Resources shared with Peer Support Providers

Jan. 27, 2022

NTTAC
National Training & Technical Assistance Center
for Child, Youth, & Family Mental Health

Peer Support Documentation – *Best Practices and Strategies for a Unique Workforce*

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DISCLAIMER

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What we will cover…

best practices in documentation

Progress notes

Support planning

Other documentation

staying current and concise in documentation

Challenges

Strategies

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Why do we document our work?

- As a memory aid
- Recording facts, goals and tasks
- Communicating with other professionals
- Accountability (CYA)
- Funding Documentation
- Legal requirements (state, federal)
- To show progress or challenges

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Failure to maintain adequate notes:

- deprives the individual or family of data needed for quality services
- can jeopardize funding if you cannot prove that services were provided
- puts you and your employer at risk of accusations that cannot be defended such as issues around service delivery or follow through on tasks

If you don't write it down, it did not happen.

Documentation will look different based on the type of peer support provided

Parent/Family Peer Support

- May refer to work with schools, juvenile court, child welfare, child mental health
- Focus on the caregiver and the whole family to benefit the child/youth
- Skill building for the caregiver of the child/youth
- May involve connection to support employment, housing, and caregiver wellness
- Focus on resiliency

Adult/Young Adult Peer Support

- May refer to employment, housing, court/legal issues, illness management
- If young adult peer support, may involve supporting in high school or college
- Independent living skills
- Focus on the individual
- Focus on recovery

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What to document – NE requirements

Documentation should include:

- Information on assisting individuals to initiate and maintain the process of recovery and resiliency
- Progress toward improvement in quality of life, increased resiliency, and promotion of health and wellness – including accomplishment of goals
- Support that is based on shared lived experience and mutuality
- Activities and support around system navigation, education and skills acquisition, empowerment, hope, resiliency, voice and choice, and system of care values (family driven, youth guided, culturally and linguistically responsive, community based)
- Services/supports in both individual and group settings, in locations in and out of an office (home, school, community)
- Collaboration with other service providers, including safety planning and care coordination tasks
- Identification of and connection with formal and informal supports
- Crisis management

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What to document – best practices

- All contacts with, for, on behalf of, or regarding the individual or family you are working with
- Activities are connected to an individualized support plan
- Concise descriptions of your work with the individual and/or family at every stage of the intervention from your first meeting through discharge:
  - Individual or family's preferences, priorities, and culturally or linguistically specific needs
  - Connection to and collaborations with formal services and informal supports
  - Growth and progress in skills acquisition, confidence in navigating systems and addressing needs, accomplishing individual/family prioritized goals, and development of a supportive network
  - Work toward and capacity in crisis management, coping and resiliency
  - Significant incidents

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Important elements of progress notes

Objective

Concise

Relevant

Timely

Well written

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How do you show “peer support” in your writing?

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Terminology & Tone

- Use human experience language – avoid clinical language
- Use the person’s words, terms, preferred name and pronouns, culturally specific terminology
- Use peer support core value language and terms related to service description
- Use strengths-based and person first language
- Objective terms – what you see, hear or are told
- Nonjudgmental, supportive, empowering, validating, respectful, and objective – avoid words/phrases that lead to sensationalism

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Using strengths-based language

Traditional documentation is more deficit-based	• Terms reflect what is NOT present or what should NOT be done
A strengths-based approach should be reflected in the language of your documentation	• Terms reflect what strengths are present or what should be done/accomplished, reflecting the goal of the individual or family

Descriptions of your activities – verbs used:

- Role modeled
- Demonstrated
- Facilitated
- Provided
- Shared
- Cued
- Discussed
- Explained
- Informed
- Focused/refocused
- Directed/re-directed
- Reframed
- Taught
- Encouraged
- Modeled
- Observed
- Recommended
- Suggested
- Guided
- Reinforced
- Reviewed skills/techniques
- Developed skills in/for
- Role played
- Clarified
- Supported
- Reflected
- Validated
- Affirmed
- Acknowledged
- Practiced
- Partnered
- Collaborated
- Coordinated
- Gave/provided feedback
- Identified
- Problem-solved
- Navigated
- Explored options
- Followed up on
- Reviewed
- Coached

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Content of your notes - examples

- Establishing boundaries as a peer
- Strategic sharing of lived experience
- Navigating various systems to help individual/family access services and supports
- Problem-solving
- Confidence-building activities including practicing skills, role playing, modeling skills
- Identifying preferences and priorities
- Connections to reduce isolation and develop support network
- Advocacy for appropriate services
- Teaching self-advocacy
- Addressing basic needs
- Accompanying to appointments, court, etc. as a support

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Basic structure of a progress note

Who – Who is present? Who is participating? Include roles of those present for clarity.

Where – Where did the visit or meeting take place?

When – Record the date, time and length of visit or meeting.

What – What occurred during the meeting? Record topics discussed, goals in progress or status of tasks, successes or challenges, concerns or examples of what is going well.

Plan – What are the next steps? Record any actions to be taken based on the discussion.

Next meeting – When is the next meeting or visit with the family? It is important to never leave a meeting with the family without establishing the date, time and location for the next meeting.

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Basic structure – Parent peer support

Who – PSP met with youth and mother

Where – at the family's home

When – on 11/20/21 at 5:30 p.m.

What – Both reported that youth had attended school all five days last week and completed the majority of his schoolwork as agreed upon in the behavior contract. Youth stated that the new medication seemed to be helping his concentration but was giving him a dry mouth and his teachers did not like him leaving class to get something to drink. Mother was also concerned about the upcoming court hearing about visitation with the youth's father; youth does not want to continue visitation due to father's alcohol use during visits.

Plan – Next week, mother will make appt. with the NP about the side effects of the medication, and youth will begin taking a water bottle to school, filling it between classes to avoid missing class time. Mother will also schedule a meeting with the atty. to prepare for the court hearing. PSP assisted mother and youth in developing list of concerns to address with atty. prior to the hearing. Also reminded mother of calming exercises she had learned and role-played ways to address possible court situations.

Next meeting - PSP will meet with family again next Thursday afternoon at 4 pm.

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Basic structure – Adult peer support

Who – APSP accompanied Jane

Where – to a watercolor workshop

When – on 11/20/21 at 1:00 p.m.

