The Recovery Orientation Model in Action: How Meaningful Change Can, and Does, Happen for Homeless Young People

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A wide set of sector reports (for example, Australian Institute of Health and Welfare National Reports 2013,[1] 2014[2]) all suggest that mental health has become a central health issue for Australians, aged 12 to 25. Much of these reports do not address homelessness, but the following points from the 2013 National Mental Health Report,[3] are important to the current discussion about how homeless young people access services:

- *Young people were less likely than other age groups to seek professional help*; only 31 per cent of young women and 13 per cent of young men with mental health problems had sought any professional help;
- *Young people are most likely to talk to friends or family members* as the first step in seeking support, and finally;
- *Young people experienced multiple barriers to accessing health care*, including negative attitudes of staff towards young people, and anxiety and embarrassment about disclosing personal issues.

Homeless young people face these exact same issues, and experience additional concerns, including involvement with multiple service sectors, living with significant mental health conditions, substance misuse, and exposure to trauma and violence. This is reflected in the *Cost of Youth Homelessness in Australia Study*[4] which compared the quality of life of youth who were identified as homeless, with those who were housed. Their results found that:

- 63 per cent of the homeless youth who were surveyed had been placed in some form of out-of-home care by the time that they had turned 18
- 53 per cent reported that they had been diagnosed with at least one mental health condition in their lifetime
- 39 per cent reported police coming to their home because of violence between parents on one or more occasions, with 14 per cent experiencing police coming to their house more than ten times.

Given these complex and interacting issues, innovative mental health approaches are needed to increase access to services that are timely, appropriate, youth-friendly, affordable, and support meaningful recovery.

The purpose of this paper is to discuss the Recovery Orientation Model, used in an on-site counselling service for homeless young people who experience a dual diagnosis (meaning a mental health concern and a substance misuse issue). Results demonstrate that young people experienced individual levels of change (as measured through the DASS-21, K-10, and a suite of drug and alcohol measures), but found maintaining change very difficult. This paper suggests that youth based mental health approaches need to include clinical indicators of change (such as reduced depression and anxiety) as well as addressing the impact of social determinants of health (such as housing, gaining meaningful employment, and improved access to services).

The concept of recovery became the bench-mark standard for Australian national mental health policies in

Principle 1 — Outcomes that are unique to the person (young people decide on the most relevant goal for them)	**Principle 2 — Real choices** (based on the strengths that are already there)	**Principle 3 — Attitude and rights** (what is important to the young person)
Principle 4 — Respectful engagement (taking their concerns seriously)	**Principle 5 — Strengths-based partnership** (YP — life expert Practitioner — expertise, knowledge and skills)	**Principle 6 — Evaluating change** (Use qualitative and quantative measures to track how change happens)

Figure 1: The Recovery Principles in Practice

Reference: The national framework for recovery-orientated mental health services: A guide for practitioners and providers, 2013.

Table 1: The Referral Trends to BYS on-site counselling service, for dual diagnosis (n=458, 2012-2017).

Reason for referrals	Key referral combinations (by gender)
Alcohol and drugs (35 per cent) Dealing with anger (60 per cent,) Feeling better about myself (30 per cent) Goal setting for the future (70 per cent) Relationships (70 per cent) Depression and anxiety (75 per cent) Ways of coping better (85 per cent) How many options did young people select at referral? • one option: <5 per cent (n=23) • 2-4 options: 20 per cent (n= 92) • 5-7 or more: 75 per cent (n=343)	**Females** (n= 247, 54 per cent): **Relationships**, Goal setting, depression and anxiety; ways of coping better, feeling better about myself **Males** (n= 196, 43 per cent): **Dealing with anger**, feeling better about myself, ways of coping better, goal setting. **Transgender** (n=15, <3 per cent): **Ways of coping better**, dealing with anger, feeling better about myself, relationships, goal setting.

2013, resulting in the National Mental Health Recovery Framework publications.

