

Recovery for Young People

Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS)

Discussion Paper

Funded by NSW Ministry of Health

November 2014





Mental Health Coordinating Council

Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

For further information please contact:

Jenna Bateman
Chief Executive Officer
Email: jenna@mhcc.org.au
Tel: (02) 9555 8388 # 102

Corinne Henderson
Senior Policy Advisor
Email: corinne@mhcc.org.au
Tel: (02) 9555 8388 # 101

© Mental Health Coordinating Council 2014

Funded by the NSW Ministry of Health

Primary author: Kerry Searle, consultant to the project.

Other contributors: Lorna Downes, Corinne Henderson, Tully Rosen (Mental Health Coordinating Council)

With special thanks to:

- Danielle Maloney and Titia Sprague, NSW Ministry of Health
- Members of the MHCC Youth Recovery Project Reference Group
- Participants of the project focus groups

Please cite this paper as follows:

Mental Health Coordinating Council 2014, *Recovery for Young People: Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS): Discussion Paper*, MHCC, Sydney, NSW.

Contents

Acknowledgments.....	4
Executive Summary	1
Purpose and Scope.....	4
Part 1: Conceptual Review.....	6
Definitions and history of recovery.....	6
Recovery-Oriented Practice - What Workers Do.....	8
Trauma-Informed Care & Practice.....	9
Contemporary Models and Philosophies of Child and Youth Mental Health.....	10
Does Recovery Apply to Children and Young People?	11
Part 2: Consultations.....	15
Results Part A: The Concept of Recovery	16
Results Part B: Supports for Recovery	22
Results Part C: Recovery-Oriented Practice- Opportunities and Challenges	26
Practice Guidelines	32
Part 3: Recommendations.....	36
Bibliography	44
Appendices	47
Appendix 1 – Young Persons’ Focus Group – session plan	48
Appendix 2 – Recovery Self Rating Tool for young peoples’ focus group	49
Appendix 3 – Parents and guardians survey	50
Appendix 4 – Workers pre-questionnaire – written response.....	52
Appendix 5 – Recovery handout and consultation questions for service provider focus group.....	53
Appendix 6 – Youth and Recovery Project survey	57
Appendix 7– Trauma-informed care & practice principles.....	60
Appendix 8 – Ten Principles for recovery oriented community based care.....	61
Appendix 9 – Suggested Reading	62

Acknowledgments

In April 2014 in order to progress the Youth and Recovery Project a reference group was formed representing a wide range of stakeholders. Three meetings were held to assist with coordination of the project, including conceptual issues and to plan and conduct the consultations.

MHCC wish to acknowledge the considerable contributions of all the members of the reference group, and thank them for their enthusiastic participation in the project.

The RYPP Reference Group consisted of the following participants:

- Danielle Maloney (MH-Children and Young People, NSW Ministry of Health)
- Anne Honey (School of Health Sciences, University of Sydney)
- Josey Anderson (Black Dog Institute)
- Claire Honey (Headspace NSW & ACT)
- Lynda Walton (Carer representative, ARAFMI)
- Sam Johnson (WEAVE)
- Jamie Lee Nolan (Youth Advocate, WEAVE)
- Janine Van Bruissen (UnitingCare Mental Health)
- Deborah Howe (Y-Central, Central Coast Local Health District)

MHCC would also like to acknowledge and thank the 5 young consumers, 76 youth mental health and CAMHS workers and 17 family carers who shared their experiences via surveys and in focus groups.

The Youth and Recovery Project Team consisted of:

- Kerry Searle – Project Consultant
- Corinne Henderson (MHCC) - Contributor
- Lorna Downes (MHCC) – Project Coordinator
- Tully Rosen (MHCC) – Project Manager

Executive Summary

As a consequence of concerted efforts by the consumer movement and the community mental health sector, recovery-oriented practice is now embedded across numerous Australian mental health policy frameworks and practice standards. Notable documents include the National Framework for Recovery-Oriented Mental Health Services¹, the National Standards for Mental Health Services (2010)² and the National Practice Standards for the Mental Health Workforce (2013)³. However, there is little evidence that work has been undertaken to define 'recovery' specifically from the perspective of young people. There has been a tendency in youth mental health services as well as child and adolescent mental health services (CAMHS) to use different language in their models of care which does not easily align to the 'recovery' literature. This paper uses the main themes identified in the adult personal recovery literature to discuss and explore the utility and relevance of these recovery processes for young people and their families.

The concept of 'recovery' emerged as a consequence of two very different but co-existing historical forces; the mental health consumer movement, and research into long-term outcomes for people diagnosed as having a severe mental illness. This has led to misunderstandings of the recovery concept. In this paper 'recovery' refers to the personal, self-defined and non-linear journey towards wellbeing which may or may not be associated with the reduction of physical and psychological symptoms or experiences.

As part of this project, a literature review was undertaken and a conceptual overview exploring the utility of these concepts for children, adolescents and young adults is contained within this paper. The main findings of the review are that the five recovery processes: Connectedness, Hope and Optimism about the future, Identity, Meaning, Purpose and Empowerment (summarised as CHIME) are relevant for young people, although how these are expressed will depend on their age and developmental stage.

Although an environmental whole-of-community approach is central to recovery, it is especially important for young people, as they generally have fewer opportunities to make decisions outside of these systems.

Both the literature and consultation with stakeholders revealed similar themes.

Connectedness is especially important for young people due to a developmental need to actively define and redefine themselves via their relationships with others. Connectedness and the health of the social systems around a young person are also crucially important due to the continuing support and developmental needs of young people. All stakeholders participating in the consultations expressed a major focus on the overall health and support needs of the families of young people, the school environment and the importance of age group peers. In addition accessibility, affordability, flexibility and age appropriateness of health services for both mental and physical health were a focus of concern.

Hope and optimism are of crucial importance for young people and their families. All approaches commonly used to promote mental health in young people incorporate these principles as an inherent part of good care. All stakeholder groups proposed that hope is important for young people and their families and work to promote hope.

Identity was seen as a complex area for young people. Identity is fluid in young people, particularly in adolescence, and the promotion of a positive identity and prevention of an 'illness' identity was seen as crucial. A developmental approach was also seen to be critical. Participants in the consultation thought that it was important to ensure that young people did not feel undue pressure to fully form their identities prematurely.

Meaning and purpose was seen as important for young people, but again developmental factors need to be taken into consideration when this is discussed with young people and their families. The young people felt that they were already under enough pressure to decide on long term life directions and thought that workers should emphasise shorter term goals and connection to valued activities. Workers were also concerned that given too much pressure, young people may take on the goals of others rather than developing their own.

Empowerment of the young person as a part of their family was seen as crucially important. Stakeholders, including young people, believed that young people need decision-making support as they are not developmentally able to make all necessary decisions, particularly concerning health care. For young people, empowerment was seen to be more around being heard and consulted as a key person in the decision-making team. Young people felt very strongly that they were a part of their family system and that decisions could not be taken outside of this system.

One of the most important findings of the review and consultation process was that although the themes were seen as relevant, the language was not generally seen as youth friendly. This study seeks to investigate improved ways of working with children, young people and their families that is trauma-informed and recovery-oriented as well as appropriately youth friendly in terms of language and approach.

Overall, recovery and recovery-oriented practice are seen to be consistent with the principles of appropriate care for young people with mental health conditions. Special consideration needs to be taken to ensure that these principles are implemented in a manner that is developmentally and contextually appropriate for young people, and discussed in youth friendly language. Various other challenges to implementation of recovery-oriented care need to be further discussed and addressed.

The ability of mental health services that work with children and young people to implement recovery-oriented practice was discussed. The vast majority of workers thought that recovery-oriented practice principles were important in their work, however, many constraints were identified:

- Flexibility and resource limitations.
- Challenges to facilitating empowerment for young people.
- A need for systems supportive of recovery-oriented practice.
- Education and support needs.
- A need for risk management policies and procedures to be trauma-informed and recovery-oriented.
- Difficulties in transitions between service settings, particularly inpatient to community and young persons' services to adult mental health services.
- A need to improve interagency collaboration.
- A need for services to be trauma-informed more broadly.
- Much of the language related to recovery in the adult literature was not seen as youth friendly.

Practice guidelines for workers were suggested and recommendations for further work were developed from the consultation process.

Recommendations

Recommendation 1: Language, literacy and opportunities for reflection

Develop language guidelines that reflect trauma-informed recovery orientation from the perspective of young people; to be utilised across service settings and systems by mental health and service provider staff.

Recommendation 2: Ensure participation of young people and their families in developing service delivery, programs and quality improvement strategies

Develop collaborative processes to ensure that the voice of lived experience of young people and their families is embedded in the model of practice and service delivery environment.

Recommendation 3: Address physical health

Develop support mechanisms that adopt a whole- of- person approach to include strategies and programs that prevent and address co-existing physical health needs.

Recommendation 4: Development of youth peer support and participation as a workforce competency

Consider the assumptions concerning the training of adult peer workers, and how the lived experience of young people might alter the approach necessary. The objective being to develop peer support and mentoring programs to meet the needs of young people and ensure broad-based access.

Recommendation 5: Trauma-informed care and practice

Ensure services provide safe environments for young consumers. Direct service delivery staff must be appropriately trained to understand and be aware of the principles and practice of trauma-informed care.

Recommendation 6: Further consultation and stage 2 review

The limitations of this review require a more in-depth study be initiated to further consult and review existing literature in relation to the many issues not touched upon in this study.

Recovery for Young People: Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS)

Discussion Paper

Purpose and Scope

In line with international directions in mental health, the Australian mental health system has progressed towards a recovery-oriented approach to care and support. A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers (Department of Health and Ageing 2013)⁴, states that:

“All people employed in the mental health service system regardless of their role, profession, discipline, seniority or degree of contact with consumers will use the framework to guide their recovery-oriented practice and service delivery.” (p.1)

Additionally both the National Standards for Mental Health Services (Department of Health and Ageing 2010)⁵ and National Practice Standards for the Mental Health Workforce (State of Victoria, Department of Health 2013)⁶ adopt a recovery-oriented focus, and provide guidance on the implementation of recovery-oriented care.

Recovery was originally defined from the narratives of adult mental health consumers, their families and carers. It is unclear as to whether these concepts are immediately transferrable to the developmental context of child, adolescent and youth experiences of mental health support. Thus, it is important to consider how recovery concepts and practices may be consistent with the needs of children, young people and their families.

Concerns have been raised that the specific needs of children and adolescents will be overlooked in a shift to recovery-oriented practice, and that this move will imply that services who work with children and young people will provide exactly the same services and models of care as adult services (Friesen 2007; Lal 2010)⁷

Extensive consultations undertaken in the United States (Friesen 2007)⁸ have shown that when given information about recovery, service providers, young people and their families are all able to identify the utility of recovery philosophy for children and young people, provided it is implemented in a developmentally appropriate, contextual manner that does not negate the importance of promotion, prevention and early intervention approaches to mental health.

This discussion paper was developed in order to articulate considerations surrounding the application of recovery-oriented practice to the unique Australian policy and practice context, particularly within the conceptual models used in Australian youth mental health services, Child and Adolescent Mental Health Services (CAMHS) and early intervention services. The research conducted to inform this paper was designed to explore the applicability of recovery concepts to mental health practice with children, young people and their families. This is executed from multiple perspectives and presented in three distinct parts:

Part 1 presents a background to the concepts and issues based on a review of the literature. The existing concepts of recovery philosophy and recovery-oriented practice are defined and compared to current models used for working with children and young people who access mental health services. This section also contains a summary of concerns expressed in existing literature about the application of recovery principles to children and young people.

Part 2 outlines the findings from consultations conducted with three stakeholder groups: young people who have been diagnosed with mental illness; parents and caregivers; and mental health professionals who work with children and young people. Their perspectives on the utility of recovery concepts and recovery-oriented practice for the needs of children and young people are discussed.

Part 3 outlines suggested practice guidelines to assist with the implementation of recovery-oriented practice for children and young people. It also makes recommendations for further work needed to assist with the implementation of recovery-oriented practice in mental health services for children and young people.

Project limitations

The scope of the project led to a number of limitations. The authors acknowledge that important issues are absent due to the limited timeframe and the constraints of resources available. Several important considerations, including the influence of trauma-informed care and practice principles on recovery-orientation are not sufficiently explored.

Likewise practice approaches and issues related to particular difficulties including: eating disorders; domestic violence; childhood abuse; disability; gender issues; sexual identity and developmental issues such as self-esteem; are all matters that should be considered in future studies.

Part 1: Conceptual Review

Definitions and history of recovery

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery— hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services. State of Victoria, Department of Health 2013).⁹

The concept of 'recovery' as a guide to living with mental health conditions emerged as a consequence of two very different, co-existing historical forces. One was the mental health consumer movement; a social justice and activist movement that evolved alongside the civil and welfare rights movements of the 1960s. Many people involved in the mental health consumer movement were ex-psychiatric patients who challenged entrenched social discrimination against people with mental illness and questioned what they perceived as ineffective and damaging treatment approaches (Anthony 1993; Chamberlin 1990; Deegan 1988; Everett 1994).¹⁰

The other major historical driving force was scientific inquiry into long-term outcomes for people diagnosed as having a 'severe mental illness'. These studies found that approximately half of people living in developed nations with severe mental health conditions made a full or significant recovery as understood by mental health professionals.

Collier (2010)¹¹ makes the case that these two historical forces have resulted in two distinct concepts of recovery in the literature.

These are:

(i) the traditional definition of recovery, referring to cure from illness; and

(ii) contemporary ideas about 'recovery' referring generally to a process of change and personal growth.

In this context, Collier further notes Perkins and Repper's argument (2004, cited in Collier, 2010, p. 1)¹² that:

[R]ecovering is not the same as rehabilitation, for example, and it is unclear how such services have accommodated this. There is therefore a risk that recovery could 'become the latest catch phrase used merely to reframe traditional activities . . .'

This has led to misunderstandings of the recovery concept in the adult mental health field. To avoid such confusion, in this paper 'recovery' refers to the personal, self-defined and non-linear journey towards wellbeing. This can be associated with, but is not the same as, the reduction of physical and psychological symptoms or experiences.

Leamy et al. (2011)¹³ conducted a systematic review of the available literature on personal recovery and then used a modified narrative synthesis to develop a new conceptual framework for recovery.

This conceptual framework is comprised of five recovery processes summarised by the acronym

CHIME:

- **Connectedness** - Peer support and support groups, connecting with friends, partners, family, school/work and other community connections. Getting support from others.

- **Hope and optimism about the future** - Believing in the possibility of recovery and the ability to live a fulfilling life, regaining dreams and aspirations for the future, setting goals and being motivated to achieve these goals, having hope-inspiring relationships, thinking positively and valuing success.
- **Identity** - Rebuilding a positive sense of self, overcoming stigma surrounding mental health problems, and seeing oneself as capable despite having experienced mental health problems.
- **Meaning & purpose in life** - Making meaning of mental illness experiences, experiencing spirituality, having a good quality of life, having a meaningful life and social roles such as participating in various community activities, rebuilding life.
- **Empowerment** - Taking personal responsibility including for one's own mental health, making decisions about one's life directions including how to work with the mental health service, self-management of mental health and focussing on strengths.

The above processes can be enhanced for individuals (and communities) regardless of a person's 'symptoms'. In fact, it has been suggested that communities are just as responsible for recovery as the individuals themselves. That is, discrimination and isolation arise from a community's failure to accept and include people with mental health conditions. Models of support and treatment that utilise an individualistic approach can potentially worsen and perpetuate exclusion by placing the onus primarily on the individual. Put simply - people experiencing mental health difficulties have a right to social inclusion, to live contributing lives and have appropriate supports to enable this, regardless of their level of 'symptoms' (Slade et al. 2014; *Convention on the Rights of Persons with Disabilities* 2007).¹⁴

Leamy et al. (2011)¹⁵ also found 13 common characteristics within many descriptions of recovery.

Recovery:

1. is an active process
2. is an individual and unique process
3. is a non-linear process
4. as a journey
5. as stages or phases
6. as a struggle
7. as a multidimensional process
8. is a gradual process
9. as a life-changing experience
10. without cure
11. aided by supportive and healing environment
12. can occur without professional intervention
13. is a trial and error process

Recovery-Oriented Practice - What Workers Do

It is important to note that personal recovery is not an intervention that others 'do to' a person, but a personal process. A mental health worker cannot provide recovery services per se. However, others around a person (including mental health workers and other service providers) can adopt a recovery-oriented approach that facilitates personal recovery. This approach is the reason that language is so important when a mental health service becomes oriented towards recovery. The use of language in recovery-oriented practice is discussed later in this document.

Although mental health workers can assist in facilitating personal recovery, research illustrates that people can and do recover without mental health services. Research also shows that recovery often involves connection with a person's 'natural supports' and 'community of choice', more so than the limited role that mental health workers play in a person's life (Davidson et al. 2009).¹⁶

The National Framework for Recovery-Oriented Mental Health Services (Department of Health and Ageing 2013)¹⁷ defines recovery-oriented practice as describing mental health care that:

- *recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues*
- *maximises self-determination and self-management of mental health and wellbeing*
- *assists families to understand the challenges and opportunities arising from their family member's experiences* (Department of Health and Ageing 2013).¹⁸

Emphasis is made on strengths-based and peer-led approaches:

Recovery-oriented mental health service delivery is centred on and adapts to the aspirations and needs of people. It requires a shared vision and commitment at all levels of an organisation. It draws strength from, and is sustained by, a diverse workforce that is appropriately supported and resourced and includes people with lived experience of mental health issues in their own lives or in close relationships (Department of Health and Ageing 2013).¹⁹

Various authors have described recovery-oriented service models designed to utilise the inherent principles of this approach. However, recovery-oriented practice is based more on 'how' workers approach their role, not specifically 'what' they do and there is no 'recovery model' as such; it is more a set of values and principles to guide a service delivery approach.

