

ARTICLE

**Recovery and Resilience in  
Children’s Mental Health:  
Views from the Field**



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*This article explores the questions, “What does recovery mean in the context of children’s mental health?” “How do recovery and resilience fit with the system of care values that underpin current transformation efforts in the children’s mental health field?” And, “What implications flow from the answers to these questions?” The author details a process designed to gather the perspectives of family members, service providers, administrators, researchers, and advocates, summarizes the results of these discussions, and concludes with recommendations for next steps.*

**Keywords:** *recovery, resilience, children’s mental health, and system of care*

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Despite many similarities in overall goals and philosophy, the child and adult mental health systems have developed different conceptual frameworks and language, along with independent service systems. This reflects real and important differences between the needs and developmental trajectories of children and adults, and services designed to support them. The development of the two systems has also been shaped by competition for resources. Since the 1980s, when public mental health services in the states were overhauled and reorganized to better address the needs of adults with severe and persistent mental health problems, children’s advocates have worked hard to build or rebuild services for children with mental health

needs and their families. Thus, the separate systems for children and adults reflect both appropriate specialization and historically rooted divergence.

A prime example of these separate paths is the adoption of a system of care framework in children’s mental health, and the development of the recovery movement among adults with mental illness. System of care principles (Stroul & Friedman, 1986; 1988) have provided a framework for building an effective and appropriate response to children with mental health problems and their families for the last 20 years, along with more recently adopted principles and practice strategies related to promoting resilience (Masten & Powell, 2003). Concepts related to

recovery in the adult mental health field have also developed and been refined over the last two decades (Anthony, Rogers, & Farkas, 2003; Deegan, 1988). The concepts of resilience and resilience-promotion that are embraced within the children's mental health field have only recently begun to be examined in adult mental health. Correspondingly, the term *recovery* has rarely been used in the children's mental health field, and recovery concepts have not generally been applied to children, youth, and families.

The exploration described in this article was undertaken to examine the ways that concepts related to recovery as conceptualized in the adult mental health field might be relevant to children's mental health. This work was undertaken by staff of the Research and Training Center on Family Support and Children's Mental Health (RTC) at Portland State University in response to a request by our federal funding agencies, the National Institute on Disability and Rehabilitation Research, and the Center for Mental Health Services. To place this examination in the context of children's mental health, we expanded the investigation to include the concept of resilience within a system of care framework.

We took a multi-faceted approach to examining three questions: 1) *What does recovery mean in the context of children's mental health?* 2) *How do recovery and resilience fit with the system of care values that underpin current transformation efforts in the children's mental health field?* and, 3) *What are the implications for practice, system development, and evaluation that flow from the answers to #1 and #2?*

Our work was conducted in three phases. In the first, we reviewed the literature addressing the concept of recovery in mental health, as well as a sampling

of writing about recovery in the substance abuse field. We also examined resilience literature applicable to children's mental health. Products of this review included a synthesis of major ideas found in the literature, and brief concept papers for use in discussions with a variety of audiences (Friesen, 2004; Walker, 2004). The second phase of our work involved discussion with individuals and groups about key resilience and recovery concepts, and their application to children's mental health services. In the third phase, we developed a framework that could be used to simultaneously consider resilience, recovery, and system of care principles and identify the similarities and unique contributions of each. A description of the procedures used and the findings from each phase is followed by discussion and recommendations.

### Phase I: Key Ideas from Literature Review

#### Differences Between Adult and Children's Mental Health

To begin considering the concept of recovery in children's mental health we first examined similarities and differences between the needs of children and adults, and between the child and adult systems. Three important areas of comparison between child and adult mental health are: 1) the definition of the population associated with each group; 2) the major treatment or rehabilitation goals typically addressed by each system; and, 3) the primary service systems with which persons receiving mental health services are likely to interact (Friesen, 1996).

#### Definition of the population.

Identification of children affected by emotional, behavioral, or mental disorders, particularly for the purpose of eligibility for services, is often *based on functioning*, as in the definition of seri-

ous emotional disturbance found on the SAMHSA website, "A diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities" (Definition of serious emotional disturbance, n.d.). It is *inclusive*, in that a variety of childhood conditions are included in the population definition, and, therefore, involves a *heterogeneous* group of children and youth. The population of children with a serious emotional disturbance is estimated to be between 9 to 13% of children; the number of youth with extreme functional impairment is estimated to be between 5 to 9%.