What – The watercolor workshop offered a chance for Jane to connect with peers to develop friendships. Before going in, we reviewed ways to start a conversation. Jane said she was feeling anxious but willing to try. She seemed interested in the demonstration and spoke to the woman next to her once they began painting. Jane reported that she felt less nervous after spending time in the class and having a positive conversation with her tablemate. She also stated that the painting was relaxing and took her mind off worries at home.

Plan – Jane will continue with the painting classes and will start conversations with others at her table next week. APSP practiced starting conversations with Jane again. APSP will accompany her for one or two more classes as a support. Also reminded Jane of appointment with the Nurse Practitioner on Tuesday and assisted her in making a list of concerns she wanted to share regarding the side effects of the new medication.

Next meeting - APSP will meet with Jane next Thursday afternoon at 4 pm for the next painting class.

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Examples of when more detail is needed…

- Suspicion or allegations of abuse
- Safety concerns (within the home, lack of supervision, suicidal ideation, homicidal thoughts, etc.)
- Legal issues (behaviors of concern to the court or child welfare that you will have to possibly report on)
- Need to break confidentiality (risk of harm to self or others, observation of abuse – mandated reporting issues)

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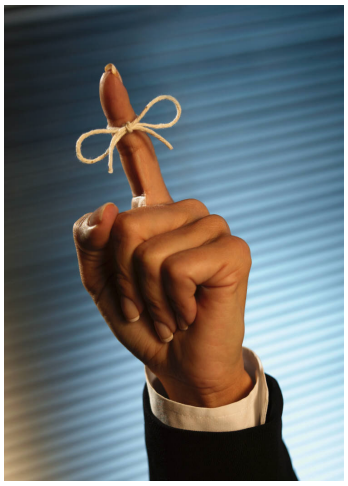
Progress note exercise

Things to remember about your documentation…



- The individual or family has a right to see their record at any time, so it is important to state the facts and be accurate to avoid embarrassment for the individual/family, you, and your agency/employer.
- The progress notes should read like the "story" of their time in your program, detailing the steps of your intervention and the individual's/family's response.
- There is always the chance that your records could be subpoenaed by the court and therefore should be neat, concise, and up to date.

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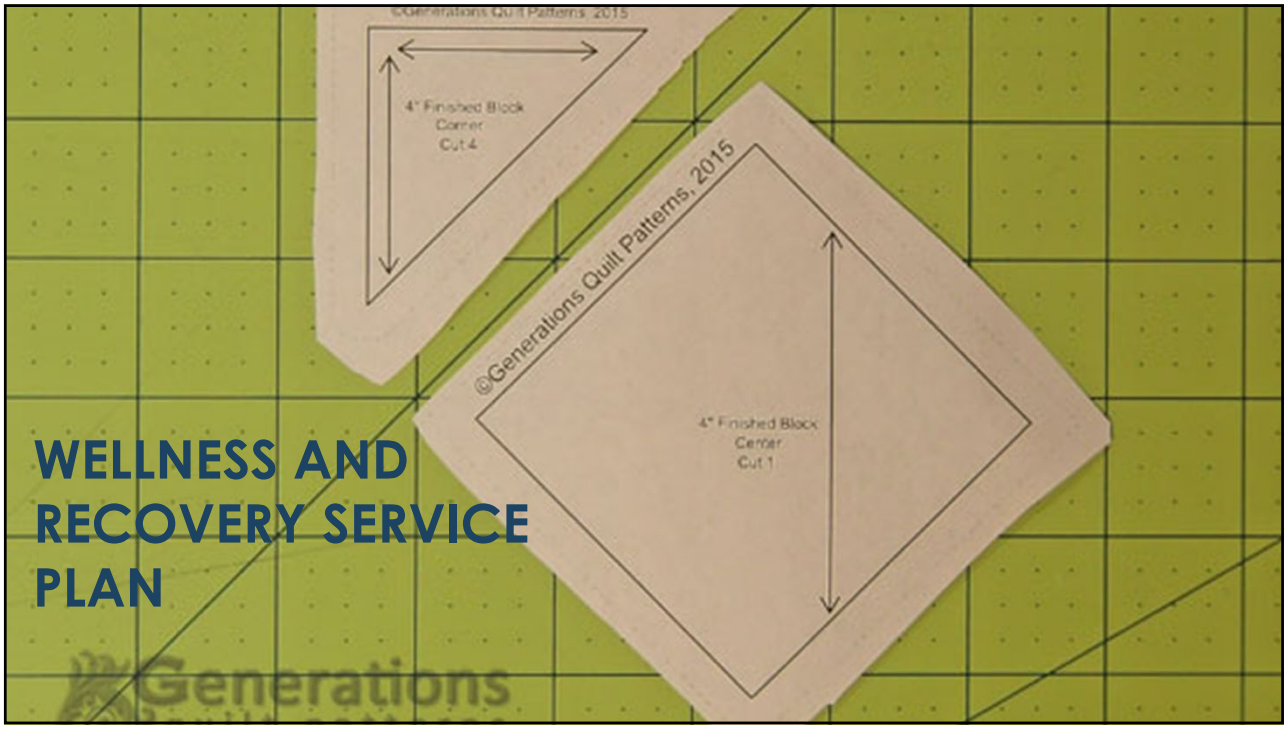

WELLNESS AND RECOVERY SERVICE PLAN

Support Plans

- Strengths-based and individualized to their specific needs, situation, and culture
- Have measurable goals
- Realistic and achievable – may need small steps initially
- Reflect all relevant life domain areas identified by individual/family and crisis or safety issues
- Incorporate formal and informal supports in the community
- Have assigned tasks and time limits for accomplishing those tasks
- Be updated regularly and as needs change/tasks are completed