The following are 6 principles from the National Practice Standards for the Mental Health Workforce (State of Victoria, Department of Health 2013, p.7)²⁰ designed to ensure that mental health practice is recovery-oriented:

- Uniqueness of the individual (which includes empowering the individual to be the centre of care)
- Real choices (which includes achieving a balance between duty of care and support for an individual to take positive risks)
- Attitudes and rights (which includes listening to, learning from and acting on communications from the individual and their carers)
- Dignity and respect
- Partnership and communication (which includes acknowledging each individual is an expert on their own life, and that recovery involves working in partnership with individuals and their carers)
- Evaluating recovery (which includes measuring outcomes on a range of indicators in addition to health and wellness, such as housing, employment and social relationships).

Davidson et al. (2009)²¹ defined 10 principles which are useful descriptors for recovery- oriented practice, which are summarised as shown in Appendix 9.

One of the most important implications of these principles is that mental health workers must address immediate and basic life needs, and be flexible to assist with meeting these needs, if they are to engage the person where they are in their recovery journey. It is important to build flexible delivery of services into service structures, such as community-based and outreach services, rather than provide office-based services merely for administrative convenience (Davidson et al. 2009)²².

While professional knowledge and evidenced-based models of psychotherapy/counselling are often very helpful to those receiving care, these must be utilised to meet the person where 'they are at' and address those issues that are important to the person. The key to delivering evidence-based care within recovery-oriented practice is to use the evidence to open a dialogue with a person, giving them information, thus, further informing their decision making processes (Davidson et al. 2009).²³

One concept that Davidson et al. use to illustrate this dialogue is the role of the worker as a '**recovery guide**'. The concept of a 'recovery guide' places the person receiving care in the driver's seat with the worker as a guide to the process. Guides typically have information about journeys from having travelled these journeys with others before, and in some cases from having travelled a recovery journey themselves.

One metaphor used to illustrate this process is that of the hiking guide. A good hiking guide assists the hiker to 'examine their backpack'; to identify their strengths and resources; their interests, and the goals and aspirations that motivate and sustain them through setbacks, difficulties and mishaps that occur along the way. They also then assist the hiker to identify personal limitations that affect the pace or path chosen, and allow hikers to experience frustrations and failure as long as they are making forward progress, however gradual. The guide's role is that of a helper, not a friend, but there is a natural sense of reciprocity and genuineness in the relationship so the hiker and guide are able to appreciate each other's humanity.

Trauma-Informed Care & Practice

Contemporary best practice proposes that to be recovery-oriented, requires trauma-informed care and practice principles as essential components to supporting recovery. This is because of the known prevalence of trauma amongst the mental health consumer population; the often traumatic nature of experiencing mental illness, stigma, discrimination and marginalisation; and the occurrence of traumatising mental health treatments (McCay & Beanlands 2006; Simonds et al. 2014);²⁴ as well as the possible presence of interpersonal violence, both in the past and present. In addition to this, certain populations such as Indigenous people and refugees, are likely to have experienced generational trauma (Friesen 2007).²⁵

Safety is essential to recover from trauma. Without awareness of the impacts of complex trauma on the emotional, psychological and social wellbeing of individuals and communities,²⁶ workers run the risk of further traumatising already traumatised people. Therefore, it is impossible for mental health services to be truly recovery-oriented if they are not also trauma-informed (Kezelman & Stavropoulos 2012; Mental Health Coordinating Council 2013).²⁷

Trauma-informed care and practice is particularly important for working with young people because young people often do not have the power to remove themselves from traumatic situations.

The following principles are useful in assisting the implementation of trauma-informed care.

Trauma-informed care and practice:

- Recognises the prevalence of trauma and understands the impact of trauma on the emotional, psychological and social wellbeing of individuals and communities

- Promotes safety and recognises the social, interpersonal, personal and environmental dimensions of safety
- Values and respects the individual, their choices and autonomy, their culture and their values
- Fosters healing relationships where disclosure of trauma is possible and is responded to appropriately
- Promotes collaborative, strengths-based practice that values the person's expertise and judgement
- Recognises the impact of power and ensures that power is shared.

(Mental Health Coordinating Council 2013)²⁸

Contemporary Models and Philosophies of Child and Youth Mental Health

There are various models and philosophies currently used by services that work with children and young people and these considerably overlap with the concepts of personal recovery.

Early intervention in mental health

Early intervention specifically targets people displaying early signs and symptoms, or experiencing a first episode of a mental disorder (Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care 2000).²⁹ Early intervention and integrated systems of care supporting young people are important due to the peak onset, incidence and disability associated with mental health conditions in the 14-24 year age group. The impact of mental health conditions (including co-existing substance use and abuse) on this age group accounts for the largest proportion of disability in 10-24 year olds (Gore et al. 2011).³⁰

However, 70% of young people with mental health conditions do not seek help, or experience unhelpful delays in seeking help (Rickwood et al. 2005).³¹ This fact necessitates specific strategies designed to engage and appropriately assist this population.

The following series of principles for early intervention and youth mental health services have been implemented across NSW:

1. Commitment to a promotion and prevention framework for mental health
2. Improving early access
3. Promoting best practice youth mental health clinical services
4. Sustainable clinical governance of youth mental health
5. Developing effective strategic partnerships
6. Focusing on recovery and hope
7. Targeting primary youth mental health
8. Improving participation of young people, families and carers
9. Developing a youth mental health workforce
10. Ensuring evaluation and quality innovation in youth mental health.

(Northern Sydney Central Coast Health & Health CaYPsM 2007)³²

Not only do these principles seek to ensure quality and access to timely care and to improve participation of young people and their families, they include a focus on recovery and hope.

Resilience and strengths-based models of care

Resilience is a concept that is often used in child and adolescent mental health services. However, there is no single accepted definition of resilience. Generally it can be understood to describe a person's ability to:

Be flexible and adapt positively in the face of stress, when they are able to resist, withstand, cope with, rebound from, and grow—or even thrive—after experiencing life events that are stressful (Substance Abuse and Mental Health Services Administration 2011).³³

Research has demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's wellbeing (Solomon & Siegel 2003).³⁴ One of the strongest predictors of a child's subsequent recovery relates to maternal and family dynamics.

When applied to children and young people with mental health problems, guidelines very similar to those of recovery emerge:

- Hope, optimism and future planning
- Active processes giving importance to the concepts of a positive sense of identity, agency and self-efficacy
- Empowerment and self-direction and awareness of self and coping strategies, competency and mastery
- Promotion of valued roles
- Utilising social supports
- Strengths-based - Actively seek to define and utilise both internal (of the person) and external (environmental) strengths
- The use of role models and mentors
- Non-linearity of the recovery and resilience processes
- Recognition that professional intervention is not necessarily required
- Importance of positive, healing environments that are personally meaningful and seek to enable the person to move forward, rather than entrap them with limited expectations of growth and success

(Friesen 2007; South London and Maudsley NHS Foundation Trust & South West London and St. George's Mental Health NHS Trust 2010; Substance Abuse & Mental Health Services Administration 2011).³⁵

Does Recovery Apply to Children and Young People?

While early intervention and resilience models suggest congruence between child and youth mental health practice and recovery concepts, concerns have been raised in the literature and by practitioners about recovery philosophy and recovery-oriented care when applied to children and young people. This is in part due to the fact that personal recovery was formulated based on narratives from adults (Friesen 2007; Simonds et al. 2013; Oswald 2006; Lal 2010).³⁶

Some concerns about the applicability of recovery for young people relate to potential differences between young people and adults due to the normal developmental processes. Young people are changing constantly. Due to the general view of recovery being to recover to a previous state, there is opposition to this term being used regarding young people. In fact, it would be undesirable for young people to return to a previous state as they should be continuing to develop rather than returning to previous developmental stages (Robinson 2006).³⁷ However, this concept of recovery arises from confusion about what is meant by recovery in the context of personal recovery.

Personal recovery is characterised as being transformative rather than a return to a previous state (Leamy et al. 2011).³⁸ In this way personal recovery could be seen to influence and be influenced by normal developmental processes. Recovery-oriented practice in the context of children and young people can be seen to have the aim of enhancing a child's or young person's overall developmental trajectory.

The relative applicability of recovery philosophy to children and young people can be evaluated according to the five central (CHIME) recovery processes:

- **Connectedness** to family, peers and community is especially important for children and young people. It is within these connections that children and young people are able to define their identities and seek experiences that enhance their sense of self and their emerging adult identities and capabilities (Robinson 2006).³⁹ It has also been found that young people who are more connected with their family and school have a lower prevalence of mental health conditions (Resnick et al. 1997).⁴⁰
- **Hope and optimism about the future** is an area of recovery philosophy that is very consistent with all approaches to working with children and young people. Both resilience and strengths-based models are inherently based on the following premises: hardship can be overcome using strengths in the individual and their environment and, hardship is necessary to build strength and the self-belief that there is hope even in difficult situations. Early intervention is based on the hope of recovery and explicitly sets out to maintain and build hope.
- **Identity** in young people is extremely fluid especially in the adolescent and young adult years, so forming a coherent sense of self is likely to be very challenging or impossible at certain developmental stages. Young peoples' identity tends to be formed around their family, peer groups, their hobbies, interests and school or work achievements rather than any existential sense of themselves. However, this fluidity makes positive identity formation especially important for young people (Robinson 2006).⁴¹

Young people may be more likely than adults to take on the identity of 'mentally ill person' or the 'sick role' because of this fluidity. Due to the prominence of concrete thinking in under 16 year olds they are particularly likely to have trouble reconciling two conflicting identities - that of competent person and person who is experiencing symptoms of a mental health condition (Simonds et al. 2013).⁴²

Trauma is also likely to complicate identity formation further, especially if the young person is subject to ongoing trauma or triggers related to previous trauma (Kezelman & Stavropoulos 2012).⁴³ Due to all of these factors, attention to the formation of a positive and coherent 'sense of self' is likely to be especially important in the recovery process of young people. However, it is important that young people are not placed under undue stress by expectations that their identities become fully formed when this may not be developmentally appropriate.

- The development of **Meaning and purpose** is also a normative developmental process that occurs gradually over time and is likely to be fluid as the young person develops. It is likely to be an important aspect of recovery for young people, but similarly one not to be rushed. Connectedness to peers, family, school, work and various community and recreational activities are likely to be avenues for the development of meaning and purpose for young people (Buckland, Schepp & Crusoe 2013; Coughlan et al. 2013; Killackey et al. 2013; Lam et al. 2011; Robinson 2006; Romano et al. 2010).⁴⁴

- It has been contended that **Empowerment and responsibility** may not apply to children and young people who at many developmental stages simply do not have the power or developmental competence to allow them to take control and responsibility over their lives. Recovery strongly emphasises the importance of individual empowerment and self-management of wellbeing (Davidson et al. 2009; Honey et al. 2013; Leamy et al. 2011).⁴⁵ Yet for children and young people who are experiencing mental health problems, especially younger children, these concepts are complex. Empowerment and self-direction would look very different for an 8 year old, a 14 year old and an 18 year old.

The role of parents and carers of children and young people is substantially different from those providing support to adult consumers particularly in relation to consent, and capacity to make informed decisions. Negotiating treatment and treatment goals is different when working with adults due to the consideration of 'informed consent to treatment' which differs with children and adolescents. Treatment goals may need to be more aligned with empowering the family (including the young person) to take control and responsibility, due to the differing developmental competencies and needs of children and young people (Oswald 2006).⁴⁶ However, due to the fact that normative development actually involves increasing levels of independence/control and responsibility during the adolescent years, exploration of this dynamic process is likely to be important in recovery for children and young people (Robinson 2006; Honey et al. 2013).⁴⁷

Although there may be some differences in expectations and implementation, the five recovery processes mirror normal developmental processes, and are useful guides to support young people to return to the developmental processes that may have been derailed due to the development of mental health problems. Recovery principles are also consistent with the principles of strengths-based care and resilience approaches to working with children and young people.

Language

The use of language in the application of recovery philosophy to children and young people is problematic.

Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes. (Devon Partnership Trust 2014).⁴⁸

Examination of the use of language and the meaning conveyed is central to recovery-oriented approaches. For this reason, MHCC developed the Recovery Oriented Language Guide⁴⁹ to assist community services and health workers to use words that convey hope and optimism and promote a culture that supports recovery (Mental Health Coordinating Council 2013).⁵⁰ It is important to note that the MHCC language guide was developed for services that primarily work with adults experiencing mental health conditions, and has not been specifically targeted at child or youth services.

Differences in terminology

Recovery-oriented mental health services and services that support children and young people use different terminology or may assign different meanings to the same terms. Children and young people experiencing mental health difficulties and those who support them - including families and carers, community and health services, child and adolescent mental health practitioners, youth workers and those working in education environments (such as teachers and school counsellors) - are unlikely to describe the child or young person's journey in terms of 'recovery'. The process is more likely to be understood as 'staying on track' or 'getting back on track' or meeting developmental milestones. Mental health workers may see their role as intervening early, preventing impairment, and supporting the child or young person to return to an expected developmental trajectory rather than as facilitating recovery.

Other commonly used terms in recovery-oriented adult mental health services may also be regarded as problematic, such as:

- 'consumer' – a term generally acknowledged in Australia as the preferred naming convention for people accessing mental health services, originally agreed on by approximately 300 adults with lived experience of mental illness at the first Alternatives Conference in Baltimore, US, in 1985. The word was chosen as it was seen to be empowering, highlighting that 'consumers' should have choices about the services they access and the right to quality service. For children and young people this is not a term that is meaningful or represents how they understand themselves in relation to service systems.
- 'carer' – used to describe foster and kinship carers and child care workers, whereas in adult mental health this term is often used to describe someone who has been nominated by the consumer and who has rights and responsibilities as outlined in the NSW *Mental Health Act 2007*⁶¹.
- 'peer' – in adult mental health this term is used to describe someone with lived experience of mental health problems, however in child and family services and schools the term relates to young people of the same age or school year.

While these are not insurmountable language conflicts, it is important to be aware of the context of documents using such terms when addressing recovery orientation of mental health services that target culturally diverse groups or are specific to children and young people.

Part 2: Consultations

This discussion paper is focused on exploring the concerns so far identified together with investigating the needs of young people and their families. To further this aim, a set of consultations were conducted with young people, families, and mental health workers.

Data collection

Consultations were conducted with 3 stakeholder groups: young people (16-25years), parents and mental health workers (including Child, Adolescent and Youth Mental Health and Early Psychosis clinicians).

Five young people (1 male, 4 females) were recruited from youth related mental health services to participate in a focus group. They rated their own recovery and goals for the future on a written scale. They then discussed the resources (what and who) were needed for their future growth. Their reactions to the processes of personal recovery (CHIME) were discussed. Data themes and quotes were recorded by two co-facilitators.

Seventeen parents and one grandparent of young people (10-24 years) with mental health problems participated in an online survey. They were asked what they thought recovery from mental health problems meant; how much of their efforts to assist their young family member related to CHIME, and questioned about anything else they do, not covered by CHIME. They were also asked what they wished they had known prior to the presentation of mental distress that would have assisted them to help their children, and were offered the opportunity to provide further comments.

Eight mental health professionals primarily from public mental health early psychosis services and one non-government mental health service participated in a focus group. Two child and adolescent mental health service (CAMHS) clinicians were also interviewed individually. These two groups completed a written response prior to the focus group or interview designed to elicit their definition of recovery; what they perceived would be the definition of recovery of the young people and families they work with, and the role their work plays in facilitating recovery. They then discussed whether CHIME and the 13 characteristics of recovery (referred to in this paper, p.11) can be suitably applied to young people and their families, and discussed the opportunities and constraints of recovery-oriented practice in their workplace. Ideas provided were recorded by two co-facilitators in the large group discussions. Smaller groups then compared recovery-oriented practice to other frameworks they currently use to support young people. These groups recorded their ideas and discussed them in the larger group.

An online survey was also completed by 65 CAMHS staff across NSW. The specific services in which the respondents were employed were not identified, but we understood that they were from a range inclusive of community, inpatient and justice health services. Professional backgrounds varied, however the majority were nursing staff (53%).

(Refer to Appendices 1-6 - Questions and materials relating to data collection from each source).

Data analysis

Thematic analysis was conducted using deductive coding to map the content of responses onto the five recovery processes (CHIME) and the 13 common characteristics of recovery (Leamy et al. 2011).⁵² Inductive coding was used to describe themes emerging from the data that were not directly related to the recovery processes or to common characteristics identified by Leamy et.al.

Results of consultations

Overall, stakeholders reported that all five CHIME processes were relevant to young people. Both parents and service providers indicated that they were concerned with facilitating all five processes. They emphasised that specific issues needed to be taken into consideration for each of these factors to make them appropriately 'youth friendly'. Stakeholders also expressed their views concerning the environmental facilitators and barriers that influence young peoples' wellbeing and the ability of parents and workers to support their wellbeing. The findings relating to the conceptualisation of recovery as it relates to young people are presented in Part A and the supports for recovery of young people are reported in Part B following. Part C contains a discussion surrounding opportunities and challenges regarding recovery-oriented practice and trauma-informed care and practice.

Note: Unless otherwise specified, the term "participants" refers to members of the three focus groups. "Young people" refers to the young person focus group and "Parents" refers to the parent focus group. The term "Workers" refers to summarised feedback of both the members of the worker focus group and the CAMHS survey respondents.

Results Part A: The Concept of Recovery

Connectedness

All stakeholder groups believed that connectedness was critical for children and young people who have experienced mental health problems. Young people talked about the need to break patterns of aloneness and isolation and to have relationships with and feel supported by family, friends, health workers and others with similar experiences to them.

Ninety-four percent of parents stated that they provide significant support in the process of connectedness for their child or young person and five of the eighteen parents referred to connectedness in response to a question about the meaning of recovery. They characterised connectedness as interaction with others within a range of meaningful activities, '*being part of their community*', '*making new friends*', and '*being able to function well in society and relationships*'.