The definition of severe mental illness in adults provided on the SAMHSA website also includes functioning, "A diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities" (Definition of serious mental illness, n.d.). In addition to functioning, definitions of serious mental illness in adults may be linked to specific diagnoses, as discussed by the Center for Psychiatric Rehabilitation ("What is psychiatric disability and mental illness?" n.d.). Although there is great diversity among adults with mental health problems, eligibility criteria for services in many states result in a relatively more *homogeneous* service population than is the case in the children's area. In any given year, between 5 and 7% of adults have a serious mental illness (New Freedom Commission, 2003).

#### Treatment or rehabilitation goals.

Goals associated with the outcomes of services also differ for children and adults. The focus for children and adolescents is on promoting their healthy development, with an assumption that

children should live within a supportive family, obtain an education, and develop healthy peer relationships. Major roles for children include family member, peer, and student. For adults, major goals include maximizing the quality of community life (focus on social, vocational, recreational skills, and appropriate housing, vocational, and educational opportunities). Major roles include worker, friend, and family member.

The primary service systems with which children interact include public education, mental health, child welfare, juvenile justice, and health, whereas adults with mental illness are most likely to come in contact with the mental health, public welfare, corrections, health, and vocational rehabilitation systems. Thus, the development of parallel and compatible, but separate, systems for youth with serious emotional disorders and for adults with mental illness is understandable from both a historical and functional perspective.

### The Context of Recovery

The term recovery gained recognition within mental health beginning in the 1980s, reflecting the confluence of several trends summarized by Walker (2004). These trends include the publication of consumer descriptions of their own experiences of getting better, coping with their symptoms, and regaining an identity (Deegan, 1988); growing research evidence of possible positive outcomes for people with severe mental illness (e.g., Harding, Strauss, & Zubin, 1992); and deinstitutionalization, with the concomitant emergence of community supports, psychosocial rehabilitation, and the growth of the consumer and family advocacy movements (Anthony, 1993). The findings that many people with mental illness went on to lead productive lives provided a basis for hope,

and served as counterpoint to a pessimistic view of mental illness and of those who experienced it that emanated from the mental health system and the general public.

The Surgeon General's Report (U.S. Department of Health and Human Services, 1999) described recovery as focusing on the restoration of hope, self-esteem, and identity, and on attaining meaningful roles in society, as contrasted with a focus primarily on symptom relief. Another characteristic of recovery described by Anthony, Rogers, and Farkas (2003) is that it is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles." A view of recovery as personal is related to two core concepts found in much of the recovery literature—self-determination and individualization. This perspective suggests that each individual ultimately defines his/her own recovery. This view also is consonant with ideas proposed by Jacobsen and Greenley (2001), who suggest that both internal conditions (the attitudes, experiences, and change processes of individuals) and external conditions (circumstances, events, policies, and practices) produce the process called recovery.

As we looked at the recovery literature in preparation for planned discussions and feedback sessions, the notions of hope, optimism, a future orientation, strengths-based services, self-determination, and individualization all appeared to be compatible with concepts widely accepted in the children's mental health field. Other aspects of recovery, however, were identified as needing particular exploration with children's mental health constituencies. These included questions related to the age and developmental level of children, and their family and cultural contexts—issues such as, "Whose self-

determination are we talking about when considering the circumstances of a 3-year-old?" and "What meaning do concepts such as personal responsibility or Jacobsen and Greenley's internal conditions have at various ages/stages of development and for diverse cultural groups?"

### Lessons from Resilience Research

Several important points were derived from our review of the resilience literature. First, the definition of resilience, as a "dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 1), carries within it the idea that the focal system (child or family) does better than might be expected, given challenging circumstances. Applying this definition, resilience can only be identified after adversity has occurred, although it may be possible to predict resilience or to identify possible protective factors. Second, ideas about resilience have changed over time. In her paper, "Ordinary Magic," Masten (2001) asserts that resilience is more likely to be present than not, "unless important adaptive systems such as cognition or parenting are compromised prior to or as a result of the adversity" (p. 232). This is in contrast to earlier concepts of a small number of resilient children who appear to be resistant to adversity.

Masten and Coatsworth (1998) summarize features of resilient children and adolescents that include *individual characteristics* (good intellectual function, easygoing disposition, self-efficacy, self-confidence, talents); *family resources* (close relationship to caring parent figure, authoritative parenting: warmth, structure, high expectations, socioeconomic advantages, and connections to extended family networks); and *assets outside of the family* (bonds to prosocial adults, connections to

prosocial organizations, and attending effective schools).