The individual or family should be the driving force behind support planning

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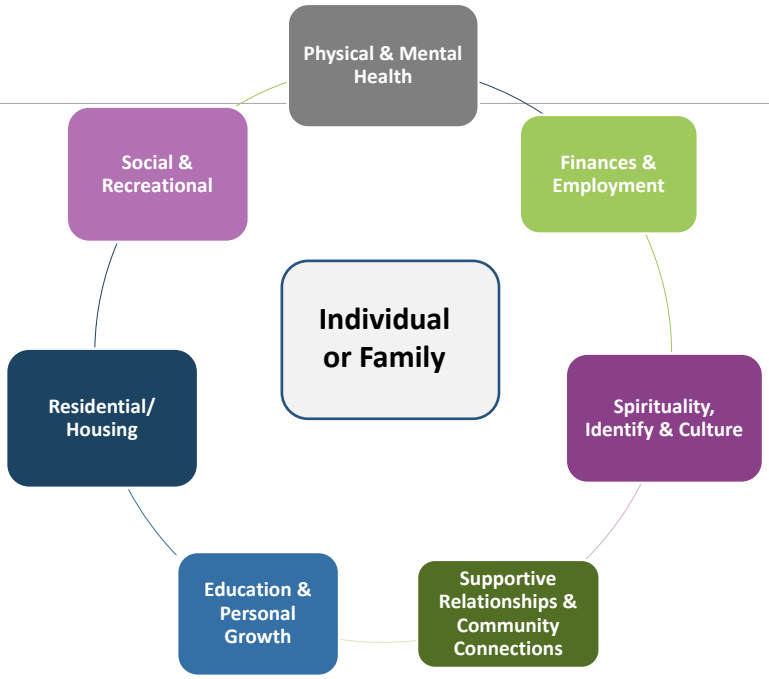
What types of goals are in a support plan?

Explore relevant life domains!



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Basic components of a support plan

- **Long term goal** (*desired outcome/overarching goal*)
- **Short term goals** (*strategies to support completion of the long term goal*)
- **Measurement** (*how will you know that progress is made on each?*)
- **Task assignment** (*who is responsible for completing each step or task under the goals?*)
- **Time frame** (*when will each be completed?*)

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Developing goals

- Focus on 3 - 4 goals
- Well-defined goals:
  - Stated in a positive way
  - Are as specific as possible
  - Stated in the individual's or family's language
  - Stated as a process, not static
  - Within the control of the family/individual

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SMART Goals

S	Specific
M	Measurable
A	Achievable
R	Reasonable
T	Time-Delineated

Example – Parent peer support

Need *Brianna is not receiving appropriate mental health services to help with anxiety and panic attacks.*

Strengths *Brianna recently completed a psychological evaluation and now has an accurate diagnosis. She wants to find a therapist with whom she is comfortable, preferably from the LGBTQ+ community. Her parents are basically supportive but are struggling with her "choice" to be gay. The family just received confirmation of enrollment in healthcare coverage through the father's job. The family has reliable transportation, and the parents share use of the vehicle.*

Long term goal: Brianna will be able to control of her anxiety and know how to handle panic attacks when they happen.

Short term goal : *Brianna will be connected with a therapist that fit her needs within the next month.*

Strategies:

1. The PPSP will provide information to the family about mental health services in their community fitting Brianna's preferences during the next visit and assist them in setting up an intake appointment at the provider of their choice.
2. If necessary, Mrs. Sutton will send a note to school regarding early dismissal of Brianna for the appointment. Mrs. Sutton will ensure that she has the family car on the day of the appointment and childcare for her youngest son if needed.

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Example – Adult peer support

Need *Colin is complaining about not sleeping well, and he is afraid to go to the grocery store because people look at him funny. He has not been consistent with his medication in the past when he is "in a good phase" with his illness (schizophrenia).*

Strengths Colin enjoys physical activity and has access to a gym at his apartment complex. He is connected with a psychiatrist that he likes and has reported that the current medication has been helpful when he is not feeling well. His apartment is centrally located in town with easy access to a local mental health center that offers both group and individual therapy and activities.

Long term goal: Colin will know how to recognize and manage the "bad phases" of his illness.

Short term goal : *Colin will identify the signs when he is entering a "bad phase" and steps to take when recognizing these signs.*

Strategies:

1. APSP will help Colin list the behaviors and feelings that occur when he is doing well ("good phase") and when he is not doing well ("bad phase"), as well as what helps him to feel better. His wellness plan will be updated to include these strategies at the next meeting.
2. APSP will problem-solve with Colin on ways to be more consistent in taking his medication, such as alarms on his cellphone or watch. APSP will support Colin in setting up any reminders.
3. Colin will schedule an appointment with the psychiatrist within two weeks to review his current medication and discuss any necessary changes to address the sleep issues.

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Vxssruw#Sodq Wlsv

- Be sure the goal is SMART
- Be sure the goal relates to the prioritized needs and reasons for referral
- Be sure the strategies relate to goal achievement
- Be sure the action steps describe the role of the all involved (individual/parent/family, peer supporter, and other providers)

Goal writing exercise

OTHER DOCUMENTATION

Meetings

You may need to maintain documentation from meetings you attend

- Committees
- Workgroups
- Task force meetings
- Advisory Councils
- Policy-making groups

WHY would you need to document these?

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Supervision notes

It is important to keep records of your supervision

- Documentation and acknowledgement of your work product
- Task reminders in casework
- Professional development goals, achievements
- Record of personnel issues or concerns
- Data to corroborate performance evaluations, performance improvement plans, etc.

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Trainings and conferences

- **Always keep a record of trainings you have *attended/received***
  - Scan certificates to have an electronic copy and keep paper copy in personnel record or separate file
  - Maintain a training log per fiscal year -- name of conference/training, date, topic or competency area, and number of hours
- **Always keep a record of trainings you have *provided***
  - Maintain a log of trainings you have provided to others – topic, date, audience (type and number of attendees)
  - Keep a folder of confirmation notices or thank you notes, as well as evaluations of the training

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DEADLINES, DEADLINES, DEADLINES!
STAYING CURRENT IN DOCUMENTATION

Timelines for documentation

- NE requirements
  - Wellness and Recovery Service Plan developed within 30 days of admission, reviewed/updated at least every 90 days or more frequently if needed
- Organizational or program requirements
  - What deadlines or timelines does your organization and program have?
- Best practice
  - Do progress notes within 72 hours
  - Update support plan goals and tasks at least every 60-90 days depending on intensity of service or number of goals/tasks in the plan

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Issues connected with record-keeping…

- Finding time to keep up with documentation
- Maintaining confidentiality of client records
- Avoiding biased reporting
- Consistency in phrases, abbreviations, etc. to ensure understanding of the documentation

Strategies for staying current and concise

- Set a consistent time to do documentation – make it a habit!
- Use alerts and "tasks" on your outlook calendar to remind you of deadlines and due dates
- Use a cheat sheet to remind you of formatting, abbreviations, etc.
- Use the progress note format to take notes during visits
- Use collaborative documentation