Seventy-one percent of CAMHS workers stated that they provide significant support in the process of connectedness for the children and young people that they work with. They described connectedness as important for children and young people, particularly in terms of connection to age peers and reported a concern in early intervention with helping young people to maintain these connections. However, they also saw it as a '*double edged sword*' when children and young people observed age peers meeting developmental milestones that they were currently unable to meet, leading to a feeling of '*being out sync*' or disconnected from peers. It was suggested by one worker that '*having connections*' may be a more youth friendly way of discussing this process with young people.

All three respondent groups reported that the informal support of family, peers and schools were especially important and these will be discussed separately in Part B of results.

Additionally, the young people discussed access issues and characteristics of workers and services that are important to them and these will also be separately discussed below in Part B.

Hope and optimism about the future

All participants saw hope and optimism as critical for young people. Parents stated that they provided significant support for their children in the domain of hope and optimism, and service providers saw it as a very important aspect of working with children and young people. The workers reported that sometimes it was necessary to *'hold the hope'* for young people, until they were able to do this for themselves and that it was important to assist young people to maintain hope by seeing that others with similar issues were further along their recovery journey.

Future planning was seen as somewhat different for young people compared to adults. Young people and workers both commented that the notion of 'dreams and aspirations' was too confronting for young people and, thus, not youth friendly. Young people stated that there is already enough pressure on them to make decisions about their future and they saw this as a contributing factor in the development of their mental health problems. They thought that if dreams and aspirations are discussed it should be in a very non-threatening way and it should be an end goal rather than something they need straight away. Young people thought that the most youth friendly way of facilitating hope and optimism was via the encouragement of short term goals which built upon each other to assist them in the longer term. As stated by a young person in the group:

It's scary when people want you to make decisions now about the future

Seventy nine percent of CAMHS workers stated that they provide significant support in the process of hope and optimism with the young people that they work with. Workers were concerned that the concept of dreams and aspirations may be developmentally inappropriate for children and young people as they may not have the capacity to think longer term and be goal driven. Age and level of concrete versus abstract thinking were seen as factors in whether they could achieve this. In terms of language, 'hope' was seen as more youth friendly than 'optimism'.

Identity

Identity was seen as an important aspect of recovery for young people by all stakeholders. The young people felt that their sense of self gets *'crushed'* during the process of having mental health problems and related life difficulties, including difficulties at school. They believed that rebuilding a positive sense of self was very important, but some of the language used was not seen as youth friendly. It was suggested that 'overcoming stigma' could be rephrased as 'coming to terms with mental health problems'.

All parents stated that they provide significant support in the domain of identity for their child or young person and six of the eighteen parents referred to identity in response to a question about the meaning of recovery. They characterised identity as *'restoring self-esteem', 'to feel you fit in', 'to have good self-esteem to have confidence in your decision making abilities- to feel complete', 'just a general feeling better and worthy'* and *'strength building'*.

Seventy-nine percent of CAMHS workers stated that they provide significant support in the process of identity for the young people that they work with. Workers believed that young peoples' identity is very fragile due to the natural fluidity of identity during adolescence and young adulthood and that the experience of mental health problems and related stigma is likely to reduce their positive sense of self. They also thought that young people are more prone than adults to taking on an 'illness identity' so taking measures to try to prevent this is important. Again, development of identity was seen as a developmental process, where ideally young people would be developing milestones for identity formation rather than needing to regain their identities. Early intervention was seen as important in preventing young peoples' identity formation being arrested. Other factors in successful identity formation were seen as age and adequate environmental resources leading to positive identity formation.

Another issue discussed by young people was mental health services' focus on the assessment and development of 'insight'. A 'lack of insight' was seen as protective of a sense of self rather than necessarily being a symptom or pathological state, however, it can create difficulties regarding

engagement with services and treatment. This was illustrated in the following quotes from workers in the group:

Connecting with us can be counter-intuitive.

Dilemma of accepting 'I have a mental illness which can be treated'.

It was concluded by the group that the term insight is not useful for working with young people. They believed that it is patronising and dismissive of the young person's strengths and struggles.

Meaning and purpose

Meaning and purpose was seen as an important aspect of recovery for children and young people by all stakeholders. However, the term 'meaning and purpose' itself was seen as not being youth friendly by both young people and workers. Young people saw this term as creating undue pressure on young people to prematurely decide on a life direction. They stated that similarly to 'hope and optimism about the future', a better way of achieving this would be the encouragement of short term goals. They also stated that for young people meaning and purpose is equated with participation in things that they enjoy, for example music, sport and other valued activities. This was summed up by a young person in the group:

It's OK to be vague about what you want in life; there is lots of pressure to make decisions about school, uni, career.

They thought that having a good quality of life was related to managing emotions, such as anger, and managing the impacts of mental health problems and physical health issues such as unwanted effects of medication.

All parents stated that they provide significant support in the process of meaning and purpose for their child or young person and eleven of the eighteen parents referred to meaning and purpose in response to a question about the meaning of recovery. They characterised meaning and purpose as returning to meaningful activities such as work or study, 'feeling complete', having a 'good quality of life', 'feeling valued in society', 'good quality of life' including 'small goals being reached that improve the quality of life for the young person', satisfaction and meaning derived from a 'young person being a part of their community', and 'enjoy everyday life'.

Sixty nine percent of CAMHS workers stated that they provide significant support in the process of meaning and purpose for the children and young people that they work with. Similarly to the young people, workers believed that a focus on short term goals and connectedness to things that they value are better ways of expressing meaning and purpose in a youth friendly way. Again this was explained by workers as being part of a normal developmental trajectory that can be derailed by the experience of mental health problems. Another concern of workers around prematurely expecting young people to find meaning and purpose was that they may take on others' ideas (workers or family) of meaning and purpose that are not likely to be helpful to them in the longer term. Other less confronting language suggested was to ask the young person 'what are you moving towards?'

Making meaning of the mental illness experience was a concept that the workers believed was helpful for young people, however, they thought phrasing it as 'making sense of what happened to me' was more youth friendly.

Due to connectedness being a key factor in the formation of meaning and purpose for young people, workers saw trauma and being in out of home care as risk factors for derailment of meaning and purpose formation.

Empowerment

Empowerment was seen as an important aspect of recovery for young people by all stakeholders. However, young people were very clear that empowerment has a very different meaning for young people compared to adults. They saw themselves very much as part of a family system. They stated that they do not feel that making independent decisions was possible or beneficial for them. They stated that instead, empowerment for young people is about being consulted, feeling that they are being listened to and having the support to make decisions as a part of their family. They thought that this decision making support was helpful to balance the pressure they felt from others to make life decisions before they felt completely ready for these. In terms of health care, they believed that they should be a key person in decisions around care but that they could not make these decisions by themselves. As stated by young people in the group:

As a young person it's not just your own decision- your family and others have opinions. As a young person it's more about being consulted and feeling confident to speak up for yourself... feeling heard... supported decision making- comfortably make decisions with support.

I can't make decisions without my parents, who have such a big role in keeping me well.

The young people did feel that a focus on strengths as a way of empowering them was very important.

Eighty-nine percent of parents thought that they provide significant support for their child or young person in the process of empowerment and nine out of the eighteen parents referred to empowerment in response to a question about the meaning of recovery. Parents characterised empowerment as living independently (or with minimal support), 'have the freedom to choose your own path', 'enabling the person', the young person taking 'responsibility for their care and treatment', 'learning to recognise and manage their mental health problems', 'using experience to build strengths and strategies while well so that "next time" doesn't have such a big impact', and 'living well as defined by the individual themselves'.

Seventy four percent of CAMHS workers stated that they provide significant support in the process of empowerment for the children and young people that they work with. The workers characterised empowerment similarly to the young people. They thought that children and young people could not be fully empowered, dependent on their age and developmental level, especially as they often have decisions made for them by their families. They thought that within mental health care they can be a part of the decision making process, but it was noted that they are naïve to the options and consequences of these options due to limited life experience and knowledge of services. Various challenges were noted concerning empowerment of young people within mental health practice and these will be discussed in Part B in a section on recovery-oriented practice.

It was noted by some workers that developmentally, especially at around 14-15 years old, most young people want more power so empowerment would seem very appealing to them; however, they need support around decision making and taking responsibility for their actions and their consequences.

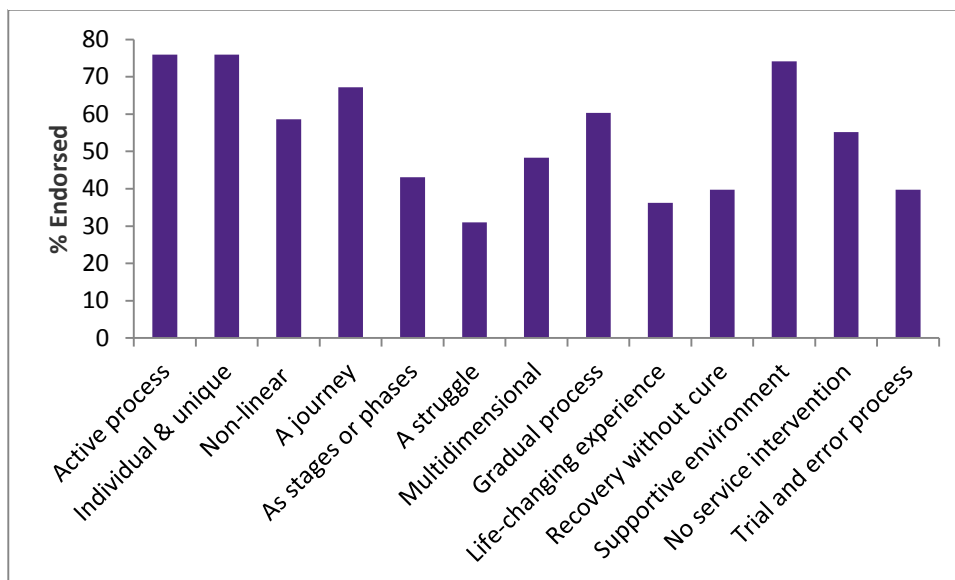
Thirteen common characteristics of recovery

The CAMHS survey respondents were also asked to endorse which of the 13 commonly noted characteristics of the recovery journey (Leamy et al. 2011)⁵³ were relevant to the children and young people that they have worked with.

The results are illustrated in Figure 1. The characteristics that were noted by the majority of respondents were of recovery as: an active process (76%); individual & unique (76%); aided by a supportive & healing environment (74%); a journey (67%); non-linear (59%); a gradual process (60%); and that recovery is able to occur without professional intervention (55%).

Participants in the focus groups, individual interviews and the parents' survey were not directly asked about these characteristics. Some of them were mentioned spontaneously in the responses to various open ended questions but there is not a sufficient amount of data, due to low participant numbers, to be able to make any conclusions based on these so they will not be reported here.

Figure 1 - Percentage of CAMHS workers who endorsed each of the characteristics of recovery



Improvement in functioning or reducing symptoms and personal recovery

Various ways in which improvements in functioning or reduction of symptoms and recovery overlap were apparent in the responses to various consultation questions. In the parent survey improvement in functioning was either an explicit or implied theme in many responses to questions about recovery such as:

Finding ways to manage.

Being able to function well in society and relationships and the home.

To live independently or with minimal support.

Reduction in symptoms was mentioned by parents on two occasions only, including:

To no longer have so many fears, phobias & insecurities.

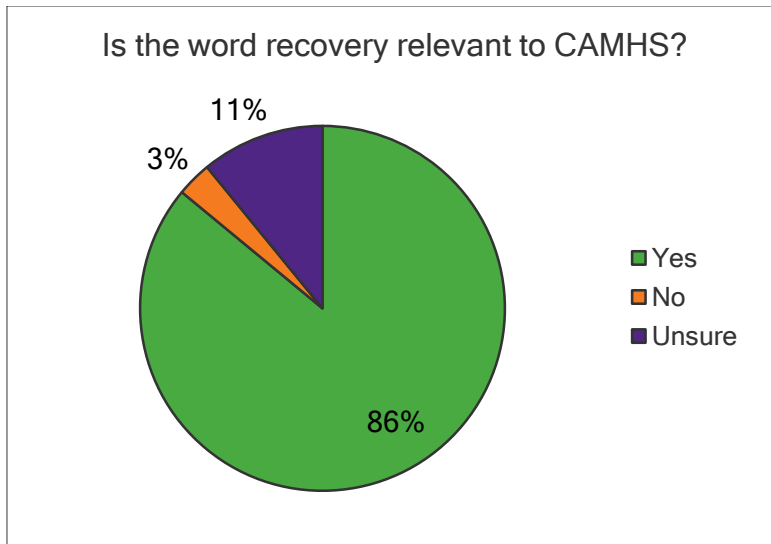
When workers mentioned clinical recovery and improvements in functioning these were framed in very holistic, empowering, and person-centred language. It appears that clinical recovery was seen by this provider group as being a function of personal recovery rather than as means to itself.

(Refer to Appendix 9: Suggested reading list. Young people and recovery)

Relevance of the word 'recovery'

Eighty-six percent of respondents to the CAMHS worker online survey stated that the word 'recovery' was relevant to Child and Adolescent Mental Health Services (Refer to Figure 2).

Figure 2 - CAMHS workers' views on the relevance of the word 'recovery' to their practice



Results Part B: Supports for Recovery

Informal supports

Support from peers, families and school was seen as particularly important. A significant factor regarding these supports was that these helpers need mental health education to be able to comfortably talk about mental health, and to offer support in a helpful way.

Peers/peer support

The young people thought that their friends and other peers should be educated about mental health so that they can understand them better. The young people discussed the need for ways that they could access peer support from other young people who have had similar experiences, specifically mentioning the need to break patterns of aloneness and isolation. They did not specifically mention formal peer support. However, avenues where they could meet other young people with mental health problems were mentioned, including adolescent specific camps and groups. Initiatives are currently underway to make formal peer support programs more accessible to young people and various research has been undertaken on the usefulness of peer-led programs in adult mental health, and general peer support programs (Refer Appendix 9: Suggested Reading List - Peer Support).

Parents and workers were also concerned with young people maintaining or regaining friendships. Workers saw that their work had a central role in either preventing disconnection and isolation from friends and other peers, or assisting young people to regain peer connections.

Importance of Mental Health Promotion, Prevention and Early Intervention in Schools

Support from schools was seen as particularly important. The young people discussed the importance of the school environment and specifically the need for their peers and teachers to be educated in and comfortable with mental health topics. This is to ensure that young people are made aware of these topics at an early age, in an age appropriate way. This was framed in both a promotion and prevention framework and a stigma reduction framework. The aim is to increase early identification of mental health problems and early support. This focus would also increase knowledge and reduce stigma so that the young people (and others like them) could receive appropriate support and consideration in the school environment to assist with recovery. The young people noted that teachers who attempt to present education about mental health and do this poorly (especially if they appear uncomfortable about the topic), actually serve to increase stigma rather than reduce it. Young people suggested that schools could have other young people talk to school students about mental health.

The authors emphasise that this was one of the themes most talked about and most valued by the young people in the group. This mirrors the research and work done on help seeking for emotional and mental health problems in young people, in that they have a clear preference for seeking help from their natural, informal support systems; particularly from peers. When young people do seek help from professionals it is usually with prompting and support from their friends, families or teachers. (This issue is not further discussed at this point in the report as it was beyond the scope of this study, although addressed in Appendix 9: Suggested Reading List - Help Seeking).

Parents and workers also discussed the importance of their role in support and advocacy for children and young people in the school environment. It was suggested that better connections with schools are required in order to facilitate earlier intervention strategies. As one worker stated:

More early intervention work needs to be done in a school setting. Schools should have more access to clinical services and staff.

Role of Family- context and support

All stakeholders believed that the involvement of families in the care of children and young people is of critical importance. All groups identified various ways in which families aid and support children and young peoples' mental health and general wellbeing. As noted earlier under the five recovery processes, parents routinely provide assistance in all of these areas. It was also identified that families of children and young people with mental health problems need various supports in order to effectively provide this support and continue to look after the wellbeing of the family as a whole. It became clear during consultations that although this support is critical there is a delicate balance to be navigated between support and protection needs, and the empowerment of children and young people to continue along the important developmental trajectory towards increasing independence and individuation from parents.

Empowering parents as a critical resource in providing decision-making support to children and young people in relation to health care needs and general life decisions was stressed as vital. This includes into young adulthood with the various developmental tasks of transition to adulthood. Discussions with young people, parents and workers all led to similar findings and the following support needs were identified for families (in particular parents):

- **Assistance in understanding how to effectively parent adolescents.** Young people understood that the previous life experiences of their parents, including how they were parented, have a big impact on the way their parents support them. Of particular note was the perception by young people that their families can sometimes treat them like adults, sometimes in their early teens, and they were not ready for this. They stated that this made them feel sad and caused them stress.
- **Education regarding mental health problems and how these interact with the normal developmental processes** of children and young people. This would assist parents to provide support in an effective manner. Parents also stated that they need education about co-existing mental health and drug and alcohol problems. Additionally, the interaction between mental and physical health was also identified by parents as an area where they require education. This is particularly in relation to mental health problems presenting in the first instance as physical symptoms.
- **Support for their own needs** in relation to their caring role, their own wellbeing and that of the whole family.
- **Knowledge of youth friendly services.** Parents discussed the need for family friendly services.

Workers believed that family involvement was crucial, and many helpful aspects were noted alongside the many challenges. The workers noted that the capacity of families to assist their children and young people in ways that promote recovery can vary considerably. This was discussed as a spectrum where some families are seen to be overprotective whilst others can experience difficulties providing enough support. It was noted that families often need assistance to get the balance right. One parent's comment illustrated this fine balance by stating that it was difficult to provide support in a way that facilitates the five recovery processes but also allows the child *'to just be a kid!'*

Another parent wished that they had known to:

Let him be himself without trying to fix everything for him.

Sometimes families can unwittingly distress their child or young person or just simply be unable to meet their needs due to various constraints. Families where intergenerational trauma was present, and where there were young carers including children of parents with mental illness, were noted as being more at risk of having lower levels of helpful family support.

