Three Legs of the Stool

A Framework for
Community Mental Health Services

Mental Health and Recovery Board of Ashland County

Offering Rays of Hope

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Introduction

In healthcare, as in other fields, it is helpful to orient programs and services around an integrated and cohesive framework of values and principles. This document provides a summary of the framework that has been adopted by the Mental Health and Recovery Board of Ashland County by which programs are prioritized, developed, funded and evaluated. This framework, referred to as the *Three Legs of the Stool*, is comprised of three distinct but related sets of principles and values: Recovery, Trauma-Informed Care and Medication Optimization.

Part I: Principles of Recovery

Formally introduced in the early 1990's, the concept of recovery as a framework for mental health programs was rejuvenated in 2003 when the New Freedom Commission, appointed by President Bush, issued the report titled *Achieving the Promise: Transforming Mental Health Care in America*. As we entered the 21st century, the report promised the possibility of significant reforms of mental health policies and practices aimed at improving the lives of people with serious mental health problems. It did not suggest simple and targeted reforms, but rather called for system wide and top to bottom transformation of the way community mental services are conceived and delivered. In addition, the report calls the development of a system of care that goes beyond the management of symptoms and promotes true recovery from mental health conditions:

> *RECOVERY*
>
> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

> *The time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the Nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. Too often, today's system simply manages symptoms and accepts long-term disability. Building on the principles of the New Freedom Initiative, the recommendations we propose can improve the lives of millions of our fellow citizens now living with mental illnesses. The benefits will be felt across America in families, communities, schools, and workplaces.* (*Achieving the Promise, 2003*)

The concept of recovery is offered as an optimistic alternative to a bio-medical model of mental illness. The medical model views mental health problems as a brain-based, chronic, organic illness that requires medical intervention as the primary treatment. The medical model focuses on identifying and managing symptoms and often advocates for life-long use of medication. The medical model often utilizes a case-

management approach to treatment that relies heavily, many times exclusively, on medication. If it is complimented, it is by case-managers who ensure that patients remain compliant with their treatment. The medical model is the dominant approach in contemporary mental health care and it consumes the majority of resources. Its effectiveness is questionable.

In contrast to the medical model, the recovery model of mental health care is reluctant to assign specific causes to mental health problems and views them as resulting from a complex combination of factors. These factors vary considerably from person to person, and include environmental, cultural, social, developmental and other factors. The cost common denominator for people seeking mental health care and help for addictions is the individual's history of exposure to severe stress (such as living in a persistent state of fear) and experiences of violence or other interpersonal trauma (such as physical or sexual abuse).

The Recovery Model is different from traditional mental health services in at least three ways:

- The individual defines the goals of treatment
- The individual is an active participant, not a passive recipient
- It acknowledges that disability results from the relationship between the person and the community, and is not merely a problem within the individual

A wide range of rehabilitative services and support programs are necessary in order to respond to the unique needs of each individual. These programs include counseling, peer support, educational and vocational supports and other psychosocial and narrative approaches that seek to promote the greatest degree of recovery and independence, and the highest quality of life possible. In addition, a recovery oriented approach looks beyond symptoms and views people holistically and in the context of their life and experiences. It is important to establish hope and to make people aware that individuals who experience even severe mental or emotional distress can and do recover and move beyond disability. The recovery model is strengths based as opposed to illness-based as in the medical model.

In 2006, the Mental Health and Recovery Board formally adopted the *Consensus Statement on Mental Health Recovery* that was issued by the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA). The consensus statement embraced 10 principles of recovery. These components are viewed by the Mental Health and Recovery Board as essential principles for community mental health and addiction programs.

The 10 Fundamental Components of Recovery:

• **Self-Direction:** Consumers determine their own path of recovery with their autonomy, independence, and control of resources.

• **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background.

• **Empowerment:** Consumers have the authority to participate in all decisions that will affect their lives, and are educated and supported in this process.

• **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and family supports as determined by the person.

• **Non-Linear:** Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience

• **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

• **Peer Support:** Mutual support plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging.

• **Respect:** Eliminating discrimination and stigma are crucial in achieving recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging.

• **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers identify coping strategies and healing processes to promote their own wellness.