The key idea is that recovery can, and does, happen,[5] and that rather than being a logical progression through set stages, recovery is an individual journey,[6] and is not concerned with achieving a certain state of being 'recovered'.

In practice, the recovery model is an over-arching framework with six practice principles (see Figure 1) all focused upon valuing the lived experience of the person, and the generation of recovery-based goals that is meaningful and relevant to the person.

For young people then, recovery is about taking control of their own lives and nominating goals that may, or may not, be related to traditional clinical indicators of 'wellness'.[7] That is, young people may not nominate recovery goals that practitioners want them to, or expect them to. Table 1 demonstrates this reality for homeless young people referred to the on-site counselling service at Brisbane Youth Service (BYS). Although dual diagnosis was evident in 95 per cent of all of the referrals to the program (n=458), only 35 per cent actually nominated alcohol and drugs as the main reason to seek counselling. Instead, young people nominated multiple reasons (75 per cent nominating five or more reasons for referral), and selected: ways of coping better (85 per cent), depression and anxiety (75 per cent), relationships (70 per cent) and dealing with anger (60 per cent) as more relevant that alcohol and drugs (35 per cent). In fact, all of the issues are inter-related, and ultimately demonstrates how living with a dual diagnosis impacts wellbeing on many levels.

For service providers, the recovery approach is about working from a strengths-based collaboration, and resisting the urge to pathologise young people.[8] The framework does this by shifting the therapeutic focus away from asking young people what is wrong with them (the medical model), to asking what has happened to them. Hence the practice style is more respectful, non-judgmental, free of jargon, and carries a sense of hope that change can occur for a young person — despite what has happened to them.

So how does this framework translate into observable service delivery outcomes, and how does change actually occur? Figure 1 showed that measurement of change using a combination of evidenced-based tools (such as those found in Cognitive Behavioural Therapy, or Acceptance and Commitment Therapy), and qualitative measures (such as the Most Significant Change Story) is paramount to tracking progress.

Of the 458 young people referred to the BYS counselling service (see Table 1), 221 engaged in on-going and regular therapy over 12 to 18 months. Depression Anxiety and Stress (DASS-21) scores revealed that young people reported reduced depression and anxiety,

Brisbane street art

Table 2: The lived experiece of how change happens for young people		
Change scale	(N=221)	Change story title (MSC) quotes by young people
I did not make the change	20 per cent	'I thought change would be easier' 'It might be bad for me, but [drugs] help me cope' 'When I've sorted out [other things], I will deal with the drugs'
I changed for a few weeks/months	15 per cent	'My friend kicked his/her habit, why didn't I?'
I made the change, but I don't always stick to it	40 per cent	'I have some relapses, I'm still learning all this new stuff.'
I made the change, <6 months ago, sticking to it	20 per cent	'I tried it out, I didn't get it all right, and I learnt as I went on'
I made the change, >6 months ago, sticking to it	5 per cent	'I kept it up, I gave myself permission to fail and then keep going.'

however, no reduction was noted on the stress scale (which contain items about responding to situational anxiety). These results suggest that individual changes were in-fact subject to on-going stressors found in the external environment (for example, 'I am still homeless' or 'I am still in that domestic violence relationship'). The Most Significant Change (MSC) approach was then used to help identify how change happened for young people, and in what situations or contexts.

So, while this evidence shows that for 20 per cent of young people found change difficult, the other 80 per cent of young people reported improvements in their thinking, feeling, problem solving abilities and their sense of self-awareness (see Figure 2).