It was also noted that at times the young person's idea of recovery compared to that of their family and the mental health service may conflict. This can relate to a lack of knowledge about mental

health and recovery or different explanatory styles of mental health conditions between young people, families and services. It was also noted that when young people would like more power but have not yet developed the ability to take responsibility, this too can be a source of conflict between parents and young people. Workers stated that sometimes as a consequence of a lack of understanding of the normal developmental processes, adolescents' parents' sometimes attribute normal adolescent behaviours to mental health problems.

Similarly, it was noted that when young people do not want their families involved in their mental health care and their life generally, this can have a large impact on the family system.

It was suggested that educating families on personal recovery using a coaching framework would be of benefit to families. Likewise, that general mental health education could be incorporated into coaching, and be facilitated either by mental health professionals or family peer educators. In general it was noted that a helpful role for workers could be as 'recovery guides for parents'.

Parents reported that sometimes the stigma surrounding mental health conditions can extend to parents; stating that being a carer of someone with a mental health condition is isolating due to general societal stigma. As one parent put it:

Society tells us they are either a) just acting out or b) it's just a stage they will get over it.

And another parent stated:

Being a mother of two daughters with mental health issues is exceptionally isolating. People are more accepting and ready to help and listen, when a health issue is physical but there is still a huge stigma around mental health.

Parents also noted that some mental health professionals can also stigmatise them. There was the perception among several respondents that mental health professionals believe that mental health issues in children and young people are primarily caused by lack of appropriate parenting and discipline. Concern was similarly expressed that at times, mental health workers can focus too much on parenting support, which may have led to delayed detection of mental health problems in their children that could have been treated earlier. It seems there is also a fine balance between supporting parents in their parenting and caring role without resorting to intervention, and the parents feeling shunned or blamed by the mental health system.

(Refer to Appendix 9: Suggested Reading List - Role of Families)

Family recovery

The notion of families needing to go through their own recovery regarding the losses and impacts on the family associated with the young person's mental health condition was discussed by the parents. In particular the energy required just to assist young people to connect with services is considerable. This is encapsulated in the following quote from a parent describing what they thought recovery was:

Several words: long, ongoing, unpredictable, different to each person, tiring, emotional roller coaster, chronic.

The concept of 'recovery for families' was described as a mix of family empowerment, recovery of the young person, grieving losses and healing as a family unit. As one worker stated:

Recovery for families means relief about getting good care for their young people, care that supports their role as part of the treating team. It also supports the independence of the young person to make informed decisions about maintaining or achieving wellness. It is about seeing the young person re-emerge from the constraints of their mental health problems; continue and participate in treatment; and get enjoyment from life, re-focusing on achieving goals and staying strong. It also means grieving for the time lost to disruption and medical care, and growing as a family, or accepting change has impacted on previously defined relationships.

In response to a question about what they wish they had known beforehand to help their young person another parent simply wished that they had been more prepared, stating they wished they had known:

... that it was going to happen. We just are not prepared that someone so young with their whole lives ahead of them can suffer debilitating mental health issues such as severe depression and anxiety.

Another parent stated that recovery to them meant:

A repairing process – of mind; body; spirit and relationships between the child and their carers (including sibling resilience) after an episode.

(Refer to Appendix 9: Suggested Reading List - Family Recovery).

Results Part C: Recovery-Oriented Practice- Opportunities and Challenges

There were many positive and negative responses from all three groups of participants when formal supports were discussed. Young people stated that various formal supports such as: doctors, psychologists, school counsellors, school social workers, teachers, adolescent specific programs/camps; and physical health supports including exercise and sports options, can assist them with their recovery goals.

Access to mental health services

The young people noted that they had a lack of knowledge of support services, specifically youth friendly support services. They highlighted their preference for a list to be made easily available in all the likely environments they usually access, including GP practices and schools.

Young people reported that they had difficulties finding youth friendly services and thought that adolescent specific programs are of particular importance. Due to the recruitment methods used (via youth related mental health services such as CAMHS, community managed mental health services and Headspace) it can reasonably be assumed that they were reflecting on previous experiences. It is also worth noting that on their self-rating sheets the young people stated a high level of comfort in their relationships with their 'key professionals'.

Characteristics of Services/Workers

The young people thought that school counsellors and other support workers should be more visible and more a part of the school to ensure young people know who they are, and feel more comfortable accessing them for support. Other important characteristics of services and workers discussed are as follows:

- Adolescent/young people oriented services- based on young people's life context and developmentally appropriate
- Affordability – for example, free services or bulk-billing
- Adequate length of service provision – '*12 sessions is not enough*'
- Flexible operating hours- including after school and weekends
- Cultural considerations taken into account
- Relationship with worker is important- importance of rapport, letting the young person lead the discussion, recognising the need for time alone to reflect and then approach the worker when they want to – '*Being able to bring stuff up in your own way, in your own time*'
- Indirect approach to make engagement and working through issues easier- fun activities/games, attention paid to the body language of the young person instead of having to ask every question verbally, different modes of expression- e.g. writing
- Care that assists in the development of routine
- Workers who encourage short-term goals.

Physical Health and Supports

The young people noted that physical and mental health interacted and that they required assistance to manage their physical as well as mental health. They specifically mentioned this in the context of the negative side effects experiences from medication, and the effects of mental health conditions, such as depression, on physical health. In particular, they wanted access to dietitians and other health professionals, as well as more affordable exercise options, in locations they could easily access such as after school exercise programs. This theme is in line with the current focus on physical health in youth mental health and is discussed elsewhere (Refer to Appendix 9: Suggested Reading List - Physical Health).

Opportunities for Recovery-Oriented Practice

Overall the workers thought that there were many ways they are already utilising a recovery-oriented framework including:

- Working collaboratively with other agencies including non-government organisations and schools
- Taking into account cultural considerations
- Taking into account the family context of the young people they work with.

It was clear that the most positive recovery-oriented outcomes presented when the goals of services were aligned with collaboratively supporting young people to meet their goals. Sometimes, this involved actively working with the tension or initial mistrust to achieve an enhanced therapeutic alliance. Some staff reported that although there are tensions involved in working with children and young people sometimes that tension can be useful:

Initially to develop genuine collaboration.

The goal of a child or adolescent may not be the same as ours. However, we shouldn't look at it as tension but to work with those patients to achieve a common goal. We can provide support and resources as well as to enhance our therapeutic relationship with them.

Challenges to Recovery-Oriented Practice

The majority of the respondents stated that there were many challenges to working on the goals of children and young people:

Some of these tensions are discussed below:

Flexibility and resource limitations

- The need to work within a time-limited approach.
- Flexibility of service delivery was seen to enhance engagement with young people but often challenging to provide. For example, availability outside of office hours is valued by young people and their families but this is usually unavailable in public mental health services.
- Resource limitations mean that at times of high demand, services can tend to reduce flexibility of location and type of support available, including family work and educational/vocational assistance, and lead to time limited access. Staff also stated that at times of high demand they may tend towards risk assessment and illness management approaches.

Challenges to facilitating empowerment for young people

Various challenges to empowerment were noted.

- Staff reported that most young people are brought to mental health services by their families rather than choosing to be there themselves. Clearly, this can lead to lower levels of engagement with mental health care. Another tension noted was whether adults actually understand the needs of young people. The example of behavioural disturbance was given: the parents' goal may be to stop challenging behaviours, but the child may actually be trying to get their emotional needs met via the challenging behaviours.
- The workers also noted that there is sometimes tension between the goals of services and young people's goals. However, the workers noted that it is important to give young people as many choices about services as possible, and that being flexible around such things as the location of service and visiting them rather than expecting them to come to a mental health centre could aid in empowerment. Another way of empowering young people is to ask them what constitutes getting better and working with them on goals surrounding the things that they identify.
- There was a perception that lack of voice for young people in service provision decisions leads to disempowerment within adolescent inpatient units. This was stated by one staff member as:

There is tension regarding stigma. Nurses' uniforms are compulsory and adolescents would value community access without the stigma of having formally dressed nurses with them. Their requests have not been listened to; therefore, they are not empowered.

- A mismatch between the needs/goals of young people and their families or other stakeholders such as the school system was identified.

This is particularly true in cases where the young person does not wish to engage in the service but there is pressure from parents/carers/other stakeholders for the service to 'do' something regardless of the effectiveness/efficacy of it. This often undermines principles of recovery as well as potentially causing young people to feel that therapy has failed or they have failed at it, rather than an acknowledgement that they were not active/collaborative participants.

Need for systems supportive of recovery-oriented practice

- Working within a health service that adopts a medical approach, focused on diagnostic assessment, and treatment that is primarily a 'medicate and management' model was not seen as helpful by participants.
- What was seen as best practice is an understanding informed by connectedness, positive relationships, attachment, mastery and many other ideas not usually embraced by medically focused diagnostic 'treatment' programs' Staff discussed the tension between evidence-based care and 'doing what the young person wants' and had difficulty reconciling how this could be achieved.
- Staff mentioned the tension of needing to work with families to address the broader context of the young person, particularly in the presence of trauma. This was often thought to be inappropriately addressed, as the following staff quote illustrates:

The goals/ treatments of our service are based on a medical model which is based on symptoms and behaviours of the individual child. Children should be seen in context of family, and effects of trauma and neglect in families is only minimally addressed.

Education and support needs:

- Staff expressed the difficulty in remaining recovery-oriented in systems seen to have little understanding of recovery. They also discussed this in the context of needing to create a safe space for practitioners to be able to raise issues and encourage collaboration and support.

- An overall theme that was expressed by various providers during the consultations was that they previously thought that they understood what recovery and what recovery-oriented practice involved. However, but that after participation in the focus group they realised their understanding was incomplete. They expressed that they do not feel they have previously had enough education and understanding of the topic of recovery. One participant expressed that they felt that services sometimes make 'tokenistic' attempts at recovery-oriented practice, in part due to a lack of understanding of the concepts and practices involved. It was also noted that there was a risk that recovery language could become jargon, which was seen as counterproductive.
- Negative staff attitudes were noted as a barrier to recovery-oriented practice. This included hopelessness in difficult situations where young people and families are not overtly exhibiting signs of change. It was suggested that staff can have a tendency to become more directive and less client centred when feelings of hopelessness become entrenched.

Risk Management

Parents stated that public mental health services are over-stretched and are, therefore, difficult to access. They become focused on risk management utilising medication rather than meaningful engagement and care for long enough periods. Several carers expressed frustration at a system seen as traumatising their children, themselves and their families. This was seen to be a major factor in some young people's unwillingness to engage with mental health care.

Recovery-oriented practice is understood as being limited by bureaucratic processes and systemic problems. These can mean services are primarily focused on meeting health service objectives and risk management priorities rather than being helpfully supportive to young people. Risk management, behavioural and illness focused models were seen by participants as leading to the disempowerment of young people. The following quotes from the focus groups illustrate the dilemmas and challenges of attempting to work in a recovery-oriented way within a risk management framework:

We are responsible versus they are empowered.

We have to protect versus dignity of risk.

Unequal relationship and decision making.

More concerned about risk (being risk adverse) than vulnerability and engagement.

Sometimes services can put too much emphasis on reactive work with pointy populations and not enough in proactive work with our kids and families.

Adolescents value social networking via internet use and service goals prioritise safety and security and deny this to all inpatients.

Inpatient unit is restrictive in its therapy model due to ongoing fears of perceived risks from young people.

Acute care services such as inpatient units were considered by participants as places where there are many challenges to providing recovery-oriented care. It was suggested that workers could advocate on behalf of young people to have their voices heard. Hospital security policies and practice were seen by young people and parents to be unnecessarily intrusive and potentially impinging on the young peoples' rights and notions of individualism and empowerment. These were also seen as inconsistent with trauma-informed care and practice principles.

Aversion to risk was discussed by one worker as a means of assisting and empowering a young person to manage their own risk via a therapeutic relationship and general goal striving.

Yes, services tend to have goals more around reducing risk; this may not be an immediate goal for the individual involved. However, I believe working with them on their own goals, often addresses areas of risk anyway. Building a therapeutic relationship allows the clinician to be open and honest about what they feel is important for the client, even if client does not agree, so they can start to look at any discrepancies between goals.

Transition between different service settings

Transition between service settings were seen by workers as times of challenge for the provision of recovery-oriented care. For example, the following quotes illustrate these challenges:

Many of the young people we see have extensive trauma histories and may not meet the criteria of adult services.

I think there are gaps between our acute services and the transition back into the community.

Need to improve interagency collaboration

The overall theme of mental health services working more collaboratively with other agencies was seen as important. For example, clinical services working more effectively with community services to support families particularly those 'at risk' families identified within the school system. School attendance was noted as particularly important to aid recovery, with a lack of school attendance leading to poorer outcomes. One worker specifically talked about their belief that working more collaboratively within the school system and conversely, schools having more access to clinical services and staff would lead to enhanced outcomes. Using the skills and resources of other services to assist with meeting the goals of young people was emphasised.

Sometimes the most pressing goal is not a mental health goal and could be better suited to working with a mentor.

Trauma-informed care and practice

Adolescents value privacy and being treated as individuals, and respond well to trauma-informed care.

Trauma-informed care was discussed by all participants as being important. This includes the provision of services to address past trauma, ensure trauma-informed practice and work with families and community child protection specialists to address ongoing trauma. Early intervention was seen as important because of the potential to limit the impacts of complex trauma¹ on mental health. It may also limit the psychosocial difficulties associated with lived experience of trauma. Likewise early intervention uses less traumatising interventions, minimising the potential of being subject to restrictive practices, such as seclusion and restraint (especially chemical restraint) in inpatient units.

Language

The workers and young people consulted thought that the concepts of recovery are helpful, if applied in a developmental context. However, the language of recovery is not considered youth friendly, including the word itself.

¹ Complex Trauma occurs as a result of traumatic stressors that are interpersonal – premeditated, planned and perpetrated by one human being on another. It is particularly damaging if it occurs in childhood. These actions can be both violating and exploitative of another person.

Limitations of this consultation process

There are several limitations that may have affected the results of this consultation process. There was a short time frame for responses to attend focus groups and complete surveys.

The respondents were a small sample of the overall populations of young people, families and mental health care providers. This may have influenced the results, and in particular, consultation participants may have been more likely to take part if they had an already existing concept or interest in recovery. Additionally, the recruitment techniques mean that the young people and families that participated were better connected with services compared to many of the overall population in these groups.

The fact that only 16-25 year olds were represented in the focus group data is very likely to have influenced the outcomes of this consultation. This is due to developmental processes closely related to the recovery process. A different cohort of participants might significantly alter the data gathered.

It is also noted that due to the short time frame and restricted method of collecting the data, many important concepts and factors were not discussed in sufficient depth or at all. This was particularly true of young people and carers.

An important concept in qualitative methodology is that of data saturation. Ideally consultations would continue until there were no new themes or ideas being discussed. This was not possible during this limited process. Ideally, a series of interviews where ideas from participants could be cross checked with other participants would have occurred, but again this was not possible. However, the main purpose of this paper is to raise ideas and concepts to inform further discussion in this field of interest.

Practice Guidelines

As a consequence of this consultation process, a clear direction identified was the appropriateness of the CHIME (Leamy et al. 2011)⁵⁴ framework in working with young people. One of the most important life context issues for children and young people is their developmental trajectory. It is important to ensure that mental health services' work with children and young people to encourage them to continue to progress along their age appropriate developmental trajectories as this can be derailed by the experience of mental health conditions. It is also important that the systems of care (both informal and formal supports) do not worsen this derailment. The CHIME (Leamy et al. 2011) framework can provide conceptual guidance to assist those who work with young people to ensure that they keep in mind personal recovery when working with young people.

This framework is encapsulated in Recommendation 1 following (p.36).

Connectedness- The importance of contact with peers of similar age with lived experience of mental health problems cannot be underestimated. Nor can the importance of families and the delicate balance that families tread daily in the goal of helping their young people to continue (or recommence) their developmental tasks. It is also necessary to find educational and vocational activities that enable young people to retain the opportunities generally available to people at their stage of life.

Guidelines for 'Connectedness':

Use and support natural connections of young people to ensure that they remain connected to valued supports or actively assist them to regain connection. Where young people are not well-connected to natural supports, assist them to find ways to develop connections for example through hobbies, sports or other interests.

Work with schools to ensure they are aware of the ways in which they can assist young people experiencing mental health conditions to remain connected with school, including via mental health promotion and stigma reduction education. Actively work with young people to assist them to maintain connections to peers and schools. Where possible provide opportunities for connections with other young people with mental health conditions e.g. groups, camps, or formal peer support services.

Actively work with families to support them to assist young people to retain connections to peers, school, and/or work.

Support families in a respectful manner by providing or facilitating access to support regarding:

- Education about the developmental stages of children, adolescents and young adults, and effective parenting strategies that can be utilised with these age groups.
- Information and support to navigate the interaction between age-appropriate developmental processes and mental health conditions.
- Guidance around strategies to assist their child or young person in the recovery process - be a 'recovery guide' for families.

Recognise the inherent strengths and life experiences of families and their knowledge of their child or young person.

- Information and assistance with accessing appropriate supports for family members' own wellbeing needs, such as carer support or respite services that are attuned to the needs of families caring for children and young people with mental health problems.

- Guide and assist families to navigate service systems and to access youth friendly services.

(continued)

Remember that families may need a period of grieving and to go through their own process of recovery.

Where possible and desired by the child or young person and their family, meet with them at home, school, youth service or other suitable location. Ask yourself- How can I meet the person where they are at, both physically and readiness-wise? Am I able to provide flexible access hours?

Ask yourself- am I an accessible and genuine person? Boundaries are important but so is having a genuine human connection with the children, young people and families that you work with.

Be creative- use alternate means of communication and expression where possible and suited to the needs of children and young people.

Hope

The promotion of hope for children and young people is of critical importance. When necessary workers can 'hold the hope' for children, young people and their families until they are able to feel hope for themselves.

Guidelines for 'Hope':

Actively promote hope for children, young people and families with mental health conditions. Tell children, young people and families the realistic truth about mental health issues in developmentally appropriate language- symptoms may or may not go away, but meaningful, contributing lives are always possible.

