

Recovery Oriented Language Guide

WORDS MATTER



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Disclaimer

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The Recovery Oriented Language Guide informs and underpins Mental Health Coordinating Council's work in policy reform, training and sector development projects and activities.

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CONTENTS

Guidelines	4	age spectrum	18
General principles for language and communications	4	Young People	18
Questions to ask ourselves	4	Older persons	19
About language	5	Language and LGBTIQ+ people	21
Recovery oriented language do's and don'ts	6	The definition of terms	22
Language that minimises stigma	8	Talking About Suicide	24
Recovery perspectives throughout life and different lenses	12	Grief and Loss	25
Explaining recovery	14	Reflecting recovery language in the written word, notes and conversations with colleagues	27
A trauma-informed recovery-oriented approach	15	Key terms in mental health	28
Overarching guidelines	15	End notes	30
Cultural diversity and language	17		
Using an interpreter	17		
Talking to people across the			

Background

People living with mental health conditions are among some of the most disadvantaged people in the community. Many live with psychosocial difficulties exacerbated by historical and current trauma, poverty and poor physical health. Frequently they may also have experienced stigma and discrimination as part of everyday experiences.¹

Mental Health Coordinating Council developed the first **Recovery Oriented Language Guide** in 2013 because language matters. The **Guide** continues to be important in the context of mental health, where words can convey hope, optimism and support, and promote a culture that fosters recovery and wellbeing.² The **Recovery Oriented Language Guide** is recognised as a valuable resource widely used across mental health and human services in Australia and overseas.

This edition includes updates to reflect contemporary language use, introduces diversity inclusive language and incorporates new topics, including talking about grief and loss, and recovery language usage in the written word.

Development of the **Guide** has been informed by several sources, including international and Australian literature, conversations with mental health practitioners across service sectors and, importantly, through listening to people with lived experience of mental health conditions concerning their recovery journeys, as well as perspectives from their carers, families and support people.

GUIDELINES FOR RECOVERY ORIENTED LANGUAGE

Words are important. The language we use and the stories we tell have great significance. They can carry a sense of hope and possibility or be associated with a sense of pessimism and low expectations. Both influence personal outcomes.³

General principles for language and communications

The power of words

The words we choose reflect our attitudes, including whether we do (or do not) truly value people, believe in and genuinely respect them. We may be unaware of how the words we use reflect our attitudes and the impact they have on those around us. Our language:

- represents the meanings we have constructed from experience
- prompts attitudes, expectations and actions
- should reflect 'unconditional positive regard'.⁴

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.

Words matter

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
- trauma-informed
- strengths-based.

We need to think about:

- how the language we use is read, as well as heard by people
- how our words may positively or negatively contribute to people's health and wellbeing
- what meanings we present to people to live by
- what our language may communicate about ourselves and our prejudices
- how words might affect engagement with services and supports.

Questions to ask ourselves

Our language not only conveys facts and information, but our thoughts and feelings. We need to reflect on our practice and question ourselves by asking:

- What else am I saying?
- How will someone else read or hear this?
- Do I communicate a sense of commitment and hope and present opportunities, or convey a sense of pessimism and disinterest?
- Do I convey an awareness and expectation of recovery?
- Are my words creating or exacerbating a power imbalance?

Our approach to language needs to take into consideration where someone is in their recovery journey. This may fluctuate or be episodic in relation to their physical and mental health, social and emotional wellbeing.^{5,6}



About language

Different language, terminology and expressions are used across the mental health, psychosocial disability, and related human services sectors. In many service environments 'person', 'client' or 'service user' are used. Some organisations or sectors prefer 'consumer', 'person with lived experience' or 'people who access mental health services'. The NDIS uses the term 'participant'.

Organisations may wish, or need, to adapt terminology used in this resource according to specific circumstances and context. The **Guide** refers to what Mental Health Coordinating Council in consultation with the sector considers best practice for mental health community-managed services while acknowledging that other community-based services may use different language.