Concepts about interventions to build resilience have also changed over time. Central to the concept of resilience is competence, and Masten and Coatsworth (1998) characterize two generations of competence-building research. The *first generation* is child-focused, emphasizing skill building. Research results suggest, however, that skill building alone has small consequences for the subsequent adjustment of children. *Second generation* research, according to Masten and Coatsworth, involves developmental, ecological, multicausal models that take into account the environments (family, school, neighborhood, community) that have an impact on the child while also working to strengthen and increase the adaptive capacity of the child. Similarly, *first generation* change strategies aimed at improving parenting include a host of parent training programs (see Kazdin, 1997 for a review). *Second generation* approaches to parenting include attention to environmental factors such as family poverty, community and neighborhood circumstances, and policy issues, as well as specific training or support for parenting (Masten & Coatsworth, 1998).

Although the concept of resilience is widely accepted in the children's mental health field, we identified several issues that need to be considered in further developing applications of resilience research for practice:

- Lists of characteristics of resilient children derived from research do not give specific guidance about what may be helpful for any given child. More study is needed to increase usefulness for individualized service planning.
- Resilience-building or protective factors are not necessarily synony-

mous with directly positive or risk-avoiding experiences for children and youth. Rutter (1987) suggests "Protection resides not in the evasion of the risk, but in successful engagement with it" (p. 318). Ungar (2007) also provides evidence that risk and responsibility are essential to help children thrive.

- Factors associated with resilience for some children are not universal across cultural groups. For example, Kotchick and Forehand (2002) point out that although "authoritative parenting" is often seen as the standard, authoritarian parenting has been found to have positive effects for African American and Asian youth.
- Developing a second-generation approach to building resilience and increasing protective factors is very complex, and cannot be accomplished by the mental health system alone. Such an approach requires changes in policies that affect families directly and indirectly, changes in access, community and neighborhood resources, and community institutions (e.g., schools), among others.

This review of recovery and resilience concepts provided a foundation for our discussions with a variety of constituencies within children's mental health.

### Phase II: Discussions with Individuals and Groups

Although we did not engage in a formal Delphi process, our approach to information gathering was iterative, i.e., information gathered at each step of the process was summarized and presented to participants in subsequent meetings. Preliminary telephone discussions held during the fall of 2004 were summarized for use in a 2-day

working meeting held at SAMHSA on December 2–3, 2004. Material developed at this meeting was used in two sessions with family members and youth at the Federation of Families for Children's Mental Health on December 10–11, 2004, and a summary of their feedback was used in a presentation made at the Recovery Consensus Conference convened by CMHS on December 16 & 17. In February 2005 large audiences of families, youth, service providers, and state children's administrators attending a meeting of federal grantees had the opportunity to provide input. In May 2005 the RTC devoted an entire issue of *Focal Point*, the Center's bulletin, to topics related to resilience and recovery in children's mental health (Walker & Thompson, 2005); it was distributed to approximately 30,000 readers. Also in May 2005 the monthly featured discussion on our website was devoted to concepts of resilience and recovery in children's mental health; this discussion, along with readers' responses to it, also added to our collection of responses from a variety of audiences.

### Telephone Conversations

Participants were provided with written materials in advance. We began our telephone discussions by reviewing the definition of recovery from the New Freedom Commission on Mental Health (2003):

Recovery is a process by which people who have a mental illness are able to work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms (p. 5).

We also reviewed short descriptions of the central concepts of recovery gleaned from the literature, including an emphasis on hope and optimism;



dignity, self-respect, and stigma-reduction; a comprehensive approach to services; an emphasis on future orientation and life planning; self-determination and full participation in decision-making about one's own life; and outcomes of life planning and service to be defined and determined by persons affected by mental illness. We also shared the framework proposed by Jacobsen and Greenley (2001).

Along with these ideas about recovery, participants also received information about resilience and resilience-building efforts for children and youth, including the definition of resilience proposed by Luthar, Cicchetti, and Becker (2000), stated above, and a short summary of the resilience literature.