Actively work with systems (including mental health services) that surround children and young people to ensure that environments are hope inducing rather than hopelessness inducing.

Get support for your own wellbeing as a worker- take feelings of hopelessness to supervision or other supports. Use other strategies to reduce feelings of hopelessness in yourself. Ask yourself- where is this hopelessness coming from? Remind yourself of the capacity for resilience that human beings possess.

Use child or youth friendly language- Hope may be a better word than optimism.

Identity

The promotion of a positive sense of self for young people with mental health conditions is critical as youth is a time of extensive identity change and fluidity.

Guidelines for 'Identity':

Ensure that you respect and highlight the inherent strengths of the child or young person.

Support children and young people to develop a positive sense of identity, to recognise their strengths and abilities and to find meaningful ways to express this.

Actively work with systems that impact the child or young person to ensure that they are promoting hope and positive identity formation rather than an 'illness' or 'disability' identity.

Meaning & purpose

The development of meaning and purpose in a young person's life is an important developmental task. However, it is important to ensure that young people do not feel overwhelmed by this concept.

Guidelines for 'Meaning & purpose':

Ensure the return to valued activities and age appropriate activities such as school, work, hobbies, sport and connection to family and peers as soon as possible.

Encourage short term goals that build upon each other to help in the longer term.

Use youth friendly language- talk about being connected to 'things that you value' or enjoy rather than overwhelming them with longer term goals and aspirations.

Provide support which is responsive to a young person's cultural, religious or spiritual beliefs and values.

Empowerment

The empowerment of children and young people is a complex concept. Crucial to this is the idea of developmentally appropriate empowerment along with developmentally appropriate responsibility.

Guidelines for 'Empowerment':

Remember that the development of age appropriate empowerment and responsibility may have been derailed by the experience of mental health problems.

Remember to empower children and young people as a part of their families where possible. Actively seek to empower the decision making of families around health care decisions. An essential part of this is listening to the opinions of the child or young person.

Remember that families offer many important types of support to children and young people and decision making support is included in these. If this type of family support is not available it is crucial that this is provided in some form. Could this be a part of your work with the child or young person? Can you actively assist the child or young person to link with a mentor or advocate to assist and provide this?

Promote positive risk taking in child or young people. Assist families to find the right balance between positive risk taking and protection.

Actively assist children, young people and their families to self-manage risk related to their mental health condition. Work to improve self-management of wellbeing in a staged and developmentally appropriate way.

Ask yourself- Is what I (or the system I work in) am doing empowering or disempowering the young person and their family?

Make sure you receive support and supervision for yourself as well- feeling powerless yourself does not help your work with children, young people and families.

Acknowledge power differentials and strive to equalise these as much as possible in your interactions with children, young people and their families.

Provide information to children, young people and families in an accessible form (which takes into account age appropriateness, language, and literacy) to support them to be able to make informed decisions about care and treatment.

(continued)

Ensure that children, young people and their families are supported in ways that ensure they are able to be empowered to understand and address any physical health problems related to mental health conditions or treatments. This includes but is not limited to supporting access to physical health supports.

Get knowledgeable about recovery and trauma-informed care- Read some of the suggested readings and/or participate in recovery-oriented/trauma-informed education/training.

Get support in your journey to becoming more recovery-oriented- Join or set up a recovery discussion group or community of practice.

Get active in interagency collaboration- recovery is about whole of life context. It is impossible to provide everything that is needed by children, young people and families.

Get to know the other services in your area. Join a local youth-oriented interagency network or run a joint project with another service. Building up these relationships can take some time initially, but they will save time and promote good outcomes in the long run for the children, young people and families that you work with. Seeing children and young people join in with activities that you have helped them get connected to is also great for your own wellbeing and sense of hope as a worker.

Part 3: Recommendations

Whilst acknowledging the limitations of this study, it is clear that the principles of recovery-oriented practice, and knowledge of the processes of recovery, are of benefit and relevance to mental health services who work with children and young people. Regardless of the age of the individual experiencing mental health problems, recovery-oriented practice is grounded in their unique environmental, historical and familial context. This understanding is especially important for children and young people as they do not generally have the power or the developmental competence to make decisions independently of the systems that surround them. In fact, this project has shown that they benefit greatly from having these systems enabled to support them.

However, there are many challenges to assisting children and young people to make the most of their life opportunities in terms of recovery. These challenges are both in relation to their mental health concerns and the complexities of the environments in which they live.

The six recommendations from this project are listed on the following pages.

Recommendation 1: Language, literacy and opportunities for reflection

Develop language guidelines that reflect trauma-informed recovery orientation from the perspective of young people; to be utilised across service settings and systems by mental health and service provider staff.

One issue of note in the survey of CAMHS workers was an apparent conceptual divergence between their understanding of recovery and the thirteen common characteristics of recovery they were presented with. The areas that scored low are commonly seen in recovery literature as a more hopeful, person-focused view of the individual journey and focus group data did not contradict this view. It appears that literacy on recovery concepts as they relate to child and youth services should be enhanced.

The five personal recovery domains are of assistance in conceptualising the journey young people take following the development of mental health problems. Many workers and parents of children and young people naturally utilise these five domains to offer assistance to these children and young people. However, it was also clear that the specific language of recovery is not always of particular use to children and young people due to various developmental needs.

Some examples of suggested language are below:

Connectedness - 'Having or going out with friends'; 'Getting back to school or work'; 'Spending time with family.'

Hope and Optimism about the future - Positive and informal statements about being able to 'get back into life' or 'get back on track' or 'getting back with your friends' or 'still being able to do things in your life' are likely to be appropriate for young people.

Identity - Language such as 'exploring or finding out who you are' is likely to be youth friendly. Care needs to be taken to ensure that language does not promote an overwhelming 'illness' identity.

Meaning and Purpose - 'Having fulfilling or important activities in your life' is likely to be more youth friendly. 'What are you moving towards?' was also language that was suggested might be helpful for this process. An emphasis on short term goals is appropriate.

Empowerment - Stakeholders thought that the concept of empowerment is complex for children and young people, therefore a term other than empowerment may be better. Both young people and workers talked a lot about the following: 'decision- making support'; 'being consulted'; 'being heard'; and 'feeling confident to speak up for yourself'. So, language around these ideas is more likely to be helpful when discussing issues of power and increasing empowerment of young people as they move through adolescence and young adulthood. Further, the use of the 'empowerment' versus 'responsibility' language is likely to be helpful as is working towards autonomy and self-determination skills.

The suggested language referred to above is reflected in the CHIME framework outlined in the Practice Guidelines (p.32).

Other terminology: 'Consumer', 'Carer', 'Peer' & 'Recovery'

The study did not consult with participants concerning the terminology commonly used in adult recovery literature - 'consumer', 'carer' and 'peer'. Whether these terms are considered youth friendly and appropriate in the child and youth field is unsubstantiated. However, anecdotal

accounts suggest difficulties with these terms, and child and youth oriented workers generally use these words very differently. Future work in this field should specifically discuss these words and amend where necessary.

The term, 'peer' in particular can be understood to mean the cohort of which the young person is a part, rather than a person with lived experience of mental health problems. Further work on defining peers and the peer workforce in child and youth mental health services would be extremely valuable.

Likewise, the term, 'recovery' is a word easily confused, with the concept of 'cure'. Nevertheless, 86% of CAMHS workers surveyed believed the word to be relevant, and therefore it may be useful to retain this word. However, it would need to be used cautiously with children, young people and families to ensure they are aware of the concepts of the recovery journey and do not confuse it with the clinical or functional definitions.

To further this recommendation:

- *MHCC review their existing Recovery Oriented Language Guide and consider additional content, terms and examples appropriate to youth mental health and CAMHS service settings and contexts.*
- *MHCC advocate with Government for capacity building initiatives, including the development of resources. These would aim to support training and professional development targeted at child and youth mental health workers in recovery-oriented service provision for young people. (This would be for CAMHS workers, as well as others working in acute, public and community managed settings and the private mental health and human service sectors).*

This recommendation aligns with actions identified in the NSW Mental Health Commission's publication: *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, in which improved ways of working with and better outcomes for children and young people are clearly highlighted as a priority.

- *MHCC support the mental health community managed sector to build collaboration and partnerships across sectors and LHDs to enhance capacity across disciplines in the recovery approach.*
- *Youth mental health and CAMHS services to demonstrate how they have embedded the principles of recovery orientation and trauma-informed care and practice in service and program design and delivery, as well as at an organisational level.*
- *Youth mental health and CAMHS services to include recovery oriented and trauma-informed care and practice assessment tools as part of an organisational quality improvement process. Toolkits have been developed for community mental health services (e.g., Recovery Oriented Services Self- Assessment Toolkit (ROSSAT), Trauma-Informed Care and Practice Organisational Toolkit (TICPOT)) and should be considered for their applicability in public services.*

Recommendation 2: Ensure participation of young people and their families in developing service delivery, programs and quality improvement strategies

Develop collaborative processes to ensure that the voice of lived experience of young people and their families is embedded in the model of practice and service delivery environment.

All participants in this survey believed that working with families was of vital importance. CAMHS services build this into their current service delivery approach. However, what is less evident is that the voice of lived experience of young people and their families is embedded in service and program design and delivery. It is also important for the mental health workforce have the skills and competences to accommodate meaningful service user participation in development and quality improvement processes. The voices of young people and their families are vital to ensuring best practice in this context.

Young people and their families present with needs that are characteristically multiple and complex. Therefore, a trauma-informed recovery oriented approach with families is likely to be of particular assistance. Aligned to this approach the idea of workers being 'recovery guides' which was discussed with participants, as was the idea of recovery and general mental health education being delivered to families.

Young people and families need to learn skills to enable recovery, and education programs are a viable method of providing these skills while also getting families involved with the young person's recovery journey. These programs would ideally have the ability to be delivered in groups and be led by workers in partnership with peer workers (those with lived experience of mental health problems or of caring for someone with a mental health problem).

Empowerment was identified by young people as an essential component of their recovery journey, specifically the need to be consulted and feel listened to. Organisationally, this translates into a commitment to ensuring consultation and engagement with young people at all levels of policy and program development and evaluation. This sense of sharing power and influencing the service delivery environment is a key factor in the provision of the recovery-oriented approach.

To further this recommendation:

- *Youth Mental Health and CAMHS services develop genuine consultation and governance structures that include representation and genuine participation from both young people and families of young people in the development of policies and programs.*
- *Youth mental health and CAMHS services to ensure consumer participation and feedback processes occur at a service delivery level.*

Recommendation 3: Address physical health

Develop support mechanisms that adopt a whole- of- person approach to include strategies and programs that prevent and address co-existing physical health needs.

The young people surveyed suggested that they would like further supports to meet their physical health needs. Research has also shown this area to be of vital importance. Preventing physical health problems and establishing good habits for life are likely to be of great assistance with ongoing physical health. They are also likely to assist in increasing the life expectancy of young people with mental health conditions. Models to ensure that these supports can be more effectively and comprehensively delivered should be investigated.

Whilst this is already a focus of CAMHS services, more emphasis and review of existing programs with the input of young people and families as to what kind of services would work best for them is vital.

To further this recommendation:

- *Youth mental health and CAMHS services further develop programs aimed at promoting better physical health and supporting existing good physical health conditions.*
- *NSW Ministry of Health review policies for youth mental health and CAMHS services regarding routine assessment and support for physical health issues identified by young people accessing their services.*

Recommendation 4: Development of youth peer support and participation as a workforce competency

Consider the assumptions concerning the training of adult peer workers, and how the lived experience of young people might alter the approach necessary. The objective being to develop peer support and mentoring programs to meet the needs of young people and ensure broad-based access.

Youth participation, mentoring and peer support programs are used inconsistently within child, adolescent and youth services. Formal programs of peer support were not investigated during this study but it became apparent that the young people consulted would like access to other young people who have had similar experiences to them.

This paper recommends that further reviews investigate models to enhance the availability of these resources to young people. It is likely that peers slightly older than the young people accessing youth mental health services will be of benefit as peer workers, because the clients are more likely to be able to relate positively to people of a similar age. However, it is recommended that care be taken to ensure that these suitably trained peer support workers are within the same generation as the young people they assist. Older people are likely to have had different experiences of mental health systems and the world in general, than young people today. It is important that along with empathy, peer workers enhance hope in the young people they assist.

To further this recommendation:

- *NSW Ministry of Health review and develop 'youth peer workforce' competencies informed by the lived experience of young people in order to define what 'youth peer worker' competencies look like in the context of young people with mental health conditions.*
- *NSW Ministry of Health support capacity building workforce training and professional development in core competencies and skills required for a peer (lived experience) workforce in youth mental health and CAMHS services.*

Recommendation 5: Trauma-informed care and practice

Ensure services provide safe environments for young consumers. Direct service delivery staff must be appropriately trained to understand and be aware of the principles and practice of trauma-informed care.

High levels of trauma exist within the mental health consumer population. Many have experienced interpersonal trauma, and are at increased risk of complex trauma as well as mental and physical health impacts including psychosocial disability. It is also vitally important that services do not exacerbate or trigger traumatisation or re-victimise a young person when they engage with services (Kezelman & Stavropoulos 2012; Mental Health Coordinating Council 2013).⁵⁵

Many participants in the consultation were very concerned that practices within mental health services are out of line with contemporary best practice in trauma-informed care and practice. Inpatient staff in particular are concerned about hospital security and risk management policies. 'Creating Positive Cultures of Care' (Massachusetts Department of Mental Health n.d.)⁵⁶ and other similar evidence-based initiatives should be utilised to reduce the use of intrusive risk management strategies. It is further recommended that youth specific policies and practices be mandated in child, adolescent and youth services, rather than using standard adult risk management models.

Services will need to implement TI principles and practice across all aspects of service delivery. This is especially important in the development of risk management policy and protocols. Other staff should have access to awareness and orientation training concerning TICP so as to embed practice across all levels of an organisation.

To further this recommendation:

- *NSW Ministry of Health integrate Trauma-informed Care and Practice principles in all quality improvement processes, including: policy development, service and program design and evaluation processes across youth mental health and CAMHS services, including administration, management and service-delivery.*
- *NSW Ministry of Health support workforce capacity building in Trauma-informed Care and Practice to ensure services are responding appropriately to the needs of children and young people in mental health services who have lived experience of trauma.*

Recommendation 6: Further consultation and stage 2 review

The limitations of this review require a more in-depth study be initiated to further consult and review existing literature in relation to the many issues not touched upon in this study.

The scope of this study was intended to provide a brief overview and was therefore unable to address the many areas of relevance that presented. This includes investigation of the recovery orientation of child and youth practice approaches and service models across service systems.

Some important areas of further study might include:

- Youth homelessness
- Substance use and misuse
- Domestic violence, childhood and generational trauma
- Gender identity and sexual development
- Bullying and exploitation
- Child and youth carer issues

Bibliography

- Anthony, WA 1993, 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s', *Psychosocial Rehabilitation Journal*, vol. 1993, vol. 16, no. 4, pp. 11-23.
- Bloom, S.L. & Sreedhar, S.Y 2008, 'The Sanctuary Model of Trauma-Informed Organizational Change', *Reclaiming Children and Youth: From Trauma to Trust*, vol. 1, no. 17, pp. 48-53.
- Bloom, S.L. & Farragher, B. 2013, *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care*, Oxford University Press, New York, NY.
- Buckland, HT, Schepp, KG & Crusoe, K 2013, 'Defining Happiness for Young Adults with Schizophrenia: A Building Block for Recovery', *Archives of Psychiatric Nursing*, vol. 27, no. 5, pp. 235-240.
- Campling, P 2001, 'Therapeutic communities', *Advances in Psychiatric Treatment*, vol. 7, pp. 365-372.
- Chamberlin, J 1990, 'The Ex-Patients' Movement: Where We've Been and Where We're Going', *The Journal of Mind and Behaviour*, vol. 11, no. 3, pp. 323-336.
- Convention on the Rights of Persons with Disabilities and Optional Protocol* 2007, opened for signature 30 March 2007, 2515 UNTS 3, entered into force 3 May 2008.
- Collier, E 2010, 'Confusion of Recovery: One Solution', *International Journal of Mental Health Nursing*, vol. 19, no. 1, pp. 16-21.
- Coughlan, H, Cannon, M, Shiers, D, Power, P, Barry, C, Bates, T, Birchwood, M, Buckley, S, Chambers, D, Davidson, S, Duffy, M, Gavin, B, Healy, C, Healy, C, Keeley, H, Maher, M, Tanti, C & McGorry, P 2013, 'Towards a New Paradigm of Care: The International Declaration of Youth Mental Health', *Early Intervention in Psychiatry*, vol. 7, no. 2, pp. 103-108.
- Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.
- Deegan, PE 1988, 'Recovery: The Lived Experience of Rehabilitation', *Psychosocial Rehabilitation Journal*, vol. 11, no. 1, pp. 11-19.
- Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- Department of Health and Ageing 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra, ACT.
- Devon Partnership Trust 2014, *Putting Recovery at the Heart of All We Do: What Does This Mean in Practice?*, 2014 edn, Devon Partnership Trust, Exeter.
- Everett, B 1994, 'Something Is Happening: The Contemporary Consumer and Psychiatric Survivor Movement in Historical Context', *The Journal of Mind and Behaviour*, vol. 15, no. 2, pp. 55-70.
- Fallot, R & Harris, M 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Community Connections, Washington, DC.
- Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38

