Three Legs of the Stool
A Framework for Community Mental Health Services
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.

County behavioral health authorities (AKA county mental health and recovery boards) conduct the planning, funding and monitoring activities of publicly funded mental health and alcohol/drug services. County mental health and recovery boards are governed by 18 (or in some cases 14) volunteer board members including consumers, professionals, advocates, family members and others. The county board receives all of the state and federal funding available to the county for mental health and addiction services. In addition, the boards are authorized by the Ohio Revised Code to leverage a property tax (with the approval of voters) in order to provide local revenue for services. Most counties in Ohio have such a levy. County boards are responsible to set priorities, direct resources and monitor services in their district. This provides an opportunity to create integrated systems of care that are most responsive to the needs and desires of the local citizens. This is important because, as in most states, characteristics of counties vary widely and there is a mix of urban and rural areas that make a “one-size-fits-all” approach particularly ineffective.

County Boards do not provide direct clinical services, but rather purchase those services from local non-profit community agencies. The Mental Health and Recovery Board of Ashland County has adopted a framework to guide the development of local services which is referred to as the Three Legs of the Stool: A Framework for Community Mental Health Services. This document describes the principles of mental health care that the Mental Health and Recovery Board of Ashland County board is promoting and upon which services are prioritized, developed, funded and evaluated.
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:

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 biomedical 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 medication treatment is complimented, it is by case-managers who ensure that patients remain compliant with their treatment, which is to say taking their medication. 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 most 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 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.

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: 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.

In the early 1990’s, the Ohio Department of Mental Health (ODMH) announced a new Trauma-Informed Care initiative for the state. This marked a shift in the way community mental health care was being conceived. It was a movement back toward an appreciation for the importance of an individual’s history and experiences and how both contribute to a person’s current mental health status. 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. Although 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) place 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 of ODMH helped to bring attention back to the psychosocial dimensions of mental health care (theoretically if not practically), which 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 or 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.
SAMHSA’s Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific. From SAMHSA’s perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. The six key principles fundamental to a trauma-informed approach include:

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, and among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: “one does not have to be a therapist to be therapeutic”

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/ or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, either directly or through referral, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma. (SAMHSA 2014)

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

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**

SAMHSA recently completed a guiding document that includes six principles of a trauma-informed approach. Although it has only been released in draft form, it is included here because of its relevance.
PART III: 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. Many researchers, mental health professionals and consumers state that the benefits of psychiatric medication are often over-stated and the risks, especially with long-term use, are minimized. There is a growing body of evidence that long-term use of these medications contributes to serious health problems such as diabetes, heart problems and obesity.

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, were invited by science and research journalist Robert Whitaker to attend a 2-day symposium in Portland, Oregon in 2012 for the purpose of writing policy briefs and clinical protocols based on 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.

Together, the Three Legs of the Stool, Recovery, Trauma-Informed Care and Medication Optimization, provide an integrated, evidence-based and useful framework upon which to build a recovery-oriented system of care. The Mental Health and Recovery Board of Ashland County and our community are not satisfied with the status quo of community mental health care and seek opportunities to influence policy and practice to better align with the Three-Legs philosophy.

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