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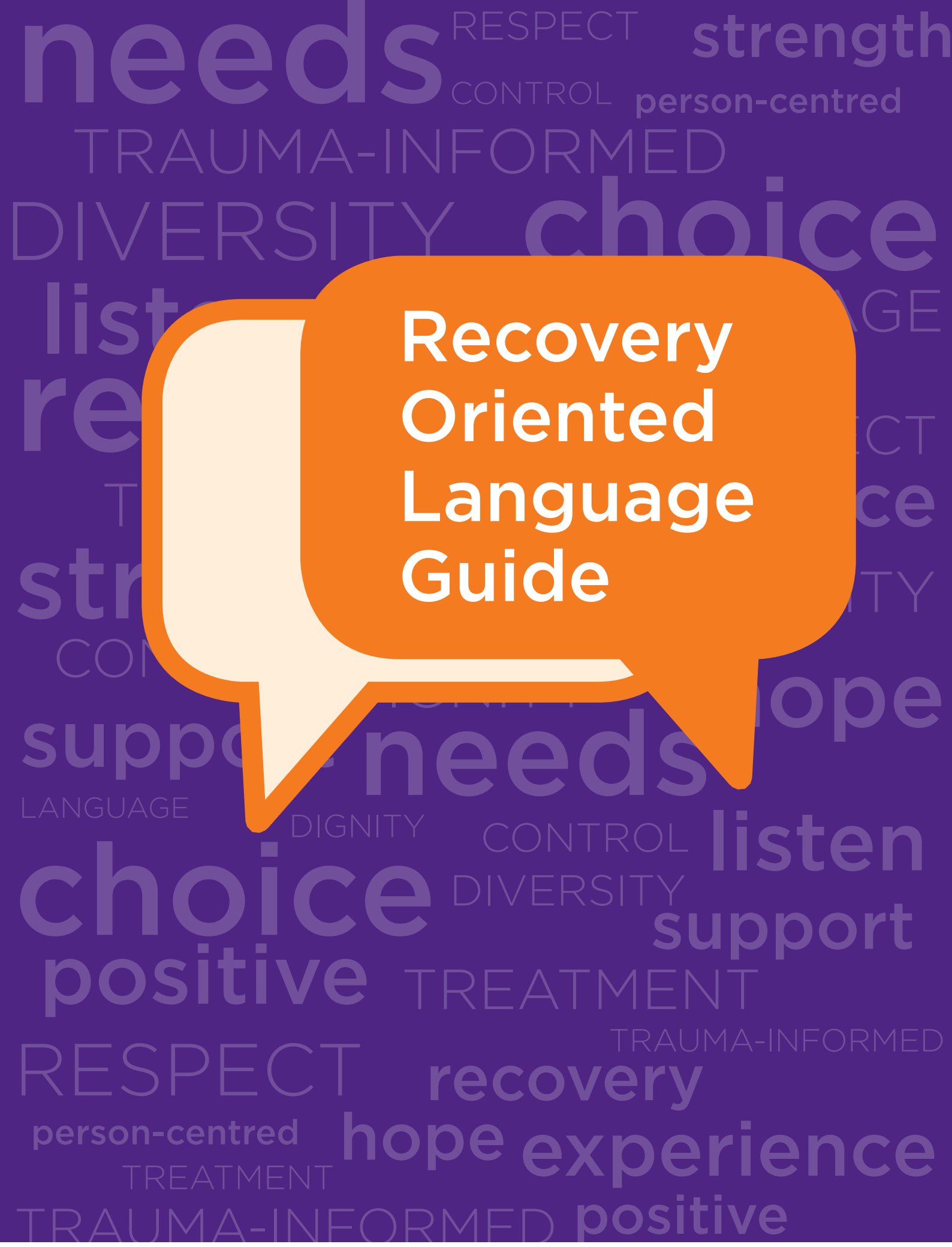
Basic progress note "*Do's*"

- Be specific and avoid generalization.
- Be complete.
- Be sure to document atypical situations, incidents, or behaviors
- Use quotes when appropriate
- Use specific time frames
- Document every contact made with a client or on behalf of an individual/family, even if you just left a message or sent a letter/e-mail
- Include who is present at the visit/meeting
- If meeting is held in a donated space, include this (for funding reasons)
- Use abbreviations that are easily understood by all or required by your employer/agency
- Use the individual's or family's name(s) and role -- unless agency directs you to do otherwise
- Include names when referring to other providers to easily track who exactly is providing services
- Include date of next scheduled visit or meeting in the note OR if meeting/visit was cancelled and by whom

Basic progress note "*Don'ts*"

- Do not include personal opinions -- be objective about what you observe (behaviors, etc.) and don't theorize
- Do not document things said by a third party ("hearsay"), only what you have heard or seen yourself
- Do not document info that is not pertinent to your service or the case (ex. disclosure about sexual preferences, etc.)
- Do not include info on past criminal behavior. You are not required to include this unless the client is seeking services to avoid legal prosecution/conviction, or it has bearing on safety or service provision (ex. babysitter is a convicted sex offender)



2ND EDITION

mhcc
mental health coordinating council

Contents

Recovery Oriented Language Guide - Second Edition Revised

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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.[1]

The Mental Health Coordinating Council (MHCC) developed the ***Recovery Oriented Language Guide*** in 2013 because language matters in all aspects of life. It continues to be particularly important in the context of mental health and recovery. It is vital that words are used that convey hope and optimism, and support and promote a culture that fosters recovery.[2]

People living with mental health conditions are amongst some of the most disadvantaged people in the Australian community, and many live with psychosocial difficulties exacerbated by historical and current trauma, poverty, poor physical health and stigma and discrimination which often feature as part of everyday experiences.[3] The words that we use may effect a person's sense of self and lead to more disadvantage and social exclusion.

The mental health and human service sectors acknowledge MHCC's *Recovery Oriented Language Guide* [4] (the *Guide*) as an extremely useful resource. We have developed this second edition primarily to align with trauma-informed care and practice language approaches, introduce age-related language use and promote the use of supported decision-making language.

Development of the Guide has been informed by a number of sources including: International and Australian literature on trauma-informed and recovery oriented practice; conversations with the mental health practitioners across service sectors; and, most importantly, through listening to the voices of people with lived experience of mental health conditions concerning their recovery journeys.

The Recovery Oriented Language Guide underpins and informs all the work MHCC undertakes in both the policy reform space and in its sector development activities.

You can access this resource from the website at **www.mhcc.org.au/our-work/resources**

Recovery perspectives throughout life

Since 'recovery' was originally defined from the perspectives of adult mental health consumers, MHCC has sought to identify whether these standpoints also apply to people at different developmental stages of life.