- Gore, FM, Bloem, PJN, Patton, GC, Ferguson, J, Joseph, V, Coffey, C, Sawyer, SM & Mathers, CD 2011, 'Global Burden of Disease in Young People Aged 10-24 Years: A Systematic Analysis', *The Lancet*, vol., 377, no. 9783, pp. 2093-2102.
- Honey, A, Fraser, V, Llewellyn, G, Hazell, P & Clarke, S 2013, 'Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.
- Kezelman, C & Stavropoulos, P 2012, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW.
- Killackey, E, Alvarez-Jimenez, M, Allot, K, Bendall, S & McGorry, P 2013, 'Community Rehabilitation and Psychosocial Interventions for Psychotic Disorders in Youth', *Child and Adolescent Psychiatric Clinics of North America*, vol. 22, no. 4, pp. 745-758.
- Lal, S 2010, 'Prescribing Recovery as the New Mantra for Mental Health: Does One Prescription Serve All?', *Canadian Journal of Occupational Therapy*, vol. 77, no. 2, pp. 82-89.
- Lam, MM, Pearson, V, Ng, RM, Chiu, CP & Chen, EY 2011, 'What Does Recovery from Psychosis Mean? Perceptions of Young First-Episode Patients', *International Journal of Social Psychiatry*, vol. 57, no. 6, pp. 580-587.
- Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.
- Massachusetts Department of Mental Health n.d., *Creating Positive Cultures of Care*, 2nd edn, MDMH, Boston, MA. Available from: <http://www.mass.gov/eohhs/docs/dmh/rsri/restraint-resources.pdf>
- McCay, E, Beanlands, H, Leszcz, M, Goering, P, Seeman, MV, Ryan, K, Johnson, N & Vishnevsky, T 2006, 'A Group Intervention to Promote Healthy Self-Concepts and Guide Recovery in First Episode Schizophrenia: A Pilot Study', *Psychiatric Rehabilitation Journal*, vol. 30, no. 2, pp. 105-111.
- Mental Health Act 2007 (NSW).*
- Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care (ed.) 2000, *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*, Commonwealth of Australia, Canberra, ACT.
- Mental Health Coordinating Council 2012, *Trauma Informed Care Training Course Handbook*, MHCC, Lilyfield, NSW.
- Mental Health Coordinating Council 2013, *MHCC Recovery Oriented Language Guide*, MHCC, Lilyfield, NSW.
- Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf

- Moses, DJ, Reed, BG, Mazelis, R & D'Ambrosio, B 2003, *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*, Policy Research Associates, Delmar, NY.
- Northern Sydney Central Coast Area Health & Health CaYPsM (eds.) 2007, *A Youth Mental Health Model on the Central Coast: Background Report on the NSW Youth Mental Health Service Model – Central Coast Pilot Project*, NSCCH, Gosford, NSW.
- Oswald, DP 2006, 'Recovery and Child Mental Health Services', *Journal of Child & Family Studies*, editorial, vol. 15, no. 5, pp. 525-527.
- Resnick, MD, Bearman, PS, Blum, RW, Bauman, KE, Harris, KM, Jones, J, Tabor, J, Beuhring, T, Sieving, RE, Shew, M, Ireland, M, Bearinger, LH & Udry, JR 1997, 'Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health', *The Journal of the American Medical Association*, vol. 278, no. 10, pp. 823-832.
- Rickwood, D, Deane, FP, Wilson, CJ & Ciarrochi, JV 2005, 'Young People's Help-Seeking for Mental Health Problems', *The Australian e-Journal for the Advancement of Mental Health*, vol. 4, no. 3, pp. 218-251.
- Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT.
- Romano, DM, McCay, E, Goering, P, Boydell, K & Zipursky, R 2010, 'Reshaping an Enduring Sense of Self: The Process of Recovery from a First Episode of Schizophrenia', *Early Intervention in Psychiatry*, vol. 4, no. 3, pp. 243-250.
- Simonds, LM, Pons, RA, Stone, NJ, Warren, F & John, M 2014, 'Adolescents with Anxiety and Depression: Is Social Recovery Relevant?', *Clinical Psychology & Psychotherapy*, vol. 21, no. 4, pp. 289-298.
- Slade, M, Amering, M, Farkas, M, Hamilton, B, O'Hagan, M, Panther, G, Perkins, R, Shepherd, G, Tse, S & Whitley, R 2014, 'Uses and Abuses of Recovery: Implementing Recovery-Oriented Practices in Mental Health Systems', *World Psychiatry*, vol. 13, no. 1, pp. 12-20.
- Solomon, MF & Siegel, DJ (eds.) 2003, *Healing Trauma: Attachment, Mind, Body, And Brain*, W.W. Norton and Company, New York, NY.
- South London and Maudsley NHS Foundation Trust & South West London and St. George's Mental Health NHS Trust 2010, *Recovery is for All: Hope, Agency and Opportunity in Psychiatry – A Position Statement by Consultant Psychiatrists*, SLAM/SWLSTG, London.
- State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne.
- Substance Abuse & Mental Health Services Administration 2011, *Recovery to Practice: Frequently Asked Questions*, SAMHSA, Rockville, MD, viewed 20 May 2014, <<http://samhsa.gov/recoverytopractice/RTPFAQ.aspx>>.
- Thomas, SP 2011, 'Open-Dialogue Therapy: Can a Finnish Approach Work Elsewhere?', *Issues in Mental Health Nursing*, vol. 32, no. 10, p. 613.

Appendices

Appendix 1 – Young Persons’ Focus Group – session plan	48
Appendix 2 – Recovery Self Rating Tool for young peoples’ focus group.....	49
Appendix 3 – Parents and guardians survey	50
Appendix 4 – Workers pre-questionnaire – written response	52
Appendix 5 – Recovery handout and consultation questions for service provider focus group	53
Appendix 6 – Youth and Recovery Project survey.....	57
Appendix 7– Trauma-informed care & practice principles	60
Appendix 8 – Ten Principles for recovery oriented community based care	61
Appendix 9 – Suggested Reading	62

Appendix 1 – Young Persons’ Focus Group – session plan

Materials- Labels, Growing Well cards, whiteboard markers, response sheets, white board, butchers paper.

Section 1

Ice Breaker - 5 mins

On labels, ask young people to put their name in the centre and in each of the four corners write their favourite: food, music, TV show, movie

Discussion Guidelines – 10 mins

- Confidentiality- what does this mean? If you wish you can talk about what someone said but not identify them.
- Only share what you feel safe/comfortable sharing- if in doubt share less or write it down if you would prefer. We don't want lots of personal details in the discussions.
- There will be a break scheduled into the session but if you need to take a moment please stay in the general area. One of us will follow to make sure you are OK.
- There will be some small writing tasks. If you need help let us know.
- Names on written tasks are optional- if you don't want to identify your stuff then don't put your name on it.
- It's not a therapy session but you might find it helpful. But sometimes these things can stir things up....we are asking you reflect on your journey.
- If you have any concerns during or after the session please talk to one of us. Or afterwards use the contacts on your info sheets to have a chat.....or your own supports. Who are they?
- - Any other ideas/concerns?

Measure recovery to date - 5 mins

Explain the scaling tool: seed, seedling, sapling, tree and get young people to fill out scale as follows:

- Where are you at in this cycle now?- tick the box in black pen (5 mins)
- Where do you want to be? – tick the box in coloured pen (5 mins)

Group Brainstorm (35 mins) - What do you need to get there? e.g. Support, resources, knowledge, how can people help you to get there? Who?

Break - 15 mins

Section 2 - 40 mins

Group Brainstorm

Recovery Philosophy- Present recovery domains/definitions- CHIME domains and recovery definition

- What do you think about these terms and concepts?
- Do they fit for young people?
- What if mental health workers used these as their guiding principles?

Debrief- 10 mins.

Anything you want to discuss?

Appendix 2 – Recovery Self Rating Tool for young peoples' focus group

In the young people's focus group the following cards from the scaling tool "Growing Well" St (Luke's Resources www.innovativeresources.org) were used:

I stay active by:

- exercising my mind
- being creative
- doing things by myself
- doing things with others
- learning new things
- doing things I enjoy

I am satisfied with:

- my ability to make decisions
- how I take risks
- myself
- my sense of purpose and meaning
- my goals in life
- the progress I am making
- my ability to change

I am organised

I stay healthy by:

- noticing change
- asking for help when I need it
- maintaining balance in my life

I am comfortable in my relationships with:

- people I live with
- my family
- my friends
- people who share my interests and values
- key professionals

Appendix 3 – Parents and guardians survey

Seeking parents and caregivers views

Do you support your child, teenager or young adult (up to 25yrs old) who has a mental health condition?

MHCC is inviting you to participate in our Youth and Recovery Project by sharing your views through this survey. The project is currently exploring how the mental health 'recovery' approach translates to the care and support of children and young people who experience mental health problems.

We would like to seek your views regarding your experience providing support to a young person with a mental health condition. All responses will remain confidential.

This survey will close on 6 June 2014, Sunday. For more information, please contact kerrysnet@gmail.com.

1. Please indicate your relationship with the youth:

- Parent Grandparent Guardian Other:

Please specify if 'Other': _____

2. How old is your young person who experiences mental health problems?

3. What do you think recovery means in relation to mental health problems?

You have probably tried many different things to try to assist your young person in their recovery. How much have your efforts to help your young person focused on the following?

4. Connectedness

Helping them to connect with friends, partners, family, school/work and other community connections

- Almost all Quite a lot A little Not at all

5. Hope and optimism for the future

Helping them have a belief that they can recover and live fulfilling lives. Helping them to continue to have, or regain their dreams and aspirations for the future, setting goals and helping to motivate them to achieve these goals

- Almost all Quite a lot A little Not at all

6. Identity

Helping them to keep or rebuild a positive sense of themselves, overcome stigma surrounding mental health problems, and to see themselves as capable despite having had a mental health problem (or continuing to have a mental health problem)

- Almost all Quite a lot A little Not at all

7. Meaning and purpose in life

Helping them to figure out what having a mental health problem means for their future, having a good quality of life, having a meaningful life with different aspects to it possibly including education or work, spirituality, and other valued activities such as music, sport, art, and social roles such as participation in various community activities

- Almost all Quite a lot A little Not at all

8. Empowerment and responsibility

Helping them to make their own decisions about their life directions, helping them to look after their own mental health and make their own decisions about how they work with the mental health service, and helping them to focus on their own strengths

- Almost all Quite a lot A little Not at all

9. Is there anything you support your young person with that doesn't fit into the above?

10. What do you wish you knew beforehand that you feel would have helped to support your young person with their mental health?

11. Any other comments?

Appendix 4 – Workers pre-questionnaire – written response

What is recovery from mental health problems?

**How do you think recovery would be defined by the young people that you work with?
What about their families?**

What is the role of your work in facilitating recovery?

Appendix 5 – Recovery handout and consultation questions for service provider focus group

Recovery Philosophy

The below describes **process that people go through** rather than a thing that workers do to people, however, workers can facilitate recovery.

Personal recovery is defined within this framework as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues (Commonwealth of Australia 2013, p.17).

- **Connectedness-** connecting with friends, partners, family, school/work and other community connections. Get support from others.
- **Hope and optimism for the future-** have a belief that they can recover and live fulfilling lives. Regain their dreams and aspirations for the future, setting goals and being motivated to achieve these goals.
- **Identity-** Rebuilding a positive sense of themselves, overcoming stigma surrounding mental health problems, and see themselves as capable despite having had a mental health problem (or continuing to have a mental health problem)
- **Meaning and purpose in life-** making meaning of mental illness experiences , having a good quality of life, having a meaningful life with different aspects to it possibly including education or work, spirituality, and other valued activities such as music, sport, art, and social roles such as participation in various community activities.
- **Empowerment-** making their own decisions about their life directions, taking responsibility for their own mental health and making their own decisions about how they work with the mental health service, and focussing on their strengths.

Thirteen characteristics of the recovery journey have also been uncovered in the literature:

1. Recovery is an active process
2. Individual and unique process
3. Non-linear process
4. Recovery as a journey
5. Recovery as stages or phases
6. Recovery as a struggle
7. Multidimensional process
8. Recovery is a gradual process
9. Recovery as a life-changing experience
10. Recovery without cure
11. Recovery aided by supportive and healing environment
12. Recovery can occur without professional intervention
13. Trial and error process

The Consultation Questions:

- Do these processes and concepts fit for young people? How and how not?
- How might they be different for young people? How the same? How different?
- Would this process fit for the families of the young people that you work with?

Recovery Oriented Practice- what workers do

“Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Recovery-oriented practice encapsulates mental health care that:

- *recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues*
- *maximises self-determination and self-management of mental health and wellbeing*
- *assists families to understand the challenges and opportunities arising from their family member’s experiences”.*

(Commonwealth of Australia 2013, p.4)⁵⁷

Recovery-oriented mental health service delivery

Recovery-oriented mental health service delivery is centred on and adapts to the aspirations and needs of people. It requires a shared vision and commitment at all levels of an organisation. It draws strength from, and is sustained by, a diverse workforce that is appropriately supported and resourced and includes people with lived experience of mental health issues in their own lives or in close relationships.

Recovery-oriented mental health services have a responsibility to:

- provide evidence-informed treatment, therapy, rehabilitation and psychosocial support that help people to achieve the best outcomes for their mental health, physical health and wellbeing (Victorian Department of Health 2011)⁵⁸
- work in partnership with consumer organisations and a broad cross-section of services and community groups
- embrace and support the development of new models of peer-run programs and services.

(Commonwealth of Australia 2013, p.5)⁵⁹

10 Principles of Recovery-Oriented Community-Based Care

1. Oriented to Promoting ‘Personal Recovery’

Care is oriented towards promoting Personal Recovery in whatever form that takes for each individual. It is not a cure, not stabilisation and not purely about maintenance of mental state and functioning. Although functional recovery may assist in personal recovery this is not what is meant by recovery in ‘recovery-Oriented care’.

2. Strengths-Based

Care is based on recognising and promoting the inherent strengths in the individual (and their families and other support systems). Although problems can be assessed and addressed this is done in a strengths based fashion and is not the focus of care. Care is not insight focussed where the individual must accept that they have a mental illness,

the focus is on their strengths and optimising these to minimise any difficulties they may have.

3. Community-Focussed

Care is focused on facilitating engagement with the natural environment. Work is undertaken with members of the general community to reduce stigma and helps consumers to develop citizenship roles.

4. Person-Driven

Care is based around the autonomy and self-direction of the individual. Recovery-Oriented care is based on the motto 'Do nothing without the clients approval'. Seeks to optimise 'person-driven care; 'Opportunities to move each client closer to being the director of the case management scenario (are to) be found, created and exploited'. The motto of person-driven care is 'do nothing without the consumer's approval'.

5. Reciprocity in Relationships

Recovery-oriented practice recognises that there is an inherent power imbalance in the worker/consumer relationship but this imbalance is addressed and minimised as much as possible. Workers need to accept appropriate gestures of reciprocity and encourage self- help. This seeks to promote the possibility that the care recipient can increasingly take on valued social roles and develop a contributing life.

6. Culturally Responsive

The worker seeks to understand the cultural values and world views of the individual especially in relation to stigma surrounding mental illness. Culturally responsive care takes into account how the individuals culture impacts on their explanatory model of mental health and mental health conditions, traditional treatments or other relevant cultural practices. Culturally responsive care may also entail working with the broader views and values inherent in collectivist cultures in contrast to a more individualistic western cultural view. However, it is important not to stereotype an individual based on their culture, but to ask about their own individual sense of their culture.

7. Grounded in the Person's Life Context

Care is grounded in the individual's unique family structure, life history, mental health history, other important experiences and current life situations. Care also seeks to understand and utilise the unique personal interests, hobbies and role models of the individual. In fact these factors are seen as being of equal or greater importance than mental health history and current symptoms. Trauma-informed care is a particularly important part of being grounded in a person's life context.

8. Addresses Socioeconomic Context

Care recognises that care (even public mental health care) can cost money to access and the socioeconomic context of the individual is understood and taken into account, and remediated where necessary and possible.

9. Relationally Mediated

Relationally mediated care holds the relationship between the individual and the worker as centrally important. It is important that this relationship is 'genuine' and that a shared recovery vision of positive expectations and hope is developed.

10. Optimises Natural Supports

Natural Supports are of the utmost importance in the individual's life and care actively seeks to engage or re-engage the individual with their natural or other mainstream community supports, as opposed to 'program citizenship'. Workers must have extensive knowledge of and partnerships with community supports and resources generally; and individually for specific individuals they are working with.

The Consultation Questions:

- How possible is recovery oriented practice in your workplace? -What are the constraints?
- How is it different to working in other frameworks? (please note; frameworks that you currently use)
- How would having a recovery oriented framework change the way you work with parents?
- How can we support parents to be recovery oriented?

Appendix 6 – Youth and Recovery Project survey

Recovery philosophy and recovery oriented practice have been developed for the adult mental health consumer population. Recently, this philosophy has been encapsulated in mental health practice nationally. The Mental Health Coordinating Council (MHCC) is currently conducting a project to investigate the utility and possible changes that may need to be made to this practice orientation in order to make it most applicable to the children, adolescents and young people and the services that work with them.

Your feedback and expertise is sought. Please assist us by completing the following questions which should take approximately 10- 15 minutes.

All responses will remain confidential. To begin the survey, please click the 'Next' button below.

This survey will close on 6 June 2014, Sunday. For more information, please contact kerrysnet@gmail.com.

Recovery Philosophy

The below describes a *process* that *people go through* rather than a thing that workers do to people. However, workers can facilitate recovery.

Personal recovery is defined within this framework as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. (National Framework p. 17)

1. Which Local Health District do you work for?

<input type="radio"/> Central Coast (CC)	<input type="radio"/> Northern Sydney (NS)
<input type="radio"/> Far West (FW)	<input type="radio"/> South Eastern Sydney (SES)
<input type="radio"/> Hunter New England (HNE)	<input type="radio"/> South Western Sydney (SWS)
<input type="radio"/> Illawarra Shoalhaven (IS)	<input type="radio"/> Southern NSW (SNSW)
<input type="radio"/> Justice and Forensic Mental Health (J&FMH)	<input type="radio"/> St. Vincent's Health Network (SVHN)
<input type="radio"/> Mid North Coast (MNC)	<input type="radio"/> Sydney (S)
<input type="radio"/> Murrumbidgee (M)	<input type="radio"/> Sydney Children's Hospitals Network (SCHN)
<input type="radio"/> Nepean Blue Mountains (NBM)	<input type="radio"/> Western NSW (WNSW)
<input type="radio"/> Northern NSW (NNSW)	<input type="radio"/> Western Sydney (WS)

2. What professional background do you come from?

<input type="radio"/> Occupational Therapist	<input type="radio"/> Social Worker
<input type="radio"/> Psychiatrist	<input type="radio"/> Other (please specify)
<input type="radio"/> Psychologist	<input type="radio"/> Social Worker

3. Is the word recovery relevant to CAMHS (Child and Adolescent Area Mental Health Service)?

<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
---------------------------	--------------------------	------------------------------

4. How much do you think you deliver recovery orientated service?

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all	<input type="radio"/> Unsure
----------------------------------	-----------------------------------	--------------------------------	----------------------------------	------------------------------

5. In your clinical practice, do you work with children and adolescents on the following?

■ Connectedness

Connecting with friends, partners, family, school/work and other community connections. Get support from others.