Participants in the telephone discussions held in October and November 2004 identified both benefits and concerns about the application of recovery concepts in the children's mental health field. There were some enthusiastic advocates, but others had grave misgivings about such a step. Recovery concepts that were seen as potentially beneficial included the goal of full participation in community life, a hopeful perspective, strengths orientation, and life planning for young people and their families. Many participants responded positively to the emphasis on self-determination, and a belief that a recovery perspective would help to change the self-perception of young people to healthy rather than sick. Other benefits identified were that a recovery framework supports a positive culture of healing, emphasizes self-monitoring, promotes supports from multiple sources, and has clear implications for system and service design. Some telephone respondents thought that a recovery orientation reduced stigma while others thought that the term itself was stigmatizing and labeling.

A concern that was shared by many of the participants is that the term "recovery" is confusing, implies "cure," at least in everyday language, and that it would be confusing to people who were familiar with the term in the substance abuse field. Several participants voiced the belief that the term "recovery" is inappropriately applied to children, especially young children, since it implies a return from ill health to a former healthy state (they asked, "Recovery from what?"). These respondents felt that the concept of recovery is at odds with a developmental perspective wherein services are geared to promote and support the healthy social and emotional development of children, not to "cure illness." Some respondents voiced the opinion that the concept of recovery was most appropriate for those with the most serious problems, especially older youth.

Other concerns included possible misunderstanding of the term by other systems. For example, in juvenile justice, where advocates are working to secure treatment, not punishment, for youth with mental health problems, use of the term might imply that a youth was "recovered," and did not need services.

Participants in the telephone interviews also asked how recovery was different from system of care principles (Stroul & Friedman, 1986), and whether there was "value added." The relationship of recovery to the more familiar term, resilience, was also raised. These

ery to children's mental health. Family members, service providers, researchers, state mental health children's administrators, and technical assistance providers attended the meeting, along with representatives from the Child, Adolescent, and Family Branch of the Center for Mental Health Services (CMHS), and other units of the Substance Abuse and Mental Health Services Administration (SAMHSA). Participants in the working meeting were energetic and thoughtful, and they produced many creative ideas. The deliberations were conducted in the context of a transformation agenda.

Major points of agreement that emerged from the discussions included:

- System of care principles provide a useful foundation for considering resilience and recovery. Participants noted overlap of many concepts across system of care and recovery frameworks;
- All consideration of concepts in children's mental health must be set within a developmental context;
- Mental health for children should be considered within an ecological perspective (i.e., the child is embedded in the family, which is embedded in the community; all systems interact);
- The term, "recovery," is problematic in that it is confusing and may detract from desired goals;
- Application of recovery concepts in

system change, administration, training, and workforce development.

The meeting included much intense discussion that included areas of significant disagreement. These were:

- Whether recovery adds anything to the current system of care and resilience framework;
- Whether the concept of recovery can be applied to all age groups, developmental spectrums and/or communities and families;
- Whether the use of the term and concepts of recovery suggest that child and adult issues are the same, thereby contributing to loss of momentum in children's mental health transformation;
- Whether use of the term recovery may create unrealistic expectations (e.g., "cure").

These areas of agreement and disagreement illustrate the complexity of considering the application of the concept of recovery to children and youth. Recommendations for next steps from this meeting included: 1) Preserve and build on core principles (strengths-based, optimistic, focus on assets, resilience, strong youth and family voice). Continue the examination of the relationship between recovery, resilience, and system of care principles (crosswalk) that was begun here; 2) Frame deliberations regarding recovery within a public health perspective. For children and youth, this means considering whether/how prevention and early intervention are/may be related to recovery; 3) Because the language associated with recovery is confusing, care is needed to avoid misunderstanding, and to be sure that the term doesn't just become rhetoric. Participants suggested using the phrase "resilience and recovery," not "recovery" alone when addressing children's issues;

4) Outcomes of mental health services should be defined by youth and families, and systems should be held accountable for progress toward these outcomes; 5) Current financing mechanisms should be realigned to support a resilience/recovery model; 6) Administrative and financial support for peer-to-peer (youth and family) and youth and family programs is crucial for the success of transformation efforts; 7) Additional input should be sought, especially from youth and families.

#### **Federation of Families Meetings**

Approximately 100 family caregivers and youth attended two feedback sessions at the annual conference of the Federation of Families for Children's Mental Health, December 10–11, 2004. Participants were given written handouts with summaries of resilience and recovery concepts, a summary of the results of the working meeting on December 2–3, and information about the recovery consensus conference scheduled for December 16–17.