The literature suggests that whilst the recovery oriented approach applies to everyone, the language and ways of communicating that approach need to be relevant to particular age groups. MHCC has expanded this edition of the Recovery Oriented Language Guide to include some material concerning the perspectives of young and older people at different stages of their recovery journey. It provides an opportunity for reflection on diversity, which includes young people coming to terms with the new experience of mental health and older people possibly coming to terms with this identity and other associated trauma, grief and loss experiences.

Whatever a person's stage of life, mental health and human services should be familiar with language that reflects a recovery oriented approach to practice, and have an awareness and understanding of the prevalence and impact of trauma, which may have resulted in a range of psychosocial difficulties, and have awareness of the ways in which this may present.

Cultural diversity considerations should always guide a worker in their communications.

When a worker is unsure of what is appropriate, they should ask the person what they would like in terms of language interpretation, disability aids, environmental accommodation or supports.

Whatever a person's background, developmental age or impairment experienced, workers should adopt strength-based language to encourage choice and control and support self-directed decision-making.

Just ask a person what they think would assist them achieve their aims and objectives, what they need now and in the future and how they can be supported to communicate and achieve their aims.

Every day we make a countless number of decisions. They are an expression of who we are - our uniqueness, our relationships with others, our achievements and hopes for the future. Sharing power is a key element in promoting recovery.

- Access to supported decision-making can assist a person of any age develop a sense of control over their lives and their recovery. Through decision-making we exercise control over our lives, experience new things and learn about ourselves. Decision-making is so important that it is recognised as a human right
- Decision-making is a skill that can be developed and practised with support.
- Supported decision-making can assist a person to live with meaning, dignity and greater independence.

Appropriate language is a vital component in communicating a sense of self-determination, because feeling powerlessness can be overwhelming, especially when decisions seem to be or are in the hands of others.

Research has shown that communication is only 7 % verbal and 93 % non-verbal. The non-verbal component is made up of body language (55 %) and tone of voice (38 %)[5] so when communicating with someone it is also important to consider:

Being mindful of the non-verbal aspects of communication, as well as boundaries maintained, appropriate eye contact and using body posture that is non-threatening nor disinterested.

Always try to accommodate a person's developmental age, hearing, cognitive or language difficulties, the time and space to think, question and express their point of view.

It is important to be authentic, transparent and sincere.

Use plain English language where possible. Using everyday language can help anyone better understand what is happening to them, their condition, care and treatment or circumstantial change.

Collaboration and openness are largely achieved through developing rapport, through connectedness, and a sense of feeling respected and heard.

Guidelines for Recovery Oriented Language[6]

General Principles

The language we use:

- Represents the meanings we have constructed from experience
- Prompts attitudes, expectations and actions
- Should always reflect 'unconditional positive regard' [7] for people.

We may be unaware of how the words we use reflect our attitudes and the impact they have upon those around us.

The words we choose reflect our attitudes - that we do (or do not) truly value people, believe in and genuinely respect them.

None of us should be defined by the mental health conditions or psychosocial difficulties that we experience, or by any single aspect of who we are; we should be respected as individuals first and foremost.

Our language needs to be:

- Respectful
- Non-judgemental
- Clear and understandable
- Free of jargon, confusing data, and speculative comment
- Consistent with our body language
- Sincere in carrying a sense of commitment, hope and presenting the potential for opportunity
- Strengths-based

We need to give thought to:

- How the language we use, is read and heard by the person to which we are communicating, and how it may positively or negatively contribute to their health and wellbeing
- What meanings we present to people to live by

Our language conveys our thoughts, feelings, facts and information, but beyond that, we need to be reflective in our practice and ask ourselves questions like:

- *What else am I saying?*
- *How will someone else read or hear this?*
- *Do I give a sense of commitment, hope and present opportunity or a sense of pessimism?*
- *Do I convey an awareness and expectation of recovery?*

The approach to language when talking to people needs to take into consideration where they are in their recovery journey. This may fluctuate in relation to their physical and mental health, and social and emotional wellbeing.

Some general guidelines for language and communications[8]

DO	DON'T
DO put people first: **DO** say *"person with mental health condition"* **DO** say *"a person who has been diagnosed with…"*	**DON'T** label people: **DON'T** say *"he is mentally ill"*, *"she is mentally ill"* **DON'T** define the person by their struggle or distress **DON'T** equate identity with a person's diagnosis *Very often there is no need to mention a diagnosis at all. It is sometimes helpful to use the term "a person diagnosed with", because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.*
DO emphasise abilities *Do focus on what is strong* *i.e., the person's strengths, skills & passions*	**DON'T** emphasise limitations. *Don't focus on what is (in your mind) wrong with the person*
DO use language that conveys hope and optimism that supports, and promotes a culture of recovery	**DON'T** use condescending, patronising, tokenistic, intimidating or discriminating language **DON'T** make assumptions based on external appearances or communication difficulties **DON'T** sensationalise a mental illness *This means not using terms such as "afflicted with," "suffers from" or "is a victim of"* **DON'T** portray successful persons with mental health conditions as superhuman. *This carries the assumption that it is rare for people with a mental health condition to achieve great things*
DO enquire as to how the person would like to be addressed	**DON'T** presume that a person wants to be called by a particular term (e.g., consumer or client) and check whether the wish to be addressed by their family or first name (e.g., Ms Smith or Kylie) or another name which they identify
DO use language that is comfortable for you and reflects your genuine, true self	**DON'T** use jargon, or unfamiliar language.
DO clarify that people understand the information they have been given Make sure that whatever a person's age, cultural background and cognitive skills that they have understood what has been said	**DON'T** use specialist or medical language unless you accompany it with plain English explanations