DO'S AND DON'TS



USING RECOVERY ORIENTED LANGUAGE

What not to say	What to say
<p>DON'T label people</p> <p>DON'T say “they are mentally ill”</p> <p>DON'T define a person by their struggle or distress</p> <p>DON'T equate identity with a person’s diagnosis. Very often there is no need to mention a diagnosis at all.</p>	<p>DO put people first</p> <p>DO say “person with a mental health condition”</p> <p>DO say “a person who has been diagnosed with...”</p> <p>DO say “a person diagnosed with...” This shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.</p>
<p>DON'T emphasise limitations</p> <p>DON'T focus on what is (in your mind) wrong with the person</p>	<p>DO emphasise abilities</p> <p>Focus on what is strong, like the person’s strengths, skills and passions</p>
<p>DON'T use condescending, disapproving, patronising, tokenistic, intimidating or discriminating language</p> <p>DON'T make assumptions based on external appearances or communication difficulties</p> <p>DON'T sensationalise a person’s mental illness. This means not using terms such as “afflicted with,” “suffers from” or “is a victim of”</p> <p>DON'T portray successful people 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</p>	<p>DO use language that conveys hope and optimism and supports and promotes a culture of recovery</p>
<p>DON'T presume that a person wants to be called by a particular term. For e.g., ‘consumer’ or ‘client’. Check whether they wish to be addressed by their family or first name (‘Ms Smith’ or ‘Aisha’) or another name to which they identify</p>	<p>DO ask how the person would like to be addressed</p>
<p>DON'T use specialist or medical language unless you accompany it with plain English explanations</p>	<p>DO clarify that people understand the information they have been given. Make sure that whatever a person’s age, culture, and cognition they have understood what has been said</p>
<p>DON'T assume that a person feels safe because they do not say anything. This is especially important if contact is being made online into their home where another person may be present</p>	<p>DO ask people whether they are comfortable in the environment before you commence the service. Let them know what alternatives are available, like a private room, open space, face to face, digital alternatives or going outside</p>
<p>DON'T use negative or judgemental language</p>	<p>DO use language that conveys optimism and positivity</p>

What not to say	What to say
<p>DON'T refer negatively to aspirations identified in the past that a person did not follow up</p>	<p>DO ask “what is important to you?” DO ask “what are you looking forward to doing?”</p>
<p>DON'T use the concept of goals with young people or older people unless it feels appropriate. Rather talk about aspirations, dreams, hopes and steps forward</p>	<p>DO ask “what do you think might be steps forward” DO ask “what do you think will help you get closer to achieving your dreams?”</p>
<p>DON'T argue with a person’s perception of events or feelings</p>	<p>DO ask whether the person feels they have been consulted and listened to about their care, treatment, or support plans</p>
<p>DON'T minimise a person’s experience in the urgency of managing symptoms</p>	<p>DO validate a person’s experiences</p>
<p>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</p>	<p>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 a person has heard and understood what has been said clearly (when you know or sense they may have hearing or cognitive difficulties) DO allow people the time to find the words and express what they need to say</p>
<p>DON'T harp on failures of the past DON'T assume someone needs support to make decisions because they have a diagnosis</p>	<p>DO ask people if they feel ready to make their own decisions or would like to be supported, and in what way</p>
<p>DON'T assume that you know what is in the best interest for a person</p>	<p>DO ask what has been helpful and unhelpful in the past</p>
<p>DON'T design a treatment, care or support plan without consultation with the person you are working with</p>	<p>DO meaningfully involve people in the development of treatment, care and support planning DO involve others providing care and coordination across services</p>
<p>DON'T make assumptions about people based on a diagnosis or multiple diagnoses they have been given over the years 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</p>	<p>DO be mindful of how important individual identity is to everyone. Be particularly sensitive to a person’s fears of being considered to lack decision-making capacity DO be mindful of an older person’s fear of losing their sense of identity or a young person not being considered mature enough to make decisions⁷</p>

FINDING THE RIGHT WORDS



DESTIGMATISING LANGUAGE

Inappropriate language	Language of acceptance, hope, respect and uniqueness
<ul style="list-style-type: none"> Sam is not normal 	<ul style="list-style-type: none"> Sam lives with a mental health condition or a disability
<ul style="list-style-type: none"> Sam is crazy, insane, nuts, mental Sam is schizophrenic Sam is bipolar Sam is an anorexic Sam has PTSD Sam is a PD Sam is a borderline Sam is an addict 	<ul style="list-style-type: none"> Sam lives with a mental health condition Sam is a person with lived experience of... Sam has been told they have... Sam has been diagnosed with... Sam has experience of anorexia Sam is a person with lived experience of trauma Sam is a person who experiences mental health and co-occurring substance use
<ul style="list-style-type: none"> Jannali is decompensating Jannali is treatment resistant Jannali is uncooperative and non-compliant Jannali doesn't accept they are mentally ill Jannali has no insight 	<ul style="list-style-type: none"> Jannali is having a rough time Jannali is having difficulty with their recommended medication Jannali's medication is not helping Jannali is experiencing unwanted effects of the medication Jannali disagrees with the diagnosis Jannali is experiencing...
<ul style="list-style-type: none"> Gurpreet is manipulative, irritable Gurpreet is demanding and unreasonable Gurpreet has challenging or complex behaviours Gurpreet is dependent 	<ul style="list-style-type: none"> Gurpreet is trying hard to self-advocate Gurpreet is working on more effective ways of getting their needs met
<ul style="list-style-type: none"> Ash is non-compliant Ash has a history of non-compliance Ash is insight less 	<ul style="list-style-type: none"> Ash is choosing not to... Ash would rather look at other options Ash would like more choice and control over their care and treatment decisions
<ul style="list-style-type: none"> Charlie is compliant or manageable Charlie has partial insight Charlie is cooperating Charlie has acquired insight Charlie lacks capacity Charlie is unmotivated 	<ul style="list-style-type: none"> Charlie is pleased or satisfied with the plan we've developed together Charlie and the team have developed a good rapport Charlie asks for help and recognises when things are not going so well Charlie is working hard towards achieving their goals Charlie is taking each day at a time