In conclusion, it seems fitting to conclude this paper with quotes from young people who received a recovery-based service:

> *'I'll be honest, I did not want to come to see the Psych's here. But then I noticed some of my mates, and the changes they made. So I said I'll only go once. That was a year ago. I'm still coming along. It wasn't as bad as I thought it would be.'*
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> — M, ATSI, 22

> *'[This has] helped me with my problems and provided me with someone I could talk to. They took what I said seriously. I felt heard.'*
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> — F, 16

Endnotes

1. Australian Institute of Health and Welfare 2013, *Alcohol and other drug treatment services in Australia: 2012–2013*, Drug treatment series, No. 24, Australian Institute of Health and Welfare, Canberra.
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3. Department of Health and Ageing 2013, *National Mental Health Report 2013: Tracking progress of mental health reform in Australia 1993–2011*, Commonwealth of Australia, Canberra.
4. McKenzie D, Flatau P, Steen A and Theilking M 2016, *The cost of youth homelessness in Australia: Research Briefing*, Report prepared by Swinburne University Institute for Social Research, the University of Western Australia, Charles Sturt University, the Salvation Army, Mission Australia, and Anglicare Canberra and Goulburn.
5. Gordon S and Ellis P 2013, Recovery of evidenced-based practice, *International Journal of Mental Health Nursing*, vol. 22, pp. 3–14.
6. Drake R and Whitley R 2014, Recovery and severe mental illness: Description and analysis, *Canadian Journal of Psychiatry*, vol. 59, no. 5, pp. 236–242.
7. Shera W and Ramon S 3013, Challenges in the Implementation of Recovery-Oriented Mental Health Policies and Services, *International Journal of Mental Health*, vol.42, no's 2 and 3, pp.17–42.
8. Gordon S and Ellis P 2013, op cit.

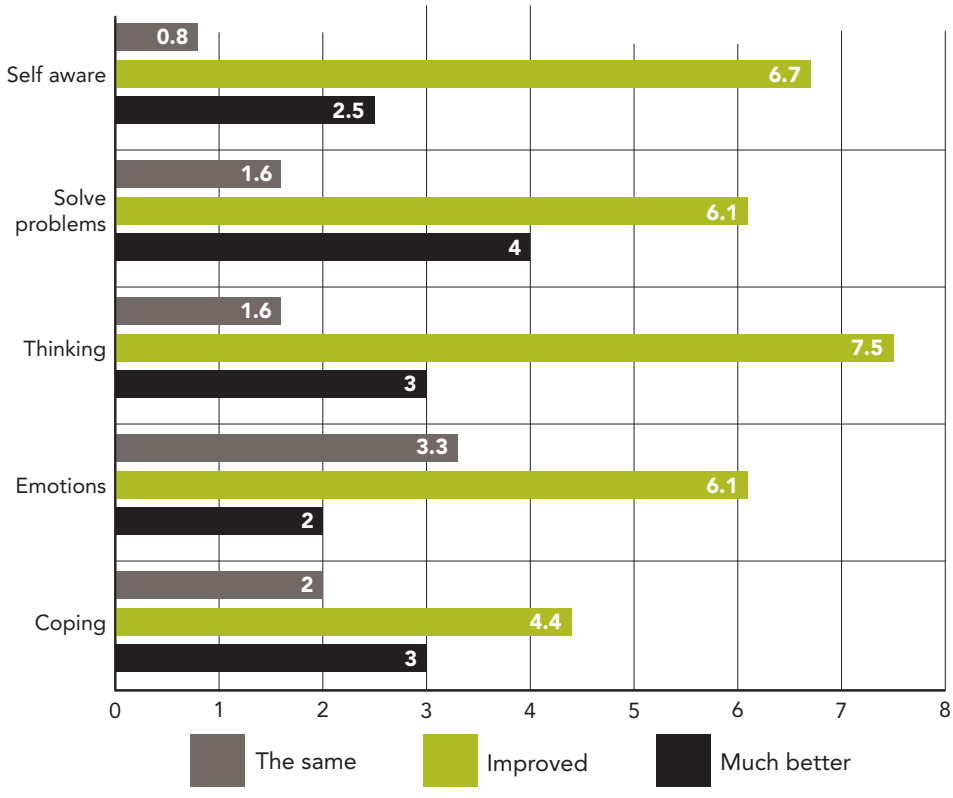

Figure 2: How change happened