• **Hope:** Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

In 2011, SAMHSA announced:

> *A new working definition of recovery from mental disorders and substance use disorders is being announced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The definition is the product of a year-long effort by SAMHSA and a wide range of partners in the behavioral health care community and other fields to develop a working definition of recovery that captures the essential, common experiences of those recovering from mental disorders and substance use disorders, along with major guiding principles that support the recovery definition. SAMHSA led this effort as part of its Recovery Support Strategic Initiative.*

The new working definition of *Recovery from Mental Disorders and Substance Use Disorders* is as follows: "*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*". (SAMHSA)

Part II: Principles of Trauma-Informed Care

The second set of principles and values of the Three Legs framework is commonly referred to as Trauma-Informed Care (TIC). The term trauma is used here in a broad sense and encompasses adverse experiences such as physical, sexual or psychological abuse, living in a state of persistent fear and anxiety, posttraumatic stress disorder/injury, neglect, exposure to violence and toxic stress.

When, in the early 1990's, the Ohio Department of Mental Health announced the new Trauma-Informed Care initiative for the state, it marked a shift in the way community mental health care was being conceived, and was a movement back toward an appreciation for the importance of an individual's history and experiences as it related to their current mental health. The emergence of managed care in the 1980's had fostered the popularity of short term problem-focused interventions which tended to minimize the past experiences of individuals. In spite of the fact that most people seek mental health care because of adverse experiences and other challenges of living, managed care and other payers, and by extension mental health providers, placed increased attention on managing symptoms and fixing "what's wrong with you" rather than addressing the more challenging aspects of "what happened to you".   This trauma-informed care initiative helped to bring attention back to the psychosocial dimensions of mental health care (theoretically if not practically) that had been abandoned when managed care emerged in the early 1980s.

Experiences in the realm of trauma are much more common than is generally acknowledged. This is in large part due to the stigma attached to many types of trauma, like child sexual and physical abuse, which cause us to deny or minimize both its occurrence and effects. However, the issue is receiving increased attention from policy makers and health care professionals, educators and others. It is well established that most individuals seeking mental health care or addiction treatment have histories of abuse, neglect of other trauma. In addition, it appears that the incidence of violence, abuse, severe neglect and other forms of trauma have been increasing in recent decades. Sociologists and trauma researchers are beginning to describe violence as being a contagious social phenomenon, much the way germs can be contagious with respect to physical health or disease.

The Adverse Childhood Experiences (ACE) study, conducted by Kaiser Permanente and the Center for Disease Control and published in 1998, is the largest study of its kind that has ever been conducted. It is based on a group of more than 17,000 patient health records and an average patient age of 57. Patients were screened for 10 common adverse experiences such as growing up in a home where a parent was alcoholic or mentally ill, or being a victim of child physical, sexual or psychological abuse. The study revealed that fully two-thirds of the patients had experienced one or more adverse childhood experience (ACE). Of the individuals who had experienced one ACE, 87% reported at least one other ACE and 70% reported 2 or more additional ACEs. In addition, the ACE study revealed a strong and direct correlation between one's ACE score and health, mental health and substance abuse problems in later life.

In spite of the high prevalence of ACEs, there is clear evidence that children who have experienced traumatic events and their families can heal and reclaim their lives in communities that have the knowledge, commitment, skills and resources to support them. Using a collaborative model, we must integrate an understanding of child traumatic stress into the policies and practices of all child-serving systems (mental health, child welfare, juvenile justice, law enforcement, health, education) as well as natural support systems and programs for adults. The Ohio Department of Mental Health has challenged local communities to direct financial and human resources to implement and support a comprehensive strategy that will:

- Reduce the incidence of preventable childhood trauma.
- Reduce the negative impact that results from trauma.
- Provide adequate trauma screening and assessment.
- Provide access to a continuum of trauma-informed services and resources.