DO	DON'T
DO use language that conveys optimism and positivity	**DON'T** use negative or judgemental language
DO ask *"what is important to you?"* **DO** ask *"what are you looking forward to doing?"*	**DON'T** refer negatively to aspirations identified in the past that a person did not follow up
DO ask *"what do you think might be steps forward"*	**DON'T** use the concept of goals with young people or older people unless it feels appropriate. Rather talk about aspirations, dreams and hopes
DO ask whether the person feels they have been consulted and listened to about their care, treatment or support plans	**DON'T** argue with a person's perception of events
DO validate a person's experiences	**DON'T** minimise a person's experience in the urgency of managing symptoms
DO ask whether the person has been given the opportunity to ask questions, and check that they have the information they need **DO** check that an older person has heard and understood what has been said clearly – when you know or sense they may have hearing and/or cognitive difficulties **DO** allow people the time to find the words and express what they need to say	**DON'T** argue that information was already provided or known **DON'T** assume that having said something, that it is understood **DON'T** jump in and speak for someone **DON'T** tell someone that certain information is irrelevant
DO ask people if they feel ready to make their own decisions or would like to be supported, and in what way	**DON'T** harp on failures of the past
DO ask what has been helpful and unhelpful in the past	**DON'T** assume that you know what is best for a person
DO involve people in the development of treatment, care and support planning **DO** involve others providing care coordination across services	**DON'T** devise treatment, care or a support plan without consultation with the person you are working with
DO be mindful of the importance of individual identity to all people, but be particularly sensitive to peoples' fears of being considered to lack decision-making capacity **DO** be mindful of older people's fear of losing their sense of identity or a young person being considered mature enough to make decisions	**DON'T** make assumptions about people based on their diagnosis **DON'T** make assumptions about age or disability. Remember older people have a lifetime of experience, and many young people have roles of responsibility despite their age

Out-dated and worn-out words[9]

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
■ Kylie has a mental health condition or a disability	■ Kylie is not normal
■ Sam lives with a mental health condition ■ Sam is a person with lived experience of .... ■ Sam has been told he has schizophrenia ■ Sam has been diagnosed with ..... ■ Sam has experienced anorexia ■ Sam is a person with lived experience of trauma ■ Sam is a person who experiences mental health and co-existing difficulties with substance use	■ Sam is mentally ill ■ Sam is schizophrenic ■ Sam is a bipolar ■ Sam is an anorexic ■ Sam has PTSD ■ Sam is a PD ■ Sam is a borderline ■ Sam has drug problems
■ Kylie is having a rough time ■ Kylie is having difficulty with her recommended medication ■ Kylie's medication is not helping her ■ Kylie is experiencing unwanted effects of her medication ■ Kylie disagrees with her diagnosis ■ Kylie is experiencing ...	■ Kylie is decompensating ■ Kylie is treatment resistant ■ Kylie is uncooperative ■ Kylie doesn't accept she is mentally ill ■ Kylie has no insight
■ Sam is trying really hard to self-advocate and get his needs met ■ Sam may need to work on more effective ways of getting his needs met	■ Sam is manipulative, irritable ■ Sam is demanding and unreasonable ■ Sam has challenging or complex behaviours ■ Sam is dependent
■ Kylie is choosing not to... ■ Kylie would rather look for other options	■ Kylie is non-compliant ■ Kylie has a history of non-compliance
■ Sam is pleased or satisfied with the plan we've developed together ■ Sam and the team have developed a good rapport ■ Sam is able to seek help and recognises when things are not going so well ■ Sam is working hard towards achieving his goals ■ Sam is taking each day at a time	■ Sam is compliant or manageable ■ Sam has partial insight ■ Sam is cooperating ■ Sam has acquired insight ■ Sam is learning to manage his illness ■ Sam is unmotivated

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
■ Kylie chooses not to... ■ Kylie is concerned about the health implications of her treatment plan ■ Kylie prefers not to... ■ Kylie is very independent ■ Kylie seems unsure about... ■ Kylie might benefit from some help at home	■ Kylie has no insight ■ Kylie is treatment resistant ■ Kylie refuses support ■ Kylie won't engage with services ■ Kylie needs support with her ADLs ■ Kylie is low functioning
■ Sam is really good at...	■ Sam is high functioning
■ Kylie has a tough time taking care of herself ■ Kylie has a tough time learning new things ■ Kylie is still considering her options ■ Kylie is still working out what she needs	■ Kylie is low functioning
■ Sam tends to (describe actions, e.g., hit people) when he is upset ■ Sam sometimes kicks people when he is hearing voices ■ Sam is finding it difficult to socialise ■ Sam likes his own company	■ Sam is dangerous; abusive; angry, aggressive ■ Sam demonstrates challenging, high risk behaviour/s ■ Sam is high risk ■ Sam is anti-social ■ Sam is isolative ■ Sam doesn't want to socialise
■ Kylie is experiencing both mental health and substance use problems ■ Kylie tends to use non-prescribed substances to help manage distress/cope with life	■ Kylie is dually diagnosed ■ Kylie has comorbidities or is comorbid ■ Kylie is MICA/MISA (mentally ill chemically abusing, mentally ill substance abusing) ■ Kylie is an addict
■ Sam doesn't seem ready to go back to work ■ Sam is not in an environment that motivates him ■ Sam is working on finding his motivation ■ Sam has not yet found anything that sparks his interests	■ Sam is unmotivated ■ Sam is not engaged or does not want to be engaged ■ Sam isolates ■ Sam rejects help

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
■ Kylie has a lot of energy right now ■ Kylie hasn't slept in three days	■ Kylie is manic ■ Kylie is hyper
■ Sam is experiencing a lot of fear ■ Sam is worried that his neighbours want to hurt him ■ Sam often disagrees and gets angry with his family, friends etc	■ Sam is paranoid ■ Sam is delusional ■ Sam is aggressive
■ Kylie has been working towards recovery for a long time ■ Kylie has experienced serious depression for many years ■ So far, Kylie has not accessed support that has been helpful to her	■ Kylie has a chronic mental illness ■ Kylie is severely mentally ill ■ Kylie will never recover - she rejects help
■ Sam and I aren't quite on the same page ■ It is sometimes challenging for me to work with Sam ■ Sam has not had good experience with services in the past ■ Sam is a young person who has recently been given a diagnosis and is a having difficulty to come to terms with this news	■ Sam is very difficult ■ Sam has challenging behaviour ■ Sam won't engage with services ■ Sam doesn't accept what he has been told by the treating team
If worn out words are used to describe people's attempts to reclaim some shred of power while receiving services in a system that may try to control them, then important opportunities to support a person's recovery will be lost. *A person trying to get their needs met – may have a perception or opinion different from, or not shared by, others - and their actions may not be effectively bringing them to the results they want.*	■ Manipulative ■ Grandiose ■ In denial ■ Passive aggressive ■ Self-defeating ■ Oppositional ■ Personality disordered
■ Charles is an older person who displays frustration at times ■ Charles is someone used to being independent who is finding it difficult accepting support ■ Charles may need some support to help him make decisions ■ Charles may need support in some areas of his life ■ We need to find out what we can do to support Charles that best suits him	■ Charles is a challenging, difficult, grumpy man ■ easily angered, irrational and short tempered ■ Charles rejects help and advice ■ Charles isn't capable of deciding for himself what's best ■ Charles has complex needs ■ Charles has poor ADLS ■ Charles is uncooperative

Key Terms

A Consumer is a person with lived experience of a mental health condition who is accessing or has previously accessed a mental health service.[10] Within a child and youth mental health context, both the parents and the child or young person may sometimes also be described as consumers.