Inappropriate language	Language of acceptance, hope, respect and uniqueness
<ul style="list-style-type: none"> • Lee refuses to cooperate • Lee is treatment resistant • Lee refuses help • Lee won't engage with services • Lee needs support with their ADLs • Lee is low functioning 	<ul style="list-style-type: none"> • Lee chooses not to... • Lee is concerned about the health implications of the treatment plan provided • Lee prefers not to... • Lee is very independent • Lee seems unsure about... • Lee might benefit from some support at home
<ul style="list-style-type: none"> • Ash is high functioning 	<ul style="list-style-type: none"> • Ash is really good at...
<ul style="list-style-type: none"> • Khuong is low functioning 	<ul style="list-style-type: none"> • Khuong has a tough time taking care of their daily needs • Khuong has a tough time learning new things • Khuong is still considering their options • Khuong is still working out what they need
<ul style="list-style-type: none"> • Ira is dangerous, abusive, angry or aggressive • Ira demonstrates challenging, risky behaviour/s • Ira is high risk • Ira is anti-social • Ira is isolative • Ira doesn't want to socialise 	<ul style="list-style-type: none"> • Ira tends to... describe the actions... when upset • Ira sometimes reacts to people nearby when hearing voices • Ira is finding it difficult to socialise • Ira likes their own company
<ul style="list-style-type: none"> • Vijaya has a dual diagnosis • Vijaya has comorbidities or has comorbid drug issues • Vijaya is MICA/MISA (mentally ill chemically abusing, mentally ill substance abusing) • Vijaya is an addict 	<ul style="list-style-type: none"> • Vijaya is experiencing mental health and co-existing conditions • Sam tends to use non-prescribed substances to help manage distress and cope with life
<ul style="list-style-type: none"> • Dara is unmotivated • Dara is not engaged or does not want to be engaged • Dara isolates • Dara rejects help 	<ul style="list-style-type: none"> • Dara isn't ready to go back to work • Dara is not in an environment that is motivating • Dara is working on finding motivation • Dara has not yet found anything that sparks their interest
<ul style="list-style-type: none"> • Jesse is manic • Jesse is hyper 	<ul style="list-style-type: none"> • Jesse has a lot of energy right now • Jesse hasn't slept in three days

Continued on following page.

FINDING THE RIGHT WORDS



<ul style="list-style-type: none"> • Amari is paranoid • Amari is delusional • Amari is aggressive 	<ul style="list-style-type: none"> • Amari is distressed and fearful • Amari is anxious that other people want to hurt him/her • Amari often disagrees and gets angry and agitated with family and friends
<ul style="list-style-type: none"> • Shiloh is chronically mentally ill • Shiloh is a manic depressive • Shiloh will never recover because any help is rejected 	<ul style="list-style-type: none"> • Shiloh has been working towards recovery for a long time • Shiloh has experienced serious depression for many years • So far, Shiloh has not found support that has been helpful
<ul style="list-style-type: none"> • Callias is very difficult • Callias is resistant to help • Callias has challenging behaviour • Callias won't engage with services • Callias doesn't accept what they have been told by the treating team 	<ul style="list-style-type: none"> • Callias and I aren't quite on the same page • It is sometimes challenging for me to work with Callias • Callias has not had good experience with services in the past • Callias is a young person who has recently been given a diagnosis and is having difficulty coming to terms with this news • Callias has been given multiple diagnoses over the years and none sit comfortably with his/her lived experience
<ul style="list-style-type: none"> • Lupo is a challenging, difficult, grumpy person easily angered, irrational and short tempered • Lupo rejects help and advice • Lupo isn't capable of deciding what's best on their own • Lupo has complex needs • Lupo has poor ADLs • Lupo is uncooperative • Lupo shows poor judgement needs to realise that he needs help 	<ul style="list-style-type: none"> • Lupo is an older person who displays frustration at times • Lupo is someone used to being independent who is finding it difficult accepting support • Lupo may need some support to help make decisions • Lupo may need support in some areas of life • We need to find out what we can do to support Lupo that best suits them⁹



Words that cause harm

There are certain words that when used to describe a person's attempts to reclaim a sense of power while receiving services - in a system that has the power to control them - may lead to the loss of valuable opportunities to support them.