The overall response of meeting participants can be characterized as, "We like recovery ideas—but do not like the word!" Similar to the sentiments expressed in previous discussions, many family and youth had positive responses to the recovery and resilience frameworks, but both negative and confused reactions to the term "recovery" itself. Despite considerable discussion about recovery as a process, and not an end state, a number of family members said that the term detracted from their appreciation of the positive aspects of recovery. Participants suggested a number of more acceptable words and phrases including "variances of life," "overcoming," "stabilization," "transitioning," "coping," "mastery," "remission" and "thriving," among others.

Beyond terminology, comments centered around five main themes: 1) The

recovery emphasis on strengths, building a positive life, and a focus on wellness is appealing, and is in stark contrast to the pessimistic messages that some youth and families have received from mental health, education, child welfare, and other systems; 2) For children, the ability to participate in regular activities, and to be included in community events, is both a sign of recovery, and a means of moving closer to it. Discussants emphasized the need for successful experiences that help children build skills and feel competent, especially in academic, recreational and social situations; 3) Application of recovery concepts needs to be carefully considered in relation to the role of the family. Some participants contrasted the idea of "family-centered services," which involve planning for the child in the context of his/her family, with "person-centered planning" which they understood as very individualistic, and perhaps even excluding the rest of the family; 4) Resilience and recovery are intertwined. One mother described the steps she takes to help her 11-year-old son prepare to meet everyday challenges, stating, "Building resilience in my son is an important part of his recovery"; 5) Envisioning a resilience-building and recovery-oriented system leads to recommendations for many changes in the current system, largely in the areas of financing, system design, and workforce recruitment and training.

In the area of financing, participants identified the need for reforms that would have the money follow the child, thus increasing individualization and flexibility. Respondents identified the need for adequate funds to provide comprehensive services, and funding that allowed choice and the cultivation of informal services and supports. Participants also emphasized the importance of mental health parity, be-

lieving that having insurance coverage on a par with other illnesses would reduce the stigma associated with mental illness. Recommended changes in system design focused on reducing fragmentation, and creating opportunities for youth to engage in regular social roles and age-appropriate experiences. Recommendations about workforce development called for mental health professionals to receive training in recovery and resilience concepts and to gain additional skills to improve the system. Participants also identified the need for training in basic mental health concepts for teachers, ministers, pediatricians, child care workers and others with whom their children interact in community settings.

### Recovery Consensus Conference

A summary of the findings from the telephone interviews, the working meeting, and the feedback from family members and youth was presented at the December 16–17 conference. This meeting was designed to identify principles of recovery, and to work toward a common definition and consensus statement. The audience, which consisted of adult psychiatric survivors, mental health professionals, researchers, and representatives of SAMHSA, was primarily focused on the adult population, although some consumers addressed the need for stigma reduction for children and youth. This meeting produced a list of 10 recovery elements that proved to very useful in considering the concept of recovery for children's mental health.

### Grantee Meeting of the Comprehensive Community Mental Health Services Program for Children and Their Families

Several feedback sessions were held from February 8–10, 2005 at a meeting of grantees in Dallas. Two meetings, each with 70 to 80 participants, included family members, service providers,

evaluators, and state children's managers. In addition, special presentations were made to state children's administrators and to technical assistance providers. Participants received copies of a document (Friesen, 2005a) that summarized many of the questions and responses contributed by project participants to date, and presented a matrix (crosswalk) comparing key concepts related to resilience, system of care principles, and recovery.

Feedback from participants in the February grantee meeting covered many of the same topics and questions that had been expressed in previous public discussions. Some participants challenged the appropriateness of applying the concept of recovery to children and suggested other frameworks that would be more useful, e.g., "resilience" and "positive youth development." State children's directors, in particular, expressed concerns that adopting the term "recovery" would cause progress in children's mental health to slow or be reversed at state and local levels.

### Phase III: Crosswalk of Resilience, System of Care, and Recovery Principles

This work involved developing a framework that could be used to concurrently consider resilience, system of care, and recovery principles, noting similarities among them, as well as the unique contributions of each.

Table 1 contains a brief comparison of these three sets of principles. A more detailed matrix and elaboration of the concepts contained in the crosswalk are provided in other documents (Friesen, 2005a & b). The symbols in Table 1 denote resilience and recovery principles that are compatible (C) with system of care principles, or represent "value added," (V) i.e., they contribute

ideas that are not emphasized within system of care principles.