Capacity refers to a person's ability to make his/her own decisions. These may be small decisions, such as what to do each day, or bigger decisions such as where to live or whether to have an operation. A person may lack capacity in some areas, but still be able to make other decisions.

Cognitive functioning refers to the underlying cognitive processes that allow for effective information processing that assist decision-making, planning and completing actions.

Complex need is commonly used to refer to individuals who present with an inter-related mix of diverse mental health and physical health issues, developmental and psychosocial problems.

Dignity of Risk refers to the individual's right to make informed choices in relation to a variety of life experiences and take advantage of opportunities for learning, developing competencies and independence and, in doing so, takes a calculated risk.

Diversity is inclusive of but not limited to the diversity among people with respect to culture, religion, spirituality, disability, power, status, gender and sexual identity and socioeconomic status.[11]

Peer Work is a fast growing occupational group in the mental health workforce. Peer services are a core component of a genuinely recovery based service. Peer work, peer workers and peer workforce includes all workers in mainstream or alternative mental health services or initiatives who are employed to openly identify and use their lived experience of mental illness and recovery as part of their work. Peer support workers provide support for personal and social recovery to other people with mental health conditions, including in acute mental health settings housing, supported employment, community-based support and so on.[12]

Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities. It is characteristically used to describe many negative outcomes for a person living with a mental health condition attempting to interact with a social environment that presents barriers to their equality with others. Psychosocial disability may also describe the experience of people regarding participation restrictions related to their mental health conditions as the loss of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Recovery is defined 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.[13]

Somatisation is a tendency to experience and communicate psychological distress in the form of somatic symptoms and behavioural features. More commonly expressed, it is the generation of physical symptoms of a psychiatric condition such as anxiety.

Supported decision-making is an approach designed to support people make significant decisions, exercise their legal capacity, make day-to-day choices and draw upon their strengths and support networks.

Trauma-informed is the re-conceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised acknowledging the prevalence of trauma throughout society. `Trauma-informed' services are aware of and sensitive to the dynamics of trauma as distinct from directly treating trauma per se.

Talking to people at both ends of the age spectrum

Young People

Just like with people from other groups or diverse cultures, when communicating with a young or older person using language that they are comfortable with is important. Be guided by their style of speech.

Young people are no different to adults in expressing the importance of collaboration and openness as worker attributes. What is particularly meaningful is displaying a genuine interest in people and their lives. Asking "how's everything going?" can be a good way of opening the door to a conversation about anything that they may need or like to talk about. Young people characteristically relate more to concepts of health and wellbeing rather than illness and recovery.

Use language that is real and familiar rather than imitate young people.

The idea of being asked to formulate recovery goals, particularly for young people can lead them to feel judged, especially when they are unable to list concrete objectives. Instilling hope is vital to everyone, but some young people feel overwhelmed thinking of the future. Talk instead about hopes and dreams that may have for themselves.	*Workers should not feel uncomfortable or needing to use language that they wouldn't normally use. However it is important to understand that swearing and 'bad language' is a prominent feature in the vocabulary of many young people - both when things are going well and when things are challenging.*
A young person may say "I feel crap" or "this is shit". Enabling conversation that is accepting of this language is important in establishing rapport with a young person. Some of the expressions used by young people may offend others from different age groups and cultures, nevertheless, it important to be accepting of contemporary vernacular.	*An alternative approach is to refer to 'steps forward' rather than 'goals'. For example, "what do you think may be some useful steps forward?" or "what are you looking forward to doing (e.g. when you are discharged from hospital, go home etc.)?" Young people are often figuring out who they are and what they want of life and don't want to be cornered.*

Young people are increasingly comfortable using technology-based communications to discuss their emotions and experiences.[14] It would appear that the absence of social cues such as facial expressions and gestures provides young people with an opportunity to disclose serious or sensitive information in what they perceive as a less-judgmental environment (where they can meet and converse with like-minded people).[15] Health practitioners have noted that meeting young people in a space where they are comfortable can help build rapport and improve communication, even when online.[16] Having discarded the formalities of meeting face-to-face, online communication can offer a vehicle for frank and sincere discussion about a person's mental health difficulties.

The NSW Child and Adolescent Mental Health Services Competency Framework[17] identifies the importance of mental health workers being culturally sensitive to adolescents when working with them; for example, appropriate non-verbal communication, eye contact and body posture.

Older persons

Using a recovery oriented approach sets out to enable a person living with a mental health condition to create and live a meaningful and contributing life in their community of choice.[18]

Many older people have a clear sense of who they are and how they define themselves, and can build on a lifetime's experience and resilience which can buffer the impact of any illness or circumstance.

Working with older people often includes:

Supporting a person to maintain a sense of enduring self-identity. Older people living with mental health conditions have described this as 'continuing to be me'.[19] It is important to express a genuine interest in knowing who they are.

Understanding that for some older people's mental health conditions may have become so entrenched that their sense of who they are is compromised by illness and its impacts. This may result in them appearing helpless and hopeless. The language we use should reflect the fact that there are other perspectives without minimising what they are actually feeling.

Awareness that older people tend to conceptualise recovery rather differently to young people and adults more generally. Their aim may be simply to maintain a sense of who they are despite the disabilities they experience, and be valued and respected to know what they want and need.

Considering that a person may feel patronised and cornered when asked about goals for recovery. Older people may prefer to have their recovery journey expressed in a way which focuses on what will give them the best life they can live in the circumstances.

There is evidence suggesting that older people's dignity and autonomy is being undermined in health care settings and that a sizable cross section of healthcare professionals hold stereotypical, negative attitudes towards older people.[20] Diminishing mental health among older people is often not identified by relatives, health care professionals and older people themselves who may attribute symptoms of to the effects of ageing or to physical and environmental changes.