These include words like:

- manipulative
- grandiose
- passive aggressive
- in denial
- self-defeating
- oppositional
- personality disordered
- borderline

A person trying to get their needs met may have a perception or opinion different from or not shared by those supporting them. Their actions and responses may not result in the outcomes they would like to secure.

RECOVERY PERSPECTIVES THROUGH LIFE STAGES AND DIFFERENCE LENSES

Every day we make a countless number of decisions, some are small others can be life changing.

Decisions are an expression of who we are - our uniqueness, our relationships with others, our achievements and hopes for the future. Sharing power and experiencing equity are key elements in promoting recovery. This is more likely to result in better outcomes when people feel like they are the driver achieving their aspirations

- Access to supported decision-making can assist a person of any age develop a sense of control over their lives and their recovery
- Supported decision-making can assist a person to live a life with meaning, dignity, and greater independence
- Through decision-making we exercise control over our lives, experience new things and learn about ourselves

- Decision-making is a skill that can be developed and practised with support
- Decision-making is so important that it is recognised as a human right.

Appropriate language is a vital component of communicating and establishing a sense of self-determination. If the wrong words are used, feelings of powerlessness can be overwhelming, especially when decisions about things important to a person seem to be or are in the hands of others.

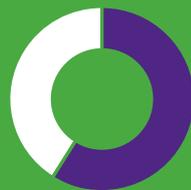
Action speaks louder than words: Nonverbal communication

Research has shown that communication is



7% verbal
93% nonverbal

Nonverbal communication

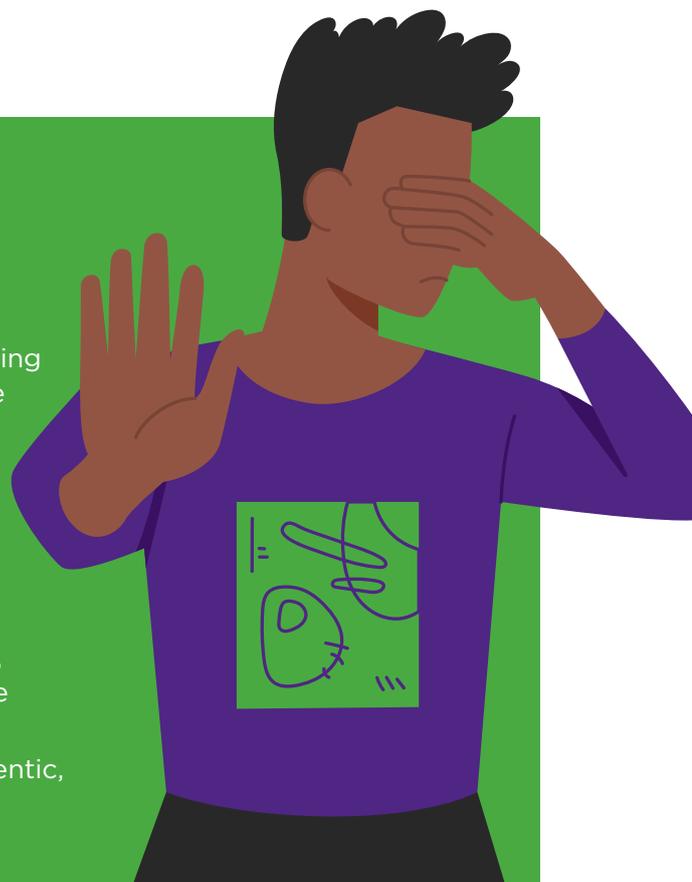


55% body language
38% tone of voice⁹

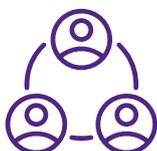


Nonverbal communication: Getting body language right

- Be mindful of the nonverbal aspects of communication by maintaining boundaries, making appropriate eye contact and using body posture that is neither threatening nor disinterested.
- Accommodate a person's developmental age, their hearing, cognitive and language difficulties.
- Always give people time and space to think, question and express their point of view.
- Silences are important. They allow for reflection, processing of information or the time to manage emotional content.
- Consider whether you are being genuinely authentic, empathic, transparent and sincere.



Use plain English language where possible. Using everyday language can help anyone better understand what is happening to them, their condition, and the supports, care and treatment planned or altered due to a change in circumstances.



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

EXPLAINING RECOVERY

Whatever a person's stage of life or diversity experience, mental health and other human services should be familiar with language that reflects a recovery-oriented approach to practice.

Contemporary recovery-oriented practice is trauma-informed, which necessitates an awareness and understanding of the prevalence of trauma in our community, and its impact on diversity across all age groups. Such impacts may exacerbate the development of mental health conditions and coexisting conditions and bio-psychosocial difficulties, including stigma and discrimination and social exclusion.