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all
----------------------------------	-----------------------------------	--------------------------------	----------------------------------

■ Hope and optimism for the future

Having a belief that they can recover and live fulfilling lives. Regaining their dreams and aspirations for the future, setting goals and being motivated to achieve these goals.

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all
----------------------------------	-----------------------------------	--------------------------------	----------------------------------

■ Identity

Rebuilding a positive sense of themselves, overcoming stigma surrounding mental health problems and seeing themselves as capable despite having had a mental health problem (or continuing to have a mental health problem).

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all
----------------------------------	-----------------------------------	--------------------------------	----------------------------------

■ Meaning and purpose in life

Making meaning of mental illness experiences, having a good quality of life, having a meaningful life with different aspects to it possibly including education or work, spirituality and other valued activities such as music, sport, art and social roles such as participation in various community activities.

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all
----------------------------------	-----------------------------------	--------------------------------	----------------------------------

■ Empowerment

Making their own decisions about their life directions, taking responsibility for their own mental health and making their own decisions about how they work with the mental health service and focussing on their strengths.

<input type="radio"/> Almost all	<input type="radio"/> Quite a lot	<input type="radio"/> A little	<input type="radio"/> Not at all
----------------------------------	-----------------------------------	--------------------------------	----------------------------------

6. The literature defines recovery as having the following characteristics; tick which ones apply to children and young people that you have worked with.

Recovery:

- is an active process
- is an individual and unique process
- is a non-linear process
- as a journey
- as stages or phases
- as a struggle
- as a multi-dimensional process
- is a gradual process
- as a life-changing experience
- without cure
- is aided by supportive and healing environment
- can occur without professional intervention
- is a trial and error process

7. Do you think there is a tension between the goals of children and adolescents and the goals of your services?

8. Any other comments?

You have reached the end of the survey. Please click "Done" to submit your responses.

Appendix 7– Trauma-informed care & practice principles

The following eight foundational principles that represent the core values and best-practice of trauma-informed care and practice outlined below:^{2 3}

- 1. Understanding trauma and its impact** - Understanding traumatic stress, and how it impacts people, and recognising that many challenging behaviours and responses represent adaptive responses to past traumatic experiences.
- 2. Promoting safety** - Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place particularly in relation to responding to suicidality, and provider responses are consistent, predictable, and respectful.
- 3. Ensuring cultural competence** - Understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.
- 4. Supporting consumer control, choice and autonomy** - Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.
- 5. Sharing power and governance** - Promoting democracy and equalisation of power differentials; and sharing power and decision-making across all levels of an organisation whether related to daily decisions or in the review and creation of policies and procedures.
- 6. Integrating care** - Maintaining a holistic view of consumers and their recovery process and facilitating communication within and among service providers and systems.
- 7. Healing happens in relationships** - Understanding that safe, authentic and positive relationships can aid recovery through restoration of core neural pathways.
- 8. Recovery is possible** - Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

² These principles were identified and adapted on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses et al. 2003), literature on therapeutic communities (Campling 2001), the work of Maxine Harris and Roger Fallot (Fallot & Harris 2009) and 'The Sanctuary Model' as developed by Sandra Bloom and colleagues (Bloom & Sreedhar 2008; Bloom & Farragher 2013).

³ Moses, DJ, Reed, BG, Mazelis, R & D'Ambrosio, B 2003, *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*, Policy Research Associates, Delmar, NY; Campling, P 2001, 'Therapeutic communities', *Advances in Psychiatric Treatment*, vol. 7, pp. 365–372; Fallot, R & Harris, M 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Community Connections, Washington, DC; Bloom, S.L. & Sreedhar, S.Y 2008, 'The Sanctuary Model of Trauma-Informed Organizational Change', *Reclaiming Children and Youth: From Trauma to Trust*, vol. 1, no. 17, pp. 48-53; Bloom, S.L. & Farragher, B. 2013, *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care*, Oxford University Press, New York, NY.

Appendix 8 – Ten Principles for recovery oriented community based care

1. Oriented to promoting ‘personal recovery’

Care is oriented towards promoting personal recovery in whatever form that takes for each individual. It is not a cure, nor stabilisation and not about maintenance of mental state and functioning.

2. Strengths-based

Care is based on recognising and promoting the inherent strengths in the individual (and their families and other supports). Although problems can be assessed and addressed this is done in a strengths based fashion and is not the focus of care. Care is not insight-focussed (where the individual must accept that they have a mental illness). The focus is on their strengths and optimising these to minimise any difficulties they may have.

3. Community-focussed

Care is focused on facilitating engagement with the natural environment. Work is undertaken with members of the general community to reduce stigma and help consumers to develop citizenship roles.

4. Person-driven

Care is based around the autonomy and self-direction of the individual. Opportunities to move each consumer closer to being the director of the case management scenario are found, created and exploited. The motto is ‘do nothing without the consumer’s approval’.

5. Reciprocity in relationships

Recovery-oriented practice recognises that there is an inherent power imbalance in the worker/consumer relationship and this imbalance is addressed and minimised as much as possible. Workers treat clients as equals, accept appropriate gestures of reciprocity and encourage self-help. This promotes the possibility that the consumer can increasingly take on valued social roles and develop a contributing life.

6. Culturally responsive

The worker seeks to understand the cultural values and world-views of the individual and how this influences their explanatory model of mental health problems. Culturally responsive care takes into account the individual’s cultural, racial or ethnic background, gender identity and/or sexual orientation without stereotyping. Care is inclusive of traditional treatments and relevant cultural practices. Culturally responsive care also entails working with the broader views and values inherent in collectivist cultures in contrast to a more individualistic western cultural view.

7. Grounded in the person’s life context

Care is grounded in the individual’s unique family structure, life history, mental health history, other important experiences and current life situations. Care also seeks to understand and utilise the unique personal interests, hobbies and role models of the individual. In fact these factors are seen as being of equal or greater importance than mental health history and current symptoms. Trauma-informed care is a particularly important part of being grounded in a person’s life context.

8. Addresses socioeconomic context

Care recognises that supports (even public mental health care) can cost money to access. The socioeconomic context of the individual is understood and taken into account, and remediated where necessary and possible.

9. Relationally mediated

Relationally mediated care holds the relationship between the individual and the worker as centrally important. It is important that this relationship is ‘genuine’. To promote recovery the worker communicates positive expectations and hope and a shared vision of recovery is developed.

10. Optimises natural supports

Natural supports and valued social roles are of the utmost importance and care actively seeks to engage or re-engage the individual with their chosen supports and community of choice, as opposed to ‘program citizenship’. Workers must have extensive knowledge of, and partnerships with, community supports and resources in general; as well as for specific individuals they are working with.

(adapted from Davidson, L, Tondora, J, Staeheli Lawless, M, O’Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.)

Appendix 9 – Suggested Reading

Young People and Recovery

Australian Housing and Urban Research Centre 2013, 'What Is the Role of Informal Community Resources in Supporting Young People Recovering from Mental Illness?', *AHURI Research & Policy Bulletin*, Issue 165, pp. 1-4.

Barnett, H & Lapsley, H 2006, *Journeys of Despair, Journeys of Hope: Young Adults Talk About Severe Mental Distress, Mental Health Services and Recovery*, Mental Health Commission, Wellington.

Buckland, HT, Schepp, KG & Crusoe, K 2013, 'Defining Happiness for Young Adults with Schizophrenia: A Building Block for Recovery', *Archives of Psychiatric Nursing*, vol. 27, no. 5, pp. 235-240.

Crickard, EL, O'Brien, MS, Rapp, CA & Holmes, CL 2010, 'Developing a Framework to Support Shared Decision Making for Youth Mental Health Medication Treatment', *Community Mental Health Journal*, vol. 46, no. 5, pp. 474-481.

Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38.

Gould, A, DeSouza, S, Rebeiro-Gruhl & KL 2005, 'And then I Lost that Life: A Shared Narrative of Four Young Men with Schizophrenia', *The British Journal of Occupational Therapy*, vol. 68, no. 10, pp. 467-473.

Grealish, A, Tai, S, Hunter, A & Morrison, AP 2013, 'Qualitative Exploration of Empowerment from the Perspective of Young People with Psychosis', *Clinical Psychology & Psychotherapy*, vol. 20, no. 2, pp. 136-148.

Killackey, E, Alvarez-Jimenez, M, Allot, K, Bendall, S & McGorry, P 2013, 'Community Rehabilitation and Psychosocial Interventions for Psychotic Disorders in Youth', *Child and Adolescent Psychiatric Clinics of North America*, vol. 22, no. 4, pp. 745-758.

Lam, MM, Pearson, V, Ng, RM, Chiu, CP & Chen, EY 2011, 'What Does Recovery from Psychosis Mean? Perceptions of Young First-Episode Patients', *International Journal of Social Psychiatry*, vol. 57, no. 6, pp. 580-587.

Leavey, JE 2003, 'The Meaning of Mental Illness to Youth: Exploring the Psychosocial Effects of Mental Illness on Identity and Life Cycle Development in Youth Aged 17-24', EdD thesis, University of Toronto.

Leavey, JE 2005, 'Youth Experiences of Living with Mental Health Problems: Emergence, Loss, Adaptation and Recovery (ELAR)', *Canadian Journal of Community Mental Health*, vol. 24, no. 2, pp. 109-126.

MacDonald, E, Sauer, K, Howie, L & Albiston, D 2005, 'What Happens to Social Relationships in Early Psychosis? A Phenomenological Study of Young People's Experiences', *Journal of Mental Health*, vol. 14, no. 2, pp. 129-143.

McCann, TV & Lubman, DI 2012, 'Young People with Depression and Their Satisfaction with the Quality of Care They Receive from a Primary Care Youth Mental Health Service: A Qualitative Study', *Journal of Clinical Nursing*, vol. 21, no. 15-16, pp. 2179-2187.

McCay, E, Beanlands, H, Leszcz, M, Goering, P, Seeman, MV, Ryan, K, Johnson, N & Vishnevsky, T 2006, 'A Group Intervention to Promote Healthy Self-Concepts and Guide Recovery

in First Episode Schizophrenia: A Pilot Study', *Psychiatric Rehabilitation Journal*, vol. 30, no. 2, pp. 105-111.

Oswald, DP 2006, 'Recovery and Child Mental Health Services', *Journal of Child & Family Studies*, editorial, vol. 15, no. 5, pp. 525-527.

Romano, DM, McCay, E, Goering, P, Boydell, K & Zipursky, R 2010, 'Reshaping an Enduring Sense of Self: The Process of Recovery from a First Episode of Schizophrenia', *Early Intervention in Psychiatry*, vol. 4, no. 3, pp. 243-250.

Simonds, LM, Pons, RA, Stone, NJ, Warren, F & John, M 2014, 'Adolescents with Anxiety and Depression: Is Social Recovery Relevant?', *Clinical Psychology & Psychotherapy*, vol. 21, no. 4, pp. 289-298.

South London and Maudsley NHS Foundation Trust & South West London and St. George's Mental Health NHS Trust 2010, *Recovery is for All: Hope, Agency and Opportunity in Psychiatry – A Position Statement by Consultant Psychiatrists*, SLAM/SWLSTG, London.

Substance Abuse & Mental Health Services Administration 2011, *Recovery to Practice: Frequently Asked Questions*, SAMHSA, Rockville, MD, viewed 20 May 2014, <<http://samhsa.gov/recoverytopractice/RTPFAQ.aspx>>.

Trauma-Informed Care & Practice

ACEs Connection 2014, *Trauma-Informed Care Toolkits*, Available from: <http://www.acesconnection.com/blog/trauma-informed-care-toolkits-1>

Massachusetts Department of Mental Health n.d., *Creating Positive Cultures of Care*, 2nd edn, MDMH, Boston, MA. Available from: <http://www.mass.gov/eohhs/docs/dmh/rsri/restraint-resources.pdf>

Medical University of South Carolina, *TF-CBT Web: A Web-Based Learning Course for Trauma-Focused Cognitive-Behavioral Therapy*, Charleston, SC. Available from: <http://tfcbt.musc.edu/>

Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf

Kezelman, C & Stavropoulos, P 2012, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW. Available from: http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

The National Child Traumatic Stress Network, *Creating Trauma-Informed Systems*. Available from: <http://www.nctsn.net/resources/topics/creating-trauma-informed-systems>

Help Seeking

Rickwood, D, Deane, FP, Wilson, CJ & Ciarrochi, JV 2005, 'Young People's Help-Seeking for Mental Health Problems', *The Australian e-Journal for the Advancement of Mental Health*, vol. 4, no. 3, pp. 218-251.

Role of Families

Honey, A, Alchin, S & Hancock, N 2014, 'Promoting Mental Health Wellbeing for a Young Person with Mental Illness: Parent Occupations', *Australian Occupational Therapy Journal*, vol. 61, no. 3, pp. 194-203.

Honey, A, Fraser, V, Llewellyn, G, Hazell, P & Clarke, S 2013, 'Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.

Honey, A & Halse, C 2006, 'The Specifics of Coping: Parents of Daughters with Anorexia Nervosa', *Qualitative Health Research*, vol. 16, no. 5, pp. 611-629.

Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT.

Family Recovery

Beale, B, McMaster, R & Hilege, S 2004, 'Eating Disorders: A Qualitative Analysis of the Parents' Journey', *Contemporary Nurse: A Journal for the Australian Nursing Profession*, vol. 18, no. 1-2, pp. 124-132.

Boulter, E & Rickwood, DJ 2013, 'Parents' Experience of Seeking Help for Children with Mental Health Problems', *Advances in Mental Health*, vol. 11, no. 2, pp. 131-142.

Chaffey, L & Fossey, E 2004, 'Caring and Daily Life: Occupational Experiences of Women Living with Sons Diagnosed with Schizophrenia', *Australian Occupational Therapy Journal*, vol. 51, no. 4, pp. 199-207.

Chandler, R, Bradstreet, S & Hayward, M 2013, *Voicing Caregiver Experiences: Wellbeing and Recovery Narratives for Caregivers*, Susses Partnership NHS Foundation Trust and the Scottish Recovery Network, West Sussex.

Corsentino, EA, Molinari, V, Gum, AM, Roscoe, LA & Mills WL 2008, 'Family Caregivers' Future Planning for Younger and Older Adults with Serious Mental Illness (SMI)', *Journal of Applied Gerontology*, vol. 27, no. 4, pp. 466-85.

Cottee-Lane, D, Pistrang, N & Bryant-Waugh, R 2004, 'Childhood Onset Anorexia Nervosa: The Experience of Parents', *European Eating Disorders Review*, vol. 12, no. 3, pp. 169-177.

Czuchta, DM & McCay, E 2001, 'Help-Seeking for Parents of Individuals Experiencing a First Episode of Schizophrenia', *Archives of Psychiatric Nursing*, vol. 15, no. 4, pp. 159-170.

Daly, P 2005, 'Mothers Living with Suicidal Adolescents', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 43, no. 3, pp. 22-28.

Gerson, R, Davidson, L, Booty, A, Wong, C, McGlashan, T, Malespina, D, Pincus, HA & Corcoran, C 2009, 'Families' Experience with Seeking Treatment for Recent-Onset Psychosis', *Psychiatric Services*, vol. 60, no. 6, pp. 812-816.

Harden, J 2005, 'Parenting a Young Person with Mental Health Problems: Temporal Disruption and Reconstruction', *Sociology of Health & Illness*, vol. 27, no. 3, pp. 351-371.

Harden, J 2005, "'Uncharted Waters": The Experience of Parents of Young People with Mental Health Problems', *Qualitative Health Research*, vol. 15, no. 2, pp. 207-223.

