission. COTS staff also organize volunteer and internship experiences for clients within the community, and organizations will sometimes call for help. The relationship with the community is mutually beneficial, as people think of COTS when they want to provide service, creating a strong volunteer base. New interventions to address client needs are brought on-site through relationships with other service providers. Examples include professional mental health consultation and the Somatic Experiencing (SE)

clinic, as well as health and dental care. People who have received help from COTS refer friends who are still on the streets, and other nonprofits often refer to COTS.

The role of organizational policy

Policies help to create an environment of health and safety while supporting the culture of recovery. One of COTS' foundational policies is "no substance use." While meals and outreach services are provided to chronically homeless people, many of whom actively use substances, engagement in COTS' programming requires a decision to stop using, with program participants agreeing to drug-testing. The decision is often an indicator of movement from contemplation to determination along the continuum of change (Prochaska & DiClemente, 2005). COTS' no use policy, combined with the cultural emphasis on social affiliations, is also supported by Zlotnick et al's (2003) discovery that social affiliation is connected to the ability of those not currently using substances to exit homelessness and their suggestion to first address substance abuse problems in order to help people exit homelessness. Policies, procedures, and the interaction of staff and client culture have helped develop a cohort of people with reasonably good attitudes and habits, which research demonstrates are "contagious" (Christakis & Fowler, 2007). This brings in respect and communication styles that are conducive to life success.

Research-practice integration

COTS provides an example for social service agencies exploring ways to integrate research to effectively serve the whole person and support recovery through a range of services. RIS implementation has led to a dramatic increase in COTS' ability to house homeless and chronically homeless adults. In 2004 – 2005, COTS housed 8 of 646 clients with conventional case management techniques, fewer programs, and the same number of full-time program staff. In 2008 – 2009, 283 of 590 unduplicated individuals were successfully housed in transitional or

permanent housing. COTS was awarded the Van Loben Sels Foundation's designation as a Model Practices Agency and received three recent awards from the United Way.

Representatives from homeless service organizations in Albany, Cleveland, Boise, and Sacramento have traveled to COTS to learn about COTS' leading edge "ACE-informed" programming.

By implementing RIS, COTS brought ACE research together with knowledge of resilience and recovery to inform the integration of locally available ESIs and research-based emerging practices within programming. Already informed by existing research, evaluation for effectiveness can easily flow from the RIS model. Duffee (2010) describes a comprehensive approach to research on service outcomes, known as "Service Outcomes Action Research" (SOAR), which is proposed as a way to determine the efficacy of COTS' research-based programs and assess a wide range of outcomes (Larkin et al, 2012). Similar methods of inquiry and action inform a University partnership with Oxford House (Davis, Olson, Jason, Alvarez, & Ferrari, 2006).

Implications for Human Service Providers

The RIS model demonstrates how social networks can be intentionally developed to help people transform their lives, bringing research-informed practices together within a recovery-oriented culture to break the ACE trajectory. RIS replication by other social service agencies allows room to include a variety of locally available best practices within the culture of recovery. Based on this case study, the following RIS implementation steps are recommended to agency leaders: 1) Develop programs that take client ACE Scores into account and engage a whole person approach to promote resilience and recovery. 2) Carefully attend to the roles of leadership and policy to create a culture of recovery. 3) Engage staff to articulate programming

values and principles that will pervade agency culture and support the mission. 4) Support self-care of the workforce that provides the role modeling and relationship building necessary for a therapeutic community. 5) Engage staff in identifying locally-available best practices that can be incorporated into recovery-oriented programs. 6) Provide community leadership, including service to the community, as well as incorporating volunteers and locally available services into programs. 7) Carry out RIS model implementation and research in diverse settings.

Conclusion

Adverse childhood experiences (ACE) are linked to high cost later in life health risks (Felitti et al, 1998) that may increase vulnerability to homelessness (Burt, 2001). COTS provides safe, sober, supportive shelter with research-informed programs carried out through community engagement. Employing the RIS model, COTS' programs emphasize personal responsibility, social affiliations, and skill-building to promote resilience and recovery from ACE consequences, including substance abuse. COTS' mission to break the cycle of homelessness is achieved when people's lives are transformed through this recovery process. RIS implementation has led to cost-effective recovery-oriented integrated programming. COTS serves as an example for social service agencies interested in employing RIS to provide a comprehensive, whole person approach to mobilize resilience and recovery. RIS implementation and research is recommended in programs serving high ACE Score groups.

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