When talking to and working with people with lived experience of trauma, practitioners must be aware of the ways in which trauma may have been experienced by the individual in the past and in the present.

The concept of 'recovery' was originally defined from the perspectives of adults with lived experience of mental health conditions. In this **Guide**, we seek to identify whether these standpoints also apply to people at

different developmental stages of life, and who experience diverse cultural identities.

While academic literature suggests that the recovery-oriented approach should apply to everyone, language use and ways of communicating the approach should be relevant and understandable to all age groups.

This **Guide** includes 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 living with a mental health condition and older people possibly living with this identity alongside associated experiences of trauma, grief and loss and increasing impairment. Recovery perspectives should be viewed through a diversity lens, and this **Guide** includes some key considerations in this context.

Diversity inclusion

Diversity inclusion should guide a worker when communicating with people accessing their service. When unsure of what is appropriate, a worker should ask the person their language preferences.

Questions you can ask to determine preferred language

- Ask how someone like to be addressed
- Check what disability aids they may need (a hearing loop, etc)
- Ask what modes of communication are most helpful (face-to-face or digital)
- Enquire what environmental accommodation is preferred (where and what helps or makes them feel safer)
- Check what supports would assist them realise their recovery aspirations

A TRAUMA-INFORMED RECOVERY-ORIENTED APPROACH

Recovery orientation has been adopted as an overarching philosophy to guide mental health practice in community-managed services and is embedded into national policy and standards across the service system.¹⁰

An understanding of trauma and the principles that underpin a trauma-informed care and practice approach is integral to a recovery-oriented approach. 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 of re-traumatisation and harm within service systems and practice.

A trauma-informed recovery-oriented approach is person-centred and person-led and involves sensitivity to an individual's particular requirements, preferences, safety, vulnerabilities and general wellbeing. It is an approach that recognises lived experience and empowers people to genuinely participate in decision-making that affects their life and the supports, care and treatment they receive.

Overarching guidelines

- Speak or write about a person living with a mental health condition, psychosocial disability, cognitive impairment, and co-occurring conditions - not about a disorder, diagnosis, symptoms, or 'case', but by terms such as 'frequent flyer' or 'blocked bed'.
- Always include a description of a person's strengths and resourcefulness alongside the difficulties they may experience.
- Where applicable, explicitly describe words and concepts such as diagnosis or assessment as from a medical and service provider opinion or perspective rather than as a pronouncement of universal truth.
- Do not make assumptions or describe achievements, possessions and connections as merely grandiose delusions.
- Do not assume that disclosures of abuse are necessarily imaginary or represent part of the psychosis or delusions a person is experiencing.
- Express 'shortfalls' as work or progress still to be achieved.
- Record the person's own hopes or aspirations 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 because of a range of involuntary treatment, including detention in a hospital environment, seclusion and restraint.
- 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.

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Overarching guidelines cont.

- Do not assume that risks presented in files and notes that relate to the distant past have current relevance.
 - Record people's progress and their efforts towards their own recovery, the steps forward that they have made, using their own words and meaning.
 - Where there are different views between the person writing a letter or report and the person under review it is important to:
 - include recognition of that awareness
 - describe their viewpoint in their own words
 - 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.
 - 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.
- Ensure demonstration of respect with reference to people's concerns about the physical and psychological impacts of medications that they are expected to accept and include discussions that appropriately factor in the competing risks.
 - When there is opportunity, such as regarding 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 of the conversation, and a reminder of decisions that were copied to the other relevant parties (for e.g., peer workers, support workers, general practitioners).
 - Set up recovery-oriented language prompts in organisational documents and data templates and include this 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 AND LANGUAGE

People from different cultures may express their distress in physical or somatic symptoms, or in descriptive terms unusual to you.

Some cultures hold spiritual beliefs about the causes of mental health conditions and behaviours. It is important that workers pay attention to the person's description of their lived experience. Some cultures do not always distinguish between physical and mental health.

Many people experience or have ways of understanding or explaining recovery which are more about concepts of overall wellbeing, rather than conceptualising it as a journey, or that one recovers from a particular illness.

Recovery may be considered as simply on the continuum of health and ill-health. Alternatively, holistic explanations may be more relevant, understandable, or applicable to the individual. A holistic explanation of recovery may be seen as a restoration of balance, equilibrium, and wholeness. Similarly, ideas about health and healing are related to harmony and cohesion, rather than individual mastery and control.¹¹

People who are interested in matters of healing as opposed to use of medication should not be thought of as 'cranks' or 'alternative'.

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, while 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 how this may affect their engagement with supports.