- Hillege, S, Beale, B & McMaster, R 2006, 'Impact of Eating Disorders on Family Life: Individual Parents' Stories', *Journal of Clinical Nursing*, vol. 15, no. 8, pp. 1016-1022.
- Honey, A & Halse, C 2006, 'The Specifics of Coping: Parents of Daughters with Anorexia Nervosa', *Qualitative Health Research*, vol. 16, no. 5, pp. 611-629.
- Jakobsen, E & Severinsson E 2006, 'Parents' Experiences of Collaboration with Community Healthcare Professionals', *Journal of Psychiatric and Mental Health Nursing*, vol. 13, no. 5, pp. 498-505.
- Kenyon, DB & Koerner, SS 2009, 'Examining Emerging-Adults' and Parents' Expectations About Autonomy During the Transition to College', *Journal of Adolescent Research*, vol. 24, no. 3, pp. 293-320.
- LeGris, J 2005, 'Parents of Young People with Mental Health Problems Experienced a Deskillling and Had to Learn to Reskill Themselves', *Evidence-Based Nursing*, vol. 8, no. 4, p. 125.
- Milliken, PJ & Northcott, HC 2003, 'Redefining Parental Identity: Caregiving and Schizophrenia', *Qualitative Health Research*, vol. 13, no. 1, pp. 100-113.
- Milliken, PJ & Rodney, PA 2003, 'Parents as Caregivers for Children with Schizophrenia: Moral Dilemmas and Moral Agency', *Issues in Mental Health Nursing*, vol. 24, no. 8, pp. 757-773.
- Mohr, WK & Regan-Kubinski MJ 2001, 'Living in the Fallout: Parents' Experiences When Their Child Becomes Mentally Ill', *Archives of Psychiatric Nursing*, vol. 15, no. 2, pp. 69-77.
- Scharer, K 2002, 'What Parents of Mentally Ill Children Need and Want from Mental Health Professionals', *Issues in Mental Health Nursing*, vol. 23, no. 6, pp. 617-640.
- Sin, J, Moone, N & Wellman, N 2005, 'Developing Services for the Carers of Young Adults with Early-Onset Psychosis: Listening to Their Experiences and Needs', *Journal of Psychiatric and Mental Health Nursing*, vol. 12, no. 5, pp. 589-597.
- Teggart, T & Linden, M 2006, 'Investigating Service Users' and Carers' Views of Child and Adolescent Mental Health Services in Northern Ireland', *Child Care in Practice*, vol. 12, no. 1, pp. 27-41.
- Tierney, S 2005, 'The Treatment of Adolescent Anorexia Nervosa: A Qualitative Study of the Views of Parents', *Eating Disorders: The Journal of Treatment and Prevention*, vol. 13, no. 4, pp. 369-379.
- Walter, UM, Petr, CG & Davis, S 2006, 'Informing Best Practices for Children in Psychiatric Crises: Perspectives and Insights from Families', *Families in Society: The Journal of Contemporary Social Services*, vol. 87, no. 4, pp. 612-620.
- Winn, S, Perkins, S, Murray, J, Murphy, R & Schmidt U 2004, 'A Qualitative Study of the Experience of Caring for a Person with Bulimia Nervosa. Part 2: Carers' Needs and Experiences of Services and Other Support', *International Journal of Eating Disorders*, vol. 36, no. 3, pp. 269-279.
- Wynaden, D & Orb A 2005, 'Impact of Patient Confidentiality on Carers of People Who Have a Mental Disorder', *International Journal of Mental Health Nursing*, vol. 14, no. 3, pp. 166-171.

Language

Mental Health Coordinating Council 2013, *MHCC Recovery Oriented Language Guide*, MHCC, Lilyfield, NSW.

Physical Health

Mental Health Coordinating Council, *Physical Health*, Lilyfield, NSW. Available from: <http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/physical-health.aspx>

Hancock, N & Cowles, CP 2014, *How NSW Mental Health Community Managed Organisations assist People Living with Mental Health Conditions to Address Their Physical Health Needs: A Scoping Study and Review of the Literature*, Mental Health Coordinating Council (MHCC), Lilyfield, NSW. Available from: <http://www.mhcc.org.au/media/41452/ph-research-project-report-final-170314.pdf>

Whole of Community

Seikkula, J, Aaltonen, J, Alakare, B., Haarakangas, K, Keränen, J & Lehtinen, K 2006, 'Five-Year Experience of First-Episode Non-affective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies', *Psychotherapy Research*, vol. 16, no. 2, pp. 214-228.

Thomas, SP 2011, 'Open-Dialogue Therapy: Can a Finnish Approach Work Elsewhere?', *Issues in Mental Health Nursing*, vol. 32, no. 10, p. 613.

Transitions- School to Employment

Davis, M 2013, 'Tools for System Transformation for Young Adults with Psychiatric Disabilities', *2013 State of the Science Conference Proceedings*, Transitions RTC, Washington, DC.

Transitions- Service Transitions

Davidson, S & Cappelli, M 2011, *We've Got Growing up to Do: Transitioning Youth from Child and Adolescent Mental Health Services to Adult Mental Health Services*, Ontario Centre of Excellence for Child and Youth Mental Health, Ottawa, ON.

Sainsbury, M & Goldman, R 2011, *Mental Health Service Transitions for Young People*, Social Care Institute for Excellence, London.

Singh, SP, Paul, M, Ford, T, Kramer, T, Weaver, T, McLaren, S, Hovish, K, Islam, Z, Belling, R & White, S 2010, 'Process, Outcome and Experience of Transition from Child to Adult Mental Healthcare: Multiperspective Study', *The British Journal of Psychiatry*, vol. 197, no. 4, pp. 305-312.

Singh, SP, Paul, M, Islam, Z, Zobia, Weaver, T, Kramer, T, McLaren, S, Belling, R, Ford, T, White, S, Hovish, K & Harley, K 2010, *Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives*, Report for the National Institute for Health Research Service Delivery and Organisation Programme, Queen's Printer and Controller of HMSO 2010, Southampton.

Recovery- Self Assessment for Services

NSW Consumer Advisory Group – Mental Health Inc. and Mental Health Coordinating Council 2011, *Recovery Oriented Service Self-Assessment Toolkit – ROSSAT: A Recovery Oriented Service Provision Quality Improvement Resource for Mental Health Services*, NSW CAG – MHI and MHCC, Sydney, NSW. Available from: <http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/rossat.aspx>

Peer Support

Canadian Mental Health Association, BC Division 2007, *An Environmental Scan: Peer Support for Youth with Mental Health Problems and Their Families*, Strengthening Family and Youth Voices Project, CMHA BC Division, Vancouver, BC.

James, AM 2007, 'Principles of Youth Participation in Mental Health Services', *The Medical Journal of Australia*, vol. 187, no. 7, p.57.

Kemp, V, Bates, A & Isaac, M 2008, 'Mental Health Consumers as Peer Supporters in Western Australia', *Health Issues Journal*, vol. 96, pp. 23-27.

Lloyd-Evans, B, Mayo-Wilson, E, Harrison, B, Istead, H, Brown, E, Pilling, S, Johnson, S & Kendall, T 2014, 'A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness', *BMC Psychiatry*, vol. 14, no. 39.

McDonald, J 2010, *Literature Review on the Mental Health Consumer Workforce*, The NSW Consumer Advisory Group (CAG) – Mental Health Inc. and The Consumer Workers' Forum (CWF) Organising Committee, Sydney, NSW. Available from:
http://www.nswcag.org.au/files//our_work/cwf_literature_review_final.pdf

Proudfoot, JG, Jayawant, A, Whitton, AE, Parker, G, Manicavasagar, V, Smith, M & Nicholas, J 2012, 'Mechanisms Underpinning Effective Peer Support: A Qualitative Analysis of Interactions Between Expert Peers and Patients Newly-Diagnosed with Bipolar Disorder', *BMC Psychiatry*, vol. 12, no. 196.

Repper, J & Carter, T 2011, 'A Review of the Literature on Peer Support in Mental Health Services', *Journal of Mental Health*, vol. 20, no. 4, pp. 392-411.

Endnotes

- ¹ Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- ² Department of Health and Ageing 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra, ACT.
- ³ State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne, VIC.
- ⁴ Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- ⁵ Department of Health and Ageing 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra, ACT.
- ⁶ State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne, VIC.
- ⁷ Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38; Lal, S 2010, 'Prescribing Recovery as the New Mantra for Mental Health: Does One Prescription Serve All?', *Canadian Journal of Occupational Therapy*, vol. 77, no. 2, pp. 82-89.
- ⁸ Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38.
- ⁹ State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne, VIC.
- ¹⁰ Anthony, WA 1993, 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s', *Psychosocial Rehabilitation Journal*, vol. 1993, vol. 16, no. 4, pp. 11-23; Chamberlin, J 1990, 'The Ex-Patients' Movement: Where We've Been and Where We're Going', *The Journal of Mind and Behaviour*, vol. 11, no. 3, pp. 323-336; Deegan, PE 1988, 'Recovery: The Lived Experience of Rehabilitation', *Psychosocial Rehabilitation Journal*, vol. 11, no. 1, pp. 11-19; Everett, B 1994, 'Something Is Happening: The Contemporary Consumer and Psychiatric Survivor Movement in Historical Context', *The Journal of Mind and Behaviour*, vol. 15, no. 2, pp. 55-70.
- ¹¹ Collier, E 2010, 'Confusion of Recovery: One solution,' *International Journal of Mental Health Nursing* Volume 19, Issue 1, pages 16–21, February 2010.
- ¹² Collier, E 2010, 'Confusion of Recovery: One solution,' *International Journal of Mental Health Nursing* Volume 19, Issue 1, pages 16–21, February 2010.
- ¹³ Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.
- ¹⁴ Slade, M, Amering, M, Farkas, M, Hamilton, B, O'Hagan, M, Panther, G, Perkins, R, Shepherd, G, Tse, S & Whitley, R 2014, 'Uses and Abuses of Recovery: Implementing Recovery-Oriented Practices in Mental Health Systems', *World Psychiatry*, vol. 13, no. 1, pp. 12-20; *Convention on the Rights of Persons with Disabilities and Optional Protocol 2007*, opened for signature 30 March 2007, 2515 UNTS 3, entered into force 3 May 2008.
- ¹⁵ Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.
- ¹⁶ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.
- ¹⁷ Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- ¹⁸ Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- ¹⁹ Department of Health and Ageing (ed.) 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT.
- ²⁰ State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne, VIC.

-
- ²¹ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.
- ²² Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.
- ²³ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.
- ²⁴ McCay, E, Beanlands, H, Leszcz, M, Goering, P, Seeman, MV, Ryan, K, Johnson, N & Vishnevsky, T 2006, 'A Group Intervention to Promote Healthy Self-Concepts and Guide Recovery in First Episode Schizophrenia: A Pilot Study', *Psychiatric Rehabilitation Journal*, vol. 30, no. 2, pp. 105-111; Simonds, LM, Pons, RA, Stone, NJ, Warren, F & John M 2014, 'Adolescents with Anxiety and Depression: Is Social Recovery Relevant?', *Clinical Psychology & Psychotherapy*, vol. 21, no. 4, pp. 289-298.
- ²⁵ Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38; Lal, S 2010, 'Prescribing Recovery as the New Mantra for Mental Health: Does One Prescription Serve All?', *Canadian Journal of Occupational Therapy*, vol. 77, no. 2, pp. 82-89.
- ²⁶ Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf
- ²⁷ Kezelman, C & Stavropoulos P 2012, *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW; Mental Health Coordinating Council 2012, *Trauma Informed Care Training Course Handbook*, MHCC, Lilyfield, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf
- ²⁸ Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf
- ²⁹ Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care (ed.) 2000, *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*, Commonwealth of Australia, Canberra, ACT.
- ³⁰ Gore, FM, Bloem, PJN, Patton, GC, Ferguson, J, Joseph, V, Coffey, C, Sawyer, SM & Mathers, CD 2011, 'Global Burden of Disease in Young People Aged 10-24 Years: A Systematic Analysis', *The Lancet*, vol., 377, no. 9783, pp. 2093-2102.
- ³¹ Rickwood, D, Deane, FP, Wilson, CJ & Ciarrochi, JV 2005, 'Young People's Help-Seeking for Mental Health Problems', *The Australian e-Journal for the Advancement of Mental Health*, vol. 4, no. 3, pp. 218-251.
- ³² Northern Sydney Central Coast Area Health & Health CaYPsM (eds.) 2007, *A Youth Mental Health Model on the Central Coast: Background Report on the NSW Youth Mental Health Service Model – Central Coast Pilot Project*, NSCCH, Gosford, NSW.
- ³³ Substance Abuse & Mental Health Services Administration 2011, *Recovery to Practice: Frequently Asked Questions*, SAMHSA, Rockville, MD, viewed 20 May 2014, <<http://samhsa.gov/recoverytopractice/RTPFAQ.aspx>>.
- ³⁴ Solomon, MF & Siegel, DJ (eds.) 2003, *Healing Trauma: Attachment, Mind, Body, And Brain*, W.W. Norton and Company, New York, NY.
- ³⁵ Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38; South London and Maudsley NHS Foundation Trust & South West London and St. George's Mental Health NHS Trust 2010, *Recovery is for All: Hope, Agency and Opportunity in Psychiatry – A Position Statement by Consultant Psychiatrists*, SLAM/SWLSTG, London; Substance Abuse & Mental Health Services Administration 2011, *Recovery to Practice: Frequently Asked Questions*, SAMHSA, Rockville, MD, viewed 20 May 2014, <<http://samhsa.gov/recoverytopractice/RTPFAQ.aspx>>.
- ³⁶ Friesen, BJ 2007, 'Recovery and Resilience in Children's Mental Health: Views from the Field', *Psychiatric Rehabilitation Journal*, vol. 31, no. 1, p. 38; Simonds, LM, Pons, RA, Stone, NJ, Warren, F & John M 2014,

-
- 'Adolescents with Anxiety and Depression: Is Social Recovery Relevant?', *Clinical Psychology & Psychotherapy*, vol. 21, no. 4, pp. 289-298; Oswald, DP 2006, 'Recovery and Child Mental Health Services', *Journal of Child & Family Studies*, editorial, vol. 15, no. 5, pp. 525-527; Lal, S 2010, 'Prescribing Recovery as the New Mantra for Mental Health: Does One Prescription Serve All?', *Canadian Journal of Occupational Therapy*, vol. 77, no. 2, pp. 82-89.
- ³⁷ Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT.
- ³⁸ Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.
- ³⁹ Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT; Honey, A, Fraser, V, Llewellyn, G, Hazell, P, Clarke, S 2013, 'Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.
- ⁴⁰ Resnick, MD, Bearman, PS, Blum, RW, Bauman, KE, Harris, KM, Jones, J, Tabor, J, Beuhring, T, Sieving, RE, Shew, M, Ireland, M, Bearinger, LH & Udry, JR 1997, 'Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health', *The Journal of the American Medical Association*, vol. 278, no. 10, pp. 823-832.
- ⁴¹ Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT; Honey, A, Fraser, V, Llewellyn, G, Hazell, P, Clarke, S 2013, 'Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.
- ⁴² Simonds, LM, Pons, RA, Stone, NJ, Warren, F & John, M 2014, 'Adolescents with Anxiety and Depression: Is Social Recovery Relevant?', *Clinical Psychology & Psychotherapy*, vol. 21, no. 4, pp. 289-298.
- ⁴³ Kezelman, C & Stavropoulos, P 2012, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW.
- ⁴⁴ Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT; Romano, DM, McCay, E, Goering, P, Boydell, K & Zipursky, R 2010, 'Reshaping an Enduring Sense of Self: The Process of Recovery from a First Episode of Schizophrenia', *Early Intervention in Psychiatry*, vol. 4, no. 3, pp. 243-250; Killackey, E, Alvarez-Jimenez, M, Allot, K, Bendall, S & McGorry, P 2013, 'Community Rehabilitation and Psychosocial Interventions for Psychotic Disorders in Youth', *Child and Adolescent Psychiatric Clinics of North America*, vol. 22, no. 4, pp. 745-758; Buckland, HT, Schepp, KG & Crusoe, K 2013, 'Defining Happiness for Young Adults with Schizophrenia: A Building Block for Recovery', *Archives of Psychiatric Nursing*, vol. 27, no. 5, pp. 235-240; Coughlan, H, Cannon, M, Shiers, D, Power, P, Barry, C, Bates, T, Birchwood, M, Buckley, S, Chambers, D, Davidson, S, Duffy, M, Gavin, B, Healy, C, Healy, C, Keeley, H, Maher, M, Tanti, C & McGorry, P 2013, 'Towards a New Paradigm of Care: The International Declaration of Youth Mental Health', *Early Intervention in Psychiatry*, vol. 7, no. 2, pp. 103-108; Lam, MM, Pearson, V, Ng, RM, Chiu, CP & Chen, EY 2011, 'What Does Recovery from Psychosis Mean? Perceptions of Young First-Episode Patients', *International Journal of Social Psychiatry*, vol. 57, no. 6, pp. 580-587.
- ⁴⁵ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY; Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452; Honey, A, Fraser, V, Llewellyn, G, Hazell, P & Clarke, S 2013, 'Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.
- ⁴⁶ Oswald, DP 2006, 'Recovery and Child Mental Health Services', *Journal of Child & Family Studies*, editorial, vol. 15, no. 5, pp. 525-527.
- ⁴⁷ Robinson, E 2006, 'Young People and Their Parents: Supporting Families through Changes that Occur in Adolescence', *Australian Family Relationships Clearinghouse (AFRC) Briefing*, no. 1, Commonwealth of Australia, Barton, ACT; Honey, A, Fraser, V, Llewellyn, G, Hazell, P & Clarke, S 2013, 'Parental Influence on

the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions', *Advances in Mental Health*, vol. 12, no. 1, pp. 63-74.

⁴⁸ Devon Partnership Trust 2014, *Putting Recovery at the Heart of All We Do: What Does This Mean in Practice?*, 2014 edn, Devon Partnership Trust, Exeter.

⁴⁹ Mental Health Coordinating Council 2013, *MHCC Recovery Oriented Language Guide*, MHCC, Lilyfield, NSW.

⁵⁰ Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from:

http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf

⁵¹ *Mental Health Act 2007* (NSW).

⁵² Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.

⁵³ Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.

⁵⁴ Leamy, M, Bird, V, Le Boutillier, C, Williams, J & Slade, M 2011, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis', *The British Journal of Psychiatry*, vol. 199, no. 6, pp. 445-452.

⁵⁵ Kezelman, C & Stavropoulos, P 2012, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW; Mental Health Coordinating Council (MHCC) 2013, 'Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia, A National Strategic Direction', *Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) & Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW. Available from:

http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf

⁵⁶ Massachusetts Department of Mental Health n.d., *Creating Positive Cultures of Care*, 2nd edn, MDMH, Boston, MA. Available from: <http://www.mass.gov/eohhs/docs/dmh/rsri/restraint-resources.pdf>

⁵⁷ Commonwealth of Australia 2013, *A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory*, Commonwealth of Australia, Canberra, ACT.

⁵⁷ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.

⁵⁸ Victorian Department of Health 2011, *Recovery-Oriented Practice: Literature Review*, Mental Health, Drugs and Regions Division, State Government of Victoria, Melbourne, (docs.health.vic.gov.au/docs/doc/EA9CBEB3FB430CE0CA2579090023087E/\$FILE/1106004_Recovery%20oriented%20practice%20literature%20review_Web.pdf).

⁵⁹ Commonwealth of Australia 2013, *A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory*, Commonwealth of Australia, Canberra, ACT.

⁶⁰ Davidson, L, Tondora, J, Staeheli Lawless, M, O'Connell, MJ & Rowe, M 2009, *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*, Oxford University Press, New York, NY.