The capacity for programs addressing the effects of violence and trauma on individuals, families and communities must be increased. Trauma-informed care must be embedded and integrated into services, programs and communities that are sensitive to the impact of trauma in every dimension, at every level and across systems. Finally, it is important for communities to commit to promoting programs and initiatives aimed at reducing and preventing the incidence of trauma and violence. There are several resources and toolkits that have been assembled to assist communities in this way, including:

- *Safe, Stable Nurturing Relationships (SSNRs)* from the Center for Disease Control
- *Strengthening Families*, Center for the Study of Social Policy at the University of Chicago

Principles of Trauma-Informed Care Include:

- Change the question from "*What's wrong with you*?" to "*What happened to you?* "
- View conventional problems (such as smoking, obesity, substance abuse) as representing unconsciously chosen solutions by the individual. (Felitti)
- Avoid the use of coercion and force; be sensitive to dynamics of power and control
- Avoid the use of diagnostic and other labels
- Avoid using bio-medical language (such as "brain disease" and "chemical imbalance") to describe mental anguish and emotional suffering; it is often dehumanizing and dismissive to victims of abuse

Part III: Principles of Medication Optimization

There are many reasons for the current emphasis on the use of medications in mental health care. There is evidence to suggest that some people benefit from short-term, selective use of medications to manage severe emotional or psychological distress during a crisis. In addition, there is a subset of individuals who may benefit from long-term medication use if it is very closely monitored. However, there has been a great deal of discussion and controversy regarding the benefits and risks associated with the use of medications in mental health care, especially long-term use.

Psychiatrists are generally trained to start medications routinely, quickly, at relatively high doses, and maintain their patients on medication for long periods of time, sometimes indefinitely. In addition, multiple drug combinations, often referred to as polypharmacy or drug cocktails, are commonly used. This is risky because much remains unknown about drug interactions.

There are a myriad of social, political and economic factors that influence the high utilization of medications. For example, direct-to-consumer advertising, permitted by the Federal Communications Commission beginning in 1997, and other issues related to the marketing of medications are frequently cited as influential factors. In addition, managed care companies and federal entitlement programs like Medicaid and Medicare incentivize medication-focused treatment because it is seen as a quick and relatively inexpensive fix. Today, it is true to say that medications are the primary and usually the only treatment provided to people diagnosed with a mental illness. The time has come to engage in a dialogue about the best use of medications to promote optimal recovery from mental health problems.

One such dialog took place when fifty four experts, including 23 psychiatrists, administrators, state and federal policy experts, mental health service users and advocates, attended a 2-day symposium in Portland, Oregon in 2012 for the purpose of writing policy briefs and clinical protocols based on an alternative, evidence-based approaches to the use of medications in mental health care. This new approach is called *Medication Optimization* and was defined by this group as:

> *A mental health recovery utility which supports the judicious use or non-use of psychotropic medications based on valid evidence-based research findings and balanced with an array of other effective, recovery-based services and supports. The goal of all of these interventions is to improve and maximize the self-determination, functioning, and quality and meaning of life of people affected by mental health challenges. Medication optimization includes postponing or avoiding the use of medications in favor of recovery-based psychosocial supports and services, sensitive and collaborative initiation of medication protocols, timely medication tapering or withdrawal protocols, and regular reassessment of recovery status to guide shared decision making to adjust medication treatment.*

The group also identified principles that should be embedded in Medication Optimization:

> *Medication optimization policies must emphasize the principles of self-determination, shared decision-making, upholding individual rights, person-centered planning and strengths-based approaches conducive to empowerment and recovery for persons responding to mental health challenges in their lives.*

Clinical protocols written by the group were based on these principles:

- *Delay Introduction (don't use medications right away, try other things first)*
- *Use minimal dose; start low and work up (American prescribers typically prescribe medications at much higher doses than in other countries)*
- *Use minimum number of medications; avoid medication combinations because of unknown drug interactions*
- *Use medication for the shortest duration possible; treatment goals should reflect an exit strategy and not be open-ended; monitor closely and address side effects*

In addition, it was decided that protocols were needed for helping to reduce or discontinue medication use in some patients, resulting in *Treatment Optimization Guidelines for Reducing Psychiatric Medications*. While tapering protocols are a matter of great importance, there is little substantive information to guide the process.

Medication Optimization does not accept the idea that medications correct chemical imbalances in the brain because there is no evidence to support this theory. However, it acknowledges that medications can play a role in mental health recovery for some people as part of an integrated recovery plan. While medication may play a part in recovery for some people (mostly on a short-term basis), it is not seen as an essential component of long-term recovery for many people. Medication Optimization approaches drug treatment with an eye of caution and a bias toward conservative medication use.

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