As illustrated in Table 1, recovery elements that are compatible with system of care principles include the concept that services should be 1) holistic and comprehensive, and 2) individualized and strengths based. An assumption in the recovery framework is that people should live and receive services in the community, rather than restrictive settings. The recovery elements of empowerment and self-direction are compatible and complementary with the system of care principle that emphasizes the full participation of family members and youth in the planning, implementation, and evaluation of services. The language of "family participation" has now been updated to "family-driven services" in response to recommendations of the report of the New Freedom Commission on Mental Health (2003).

Two core concepts of resilience that can enhance the implementation of system of care principles are the specification of risk and protective factors that can be useful in individualizing and refining services, and provision of a solid base of information for prevention and early intervention programming. The resilience literature contains many concepts and research findings that can be used to build interventions and improve practice.

Both resilience and recovery frameworks place an emphasis on acknowledging and healing historical trauma. Trauma may be at the individual level (e.g., experience with abuse, trauma related to the experience of the illness itself, or trauma experienced in the course of receiving services). The concept of resilience is also used to describe the survival, and even thriving, of groups such as Native Americans who experienced genocide, displacement, and separation of children from

**TABLE 1—COMPARISON OF KEY IDEAS: SYSTEM OF CARE, RESILIENCE, AND RECOVERY**

<b>Resilience Core Concepts</b>	<b>System of Care Principles</b>	<b>Recovery Elements*</b>
	1. Comprehensive services	1. Holistic (C)
Specification of Elements: (V) Reducing Risk Enhancing Protective Factors	2. Individualized services	2. Individualized & person centered (C) 3. Strengths Based (C)
	3. Community based	(Assumed)
Racial Socialization Healing Historical Trauma (V)	4. Culturally & linguistically competent	Healing historical trauma (V)
Solid Basic and Applied Research Base for Prevention and Early Intervention (V)	5. Early intervention	
	6. Family & youth participation family-driven youth-guided	4. Empowerment (C) 5. Self-direction (C)
	7. Service coordination	
	8. Interagency coordination	
	9. Protective of rights	6. Respect, stigma reduction (V)
	10. Transition	(Life planning) (C)
Future Orientation, Optimism (V)		7. Hope, optimism (V)
		8. Non-linear (acceptance of setbacks)
		9. Personal responsibility
		10. Peer support

\*Note. These “Recovery Elements” are the “10 Fundamental Components of Recovery” identified in the National Consensus Statement on Mental Health Recovery at the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16–17, 2004. The conference was convened by the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies.

To read the complete the full statement, see: [www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/](http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/).

their families and culture (Duran & Duran, 1995; Strand & Peacock, 2003) and the trauma suffered by African Americans during slavery, as well as current racism and discrimination (Eyerman, 2001; 2004).

The ideas that were greeted with the most enthusiasm, especially from family members and youth, were the related concepts of hope, optimism, and future planning. These ideas are key

elements of both resilience and recovery frameworks, but are not explicitly addressed by system of care principles. Conversely, two system of care principles not addressed by resilience and recovery are service coordination (case management), and interagency coordination. Neither the resilience nor the recovery framework identifies specific service strategies.

Recovery elements that are not specifically included in resilience and system of care frameworks are the idea of recovery as non-linear (acceptance of setbacks), an emphasis on personal responsibility, and a focus on peer support. The notion of the recovery process as non-linear is compatible with the characterization of resilience as changing over time. The explicit recovery focus on peer support is also entirely compatible with movement



towards more central roles for families and family organizations, and the development of formal youth networks in children's mental health. Personal responsibility is an example of a recovery concept that cannot be directly applied to all children and youth. Learning to assume responsibility is a developmental task for all children; the meaning of "personal responsibility" as used in the adult recovery movement becomes more relevant as young people enter and move through adolescence.

Many participants said that the written comparison of resilience, system of care, and recovery concepts helped to clarify their thinking. However, respondents who embraced the recovery framework also warned about the difficulty of communicating the important ideas about recovery to a variety of audiences across the country without creating confusion and negative reactions associated with the term.

### Discussion and Recommendations

An overall recommendation is to increase the avenues and support for family and youth participation in planning and decision-making within the children's mental health field. This step is fundamental to achieving authentic and lasting system transformation. Following are more specific recommendations related to our literature review and analysis of the discussions that we conducted.