Often service providers make assumptions about older people, and what is appropriate communication. Important to language in this context is communicating respect and supporting choice and autonomy whatever difficulties a person may be having. Importantly, assuming capacity as a first principle.[21]

Three components of recovery appear to be distinct to older people: the significance of an established and enduring sense of identity; coping strategies which provide continuity and compensation and therefore reinforce identity, and the impact of coexisting physical illness.

It is vital that when communicating with an older person that they are supported to have their voice heard and their choices understood. Older people should be reassured that their autonomy and ability to self-determine life choices will not be undermined unnecessarily, especially when other disabilities may be involved.

Avoid asking others, even those close to them about what they want, unless a person clearly wants someone else to speak on their behalf, or are unable to communicate their preferences.

A trauma-informed recovery-oriented approach

Recovery orientation has been adopted as an overarching philosophy to guide mental health practice and is embedded into policy and standards nationally.[22] An understanding of trauma is integral to a recovery-oriented approach. In fact developing and implementing trauma-informed systems of care is one of the first steps towards becoming recovery oriented. Critical to this objective is to use language that reduces the possibilities for re-traumatisation and harm within service systems and practice. A trauma-informed recovery-oriented approach is person centred and involves sensitivity to individuals' particular needs, preferences, safety, vulnerabilities and wellbeing, recognises lived experience and empowers people with lived experience to genuinely participate in decision-making.

Overarching guidelines

- Speak or write about a person with a mental health condition, psychosocial disability, cognitive impairment, problem and/or difficulty; not about a disorder, diagnosis, symptom/s and/or case or bed or a derisory term such as 'frequent flyer' or 'blocked bed'.
- Always include a description of a person's strengths and resourcefulness alongside the difficulties they experience.
- Where applicable, explicitly own words and concepts such as diagnosis or assessment as from a medical/service provider opinion or perspective rather than as a pronouncement of universal truth.
- Do not make assumptions and describe achievements, possessions or connections as merely grandiose delusions.
- Do not assume that disclosures of abuse are necessarily imaginary or represent part of the psychosis a person may be experiencing.
- Do not assume that risks presented in files and notes that relate to the distant or very distant past have current relevance.
- Record people's progress and their efforts towards their own recovery, the steps forward that they have made, using the person's own words and meaning.
- Where there are different views between the person writing a letter or report and the person it is important to:
  - include recognition of that awareness
  - describe their viewpoint in their own words, and
  - describe how their viewpoint contrasts with the author's

    For example, *"whereas I think ... I'm aware that Sam has a very different point of view and considers or stated that ..."*
  - Note directions for negotiating these differences
- Express 'shortfalls' as work or progress still to be achieved.
- Record the person's own hopes or ambitions as well as those held by the support or treating team and what needs to happen for such hopes to be realised.
- Seek to express issues of risk (safety appraisal) in terms of planning for recovery, safety and success; including for people who may be required to comply with involuntary treatment.
- Seek to ensure that issues of compromised safety include risk of re-traumatisation as a consequence of a range of involuntary treatment, including detention in a hospital environment.
- When actions are suggested that the person disagrees with, give a clear reason why these are considered necessary in terms of supporting someone's recovery, and acknowledge their alternate view.
- Ensure demonstration of respect with reference to people's concerns about the physical and psychological impacts of medication/s that they are expected to accept, and that discussions appropriately factor in the competing risks.
  - When there is opportunity, such as in regards to Mental Health Review Tribunal determinations, always offer a copy to the person following the hearing decision.
- In respect to reports to be presented to a Tribunal, always offer to discuss the draft prior to a hearing unless there is good reason, in which case:
  - offer to review and respond to their views on what you have written
  - where there are significantly different viewpoints, consider how these can be included either by amending what you have written if it is acceptable to you or otherwise include a description of the person's alternate viewpoint in the file

- Be aware that letters and reports are constructions rather than objective descriptions:
  - where possible, write reports with the person they are about, while at the same time preserving the integrity and authenticity of your own viewpoint
  - Where not possible, write them knowing that the person may read them
- Where there is a practice of offering people copies of letters written about a person, consider if the letter could instead be written directly to the person it is about - as a record of the conversation and a reminder of decisions - and copied to the other relevant parties (e.g., peer workers, support workers, general practitioners).
- Set up recovery-oriented language prompts in organisational documents and data templates, and include in continuous improvement audit processes.
- Ensure that in talking to anyone, that environmental safety has been established before discussing anything that may represent a trauma trigger for a person you are supporting.

Cultural Diversity

People from different cultures may express their distress in physical or somatic symptoms, or in descriptive terms unusual to you. It is important that workers pay attention to the person's description of their lived experience.

Living with a mental health condition may be considered a weakness in some cultures, and some people may find a diagnosis shaming or guilt provoking, whilst others may consider it a relief to put a name to their difficulties. Try and find out how a person's culture affects the way they perceive their condition and use language that most appropriately relates to their experience.

Talking About Suicide[23]

One impetus to change the language of suicide began in the bereavement community. In addition to the insensitive language often used to describe suicide, and the silence and denial - the absence of suicide language and conversation is a major contributor to the stigma people face in the community.[24]

Suicide often leaves the bereaved with especially acute feelings of self-recrimination. Those who are left behind may feel the full burden of suicide's stigma, and can feel abandoned and ashamed. Added to this injury is the mention of suicide in euphemistic language that goes to great lengths to neutralise the real meaning that exists concerning death as a consequence of suicide and the loss attached to it. Because this silence can be debilitating, the need for language that addresses the act of suicide in a direct but respectful way was identified and has, in recent years, gathered momentum.[25]

Suicide is no longer a crime, and so we should stop saying that people commit suicide. We now live in a world where we seek to understand people who experience suicidal thoughts, behaviours and attempts, and then to treat them with compassion rather than condemn them.[26] Part of this is to use appropriate, non-stigmatising language when referring to suicide.

Often people seek attention from others for comfort and reassurance when they are distressed. In the context of a suicide attempt or suicidal ideation people are often described as 'attention seeking'. This is unhelpful language suggesting that a person is repeatedly displaying negative behaviours to gain attention. It is important to acknowledge the sequence of events leading to the situation arising and then state the actual behaviour of concern.

Appropriate Words	Worn-out words
Died by suicide	Committed suicide
Took his or her life	Successful suicide
Ended his or her life	Completed suicide
Non-fatal attempt at suicide	Failed attempt at suicide
Attempt to end his of her own life	Unsuccessful suicide

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