Using an interpreter

If you are using an interpreter to speak to a person you are working with or their family or carer, check that they are not from that person's community or known to them so that confidentiality is not breached. Interpreters are trained in precise listening skills under taxing conditions, using memory and note-taking techniques for consecutive interpreting.

It is not appropriate for worker to ask the interpreter to express an opinion about what the person has said. But you can ask for clarification or use of a word or phrase that may have a different meaning in another language or culture. It is essential that a worker and the consumer remain engaged with each other during a conversation, and not have the worker communicating solely with the interpreter. This can affect rapport and the communication of non-verbal cues can be lost unless the worker remains engaged with the consumer.

Trauma and interpreters

A person known to have experienced trauma should be provided with an interpreter who has received relevant training in this area, where possible. Having the assistance of a professionally trained, trauma-informed interpreter is critical to assist people make first contact with frontline services, feel safe to disclose abuse, and access help for themselves and their children.

For interpreting sessions identified as potentially traumatic, a worker should ensure that extra time is scheduled to pre-brief and debrief the interpreter and other practitioners.¹²

TALKING TO PEOPLE ACROSS THE AGE SPECTRUM

When communicating with people from any group or diverse culture, whether a young or an older person, using language they are comfortable with is important.

Appropriate language is key to building trust and rapport.

- Be guided by each person's style of speech and use of terminology.
- Be mindful not to parrot what they say, as that may come across as artificial
- Consider what will best speak to their experience.



Young People and recovery oriented language

Young people are no different to adults in expressing the importance of collaboration and openness as powerful 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. Characteristically young people relate more to concepts of health and wellbeing rather than illness and recovery.

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

Hopes and dreams

Being asked to formulate recovery goals, particularly for young people, can lead to a feeling of being judged or intimidated, especially if they are unable to list concrete objectives.

Steps forward

An alternative approach to talking about 'recovery goals' is to refer to 'steps forward'.

For example, ask "What do you think may be some useful steps forward?" or "What are you looking forward to doing... (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 do not want to feel they are being cornered or are expected to plan their entire future.

Enabling conversation

Some expressions used by young people may offend others from different age groups and cultures, nevertheless, it is important to be accepting of contemporary vernacular.

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.

Swearing and 'bad language'

Workers should not need to feel uncomfortable or think they should use language they would not normally use.

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.

Sometimes, the vernacular used by young people is contradictory. For example, 'Bad' can mean good, 'Goat' greatest of all time and 'Gucci' cool or going well.

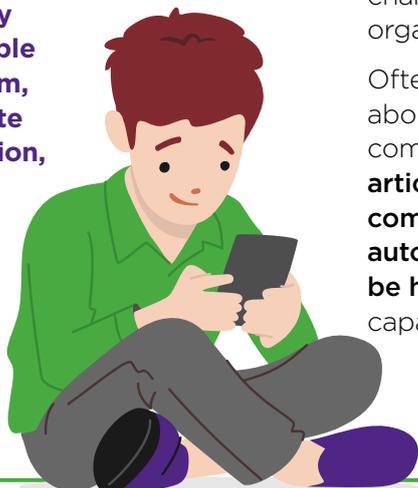
Using swear words may a young person's way of equalising the power dynamic with their workers. It is important to not put them down or punish them for this.

Technology-based communication

Young people are increasingly comfortable using technology-based communications to discuss their emotions and experiences.¹³ It seems likely 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).¹⁴ However young adults will often utilise other means to add to their expression of how they feel through emojis, music, poetry, etc.

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.¹⁵ 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 Framework¹⁶ identifies the importance of mental health workers being culturally sensitive to young people when working with them, for example, appropriate nonverbal communication, eye contact and body posture.



Older persons and recovery oriented language

Many older people have a clear sense of who they are, can define themselves and can build on a lifetime of experience and resilience. These strengths and skills can buffer the impact their condition and circumstances have on them.

However, using a recovery-oriented approach may enhance a person's likelihood of creating and continuing to live a meaningful and contributing life in their community of choice.¹⁷

Minimising negative attitudes towards ageing

There is evidence suggesting that older people's dignity and autonomy is undermined in many health care settings, and that a sizable cross section of healthcare professionals hold stereotypical, negative attitudes towards older people.¹⁸ Diminishing mental health among older people is often not identified by relatives, health care professionals and older people themselves who may attribute symptoms to the effects of ageing or to physical and environmental changes. It is important to investigate potential organic causes of symptoms.