#### Hope, Optimism, and Future Planning

These ideas resonated almost universally with family members and youth. Participants gave many examples of interactions with mental health and other professionals that contained pessimistic messages or emphasized short-term, narrowly focused goals. The first major recommendation relat-

ed to hope and optimism is to *review current practice and policy with regard to the messages conveyed to families and youth*. This review could involve a variety of activities, from formal agency or system-wide surveys of families, youth, and staff to informal reflection by individual practitioners. Questions to consider are those such as, "Do intake practices inadvertently communicate blame to family members?" "What is stated or implied about the future in discussions and planning with families?" "Do service providers hold pessimistic attitudes and beliefs about the future of children and youth with emotional disorders?" Answers to these questions would provide a basis for implementing steps to specifically promote hope and a future orientation.

#### Develop and Test Specific Interventions Related to Hope and Positive Emotions

A second important step in improving practice related to hope, optimism, and strengths-based practice is to extract possible practice and program lessons from existing research literature addressing hope and positive emotions, and then to develop and test specific strategies. Researchers such as Fredrickson and colleagues (Fredrickson & Joiner, 2002; Fredrickson & Levenson, 1998; Fredrickson, Mancuso, Branigan, & Tugade, 2000) offer considerable evidence to support the benefit of positive emotions in enhancing health and problem-solving abilities, and Snyder (1994; 2002) provides specific strategies for promoting the development of hope in young people.

#### Acknowledge and Address Trauma

Dealing with trauma in the context of resilience and recovery involves three broad categories of concern. First, we need to *strengthen practice approaches that promote learning about and addressing trauma experienced by*

*individuals as a result of physical or sexual abuse, exploitation, profound loss, or other negative events*. These trauma-producing experiences may precede the development of mental illness, may contribute to its development, or may occur because of increased vulnerability due to the circumstances associated with illness. Such trauma can be addressed through a variety of existing individualized treatment and service approaches. Additional staff training in recognizing and dealing with trauma in children and adolescents may be required. The second set of concerns involves negative experiences that children, youth, and families may have because of symptoms or circumstances associated with a serious emotional disorder, or as a result of seeking treatment. *To the extent that the policies and practices of service providers and programs induce negative experiences, efforts should be undertaken to identify and eliminate them*. Central to accomplishing this aspect of transformation is the full participation of youth and families to help identify problems, make recommendations for change, and evaluate the results of change efforts. Guidelines for developing recovery-oriented services such as those developed by the American Association of Community Psychiatry (2003) may also be useful in this endeavor. A third area of action needed is related to the direct and indirect effects of trauma experienced by entire groups or populations, such as American Indians, African Americans, Asian Americans, and other groups in the U.S. *Culturally appropriate practice models that incorporate understandings of the historical and cultural context of cultural groups, and their implications for services to individuals, families, and communities should be broadly disseminated and implemented*. The physical and emotional survival of oppressed groups is evidence of

their strength and resilience, which can serve as the foundation for practices that support healthy development and growth.

### Applying Resilience Knowledge to Practice

Translating knowledge developed through research about resilience into evidence-supported practice calls for a careful survey of the resilience literature, including studies of resilience-building interventions, to identify promising knowledge and strategies that may inform practice. Despite the enthusiasm among children's mental health service providers for the goal of resilience building, there is a need to move from general "strengths-based" practice to practice based on specific resilience-related knowledge. Considerable attention should be given to gleaning useful information, to developing and testing interventions, and to sharing the results of that study. Examples of issues that need consideration include understanding the dynamic nature of resilience, the need for greater individualization of resilience-related interventions, evidence of cultural variation in responses to parenting or other practices, and the need to develop complex, ecologically-based interventions that address the child in the context of family and community.

Our examination of the relationships between resilience concepts, system of care principles, and recovery elements, and consideration of practice implications led us to several conclusions. First, because of the strong and consistent reaction to the word *recovery* across a wide variety of participants, we recommend that the phrase "resilience and recovery" should be used in children's mental health. We found that some recovery elements are entirely compatible with system of care principles and a resilience framework

(holistic, individualized, strengths-based, focus on empowerment and self-direction). Other resilience and recovery concepts bring "value added" to system of care principles (focus on hope and future planning; the importance of addressing trauma). Yet others, such as the application of the recovery element, personal responsibility, were not as clearly useful or easily applied.

The process described in this report was useful in identifying ideas from resilience and recovery frameworks that can be useful in implementing a transformation agenda in children's mental health. The next crucial step is to summon the commitment and resources needed to translate these good ideas into carefully evaluated practice and program strategies that make a substantial positive contribution to improving the lives of children and youth with or at risk of serious emotional disorders and their families.

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