Often service providers make assumptions about older people, and what is appropriate communication. **It is important that language articulates respect, fosters trust, and communicates that supporting choice and autonomy whatever difficulties a person may be having is a priority.** Importantly, assuming capacity should be a first principle.¹⁹



Ways to work with older people

- Support 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'.²⁰ It is important to express a sincere interest in knowing who they are.
- Understand that for some older persons, their 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 how they express that they feel.
- Be aware that older people may conceptualise recovery differently to younger adults more generally. Their aim may be simply to maintain a sense of who they are despite the difficulties they experience and be valued and respected to know what they want and need.
- Keep an awareness that many older people who have lived with mental health conditions throughout their life may have experienced negative social responses and interactions with health and support services. This may impact on their ability to feel comfortable and safe with workers. This highlights the importance of language used and acknowledgement of past experiences of stigma and discrimination to foster rapport.
- Consider 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.

Three components of recovery for older people

Three components of recovery appear to be distinct to older people:

- the significance of an established and enduring sense of identity
- coping strategies that compensate and provide continuity reinforce identity
- and, the impact of coexisting physical health conditions and disability.

It is vital 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 an older person, about what they want, unless a person clearly wants someone else to speak on their behalf or are unable to communicate their preferences.
- Do not let others jump in first or invalidate what the person may have said.

Give someone time to answer, and make sure that they can hear and see what is going on



LANGUAGE AND LGBTIQ+ PEOPLE

A disproportionate number of LGBTIQ+ people experience worse bio-social outcomes than their non-LGBTIQ+ peers in a range of areas, including in relation to mental health and suicidality.

Particularly poor outcomes are found in all age groups, and evidence shows that people from LGBTIQ+ communities report much higher rates of depression and anxiety, high and very high levels of psychological distress as well as suicidal ideation and suicide attempts.²¹

LGBTIQ+ people often experience more discrimination and abuse than is generally experienced by the broader population in Australia, and lived and living experience of trauma is extremely prevalent in LGBTIQ+ communities.

The elevated risk of mental ill-health and suicidality among LGBTIQ+ people is not due to sexuality, sex or gender identity in and of itself, but rather due to discrimination and exclusion people experience as key determinants across all areas of physical and mental health.

Safety in language

Mental health workers can do much in terms of language to ensure that people feel safe when accessing services. Organisations that aim to eradicate prejudice against people who do not conform to mainstream male or female gender norms can demonstrate better outcomes for their clients.

A judgemental stance is often expressed as stereotyping, ostracising, discrimination, harassment, abuse and violence. Exposure to and fear of discrimination and isolation can directly effect people's mental health, causing stress, psychological distress and suicidality.^{22,23}

Using correct language can help build more inclusive environments for diverse communities.²⁴ By using inclusive LGBTIQ+ language we demonstrate respect in workplaces and in delivering policy and programs to these communities. This can build trust and address some of the prejudice and discrimination LGBTIQ+ people experience.²⁵

The definition of terms and the way they are used changes over time, and can vary depending on location and culture. While acknowledging this, the term used in this language guide is LGBTIQ which traditionally stands for lesbian, gay, bisexual, transgender, intersex and queer or questioning. In some information and resource documents the + symbol is used to expand this definition to include the full range of sexual and romantic attractions (e.g. asexual, polysexual, pansexual), and all gender identities.

Gender identity describes someone's own understanding of who they are with regards to their gender-related identity (for e.g. woman, genderqueer, man, no gender, etc.), as distinct from their physical characteristics. This includes the way people express or present their gender and recognises that a person may not identify as either a woman or a man.

Sexuality describes a person's emotional, romantic, or sexual attractions towards others, often describing the gender of people with whom someone builds sexual or romantic relationships, for e.g. lesbian or gay. Some people experience sexuality as fluid and changing across their lifespan, therefore we choose not to use the term 'orientation'.

Intersex variation is an umbrella term for people with physical characteristics that are seen as different from what is typically thought of as 'female' and 'male' bodies. These physical characteristics are present at birth and may become more noticeable during physical development. Intersex variation is distinct from sexuality and gender identity. Therefore, intersex people may identify as male, female or another gender, and gay, lesbian, bisexual, heterosexual, etc.²⁶



Interacting with Transgender People

This section includes information on respectfully interacting with transgender individuals one-on-one or when in a small group.

Use the language a transgender person uses for themselves

Different transgender people may use different words to describe themselves. You should follow the lead of each transgender person, as they will best know the language that is right for them.

If you do not know what pronouns to use, ask.

A simple way to see what pronouns someone uses - 'he', 'she', 'they' or something else - is to wait and see if it comes up naturally in conversation. If you are still unsure, ask politely and respectfully, without making a big deal about it. Sharing your own pronouns is a great way to bring up the topic. For example, "Hi, I'm Bec and I use she/her/hers as my pronouns. How about you?" If you accidentally use the wrong pronouns, apologise and move on.

Be careful and considerate about what other questions you ask.

There are two questions you can ask yourself that may help determine if a topic is appropriate to bring up.

- "Do I need to know this information to treat them respectfully?" Asking someone's name and pronoun is almost always appropriate, as we use that information in talking to and about each other every day. Beyond that, make sure what you are asking about is information that you need to know to do your job.
- "Would I be comfortable if this question was turned around and asked of me?" A good way to determine if a question is appropriate is to think about how it would feel if someone asked you something similar.²⁷



Tips about pronouns in mental health services

Some people choose not to use gendered pronouns to refer to themselves, as they may identify themselves as having a gender other than male or female, having more than one gender identity, or having no gender at all. If a person you are assisting is not familiar to you and you are unsure of the person's gender identity, you should:

- Communicate in terms that are gender and relationship neutral, for example, use 'partner' rather than 'boyfriend' or 'girlfriend'.
- Use non-gendered pronouns ('they', 'them', 'their' when referring to an individual) or use the person's name in place of a gendered pronoun. Instead of saying, "That belongs to her", say "That belongs to Sam".
- Ask about pronouns in a respectful and inclusive way. "I use she/her pronouns to refer to myself. Can I ask what pronouns you use?"

TALKING ABOUT SUICIDE²⁸

One significant impetus to change the language of suicide began in the bereavement community. In addition to the insensitive language often used to describe suicide, as well as silence and denial - the absence of suicide language and conversation is a major contributor to the stigma people face in the community.²⁹

Suicide often leaves the bereaved with especially acute feelings of self-recrimination. Those who are left behind may feel the full burden of suicides 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 from suicide and the loss attached to it.

Because 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.³⁰

Suicide is no longer a crime, 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.³¹ To find the right words, use appropriate, non-stigmatising language when referring to suicide.



‘Attention seeking’

Often people seek attention from others for comfort and reassurance when they are distressed. In the context of a suicide attempt, suicidal ideation or self-harm, 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.

Certain language may be problematic when discussing suicide. Inaccurate language can alienate members of the community or inadvertently present suicide as glamorous and courageous or as an option for dealing with problems.

What not to say	What to say	Why?
“Unsuccessful suicide”	“Non-fatal” “Made an attempt on their life”	Avoid presenting suicide as a desired outcome or glamorising a suicide attempt.
“Successful suicide”	“Took their own life” “Died by suicide” “Ended their own life”	Avoid presenting suicide as a desired outcome.
“Committed or Commit suicide”	“Died by suicide” “Ended their own life”	To avoid association between suicide and ‘crime’ or ‘sin’ that may alienate some people.
“Suicide epidemic”	“Concerning rates of suicide”	To avoid sensationalism and inaccuracy.

We need to ensure we are not ‘too afraid’ to talk about suicide as a community while respecting and understanding the risks in certain situations. Suicide is an important issue of community concern and needs to be discussed.³²



GRIEF AND LOSS

Everyone's experience of grief and loss is unique. People might experience all kinds of difficult and at times overwhelming emotions, and they may sometimes wonder if the sadness will ever end. This is a normal reaction.³³

Grief has its own language. There are words and phrases commonly used by those who are grieving, and while they are not unique to those who have experienced loss, the meaning behind them is special and needs to be paid attention.³⁴

These phrases usually follow a much longer and more complicated story of love and loss, filled with the obstacles and roadblocks that so many people face as they try to figure out what is next and where to go from here.

As we talk about grief and loss, whether it is in our own heads or when speaking to others, it is important to examine what is really being communicated.

Considering what your words really mean matters because communication is key when trying to connect with others. Connection is ultimately what saves the person from feeling lost and adrift in the sea of grief. Connecting is why it is so important to learn how to express ourselves to those around us.

We can become complacent in our language and our communications and feel frustrated if we are misunderstood, but often that is because we do not always understand these thoughts ourselves or know how best to express them to others.

What we say to ourselves

It matters what words or phrases we are choosing, even if it is only in our own head. We often speak to ourselves with a language that is filled with defeat, and it can become hard to break the cycle of negativity, especially after a devastating loss.

Loss and the grief that comes with it can, for better or worse, offer an unparalleled opportunity for reflection, contemplation, introspection, and self-growth. However, how this is communicated can sound trivialising and smug.

What to say to someone grieving

- Acknowledge the situation and let people know you care. "I was really sad to hear about..."
- Talk openly about their loss.
- Be genuine and honest. "I'm not sure what to say or do, but I want you to know I am here for you".
- Offer your support. "What can I do to help? Do you feel like talking?"
- Ask how they are feeling. Each day can be different for someone who is grieving. Take the time to listen and understand what they are going through.
- Talk about everyday life too. Their loss and grief do not have to be the focus of all your conversations.
- Avoid statements that are intended to comfort them but minimises their grief. They know they have things to be thankful for, or that at some point they will move on, but for now they need time to grieve.



Listen with compassion



- Offer comfort. They need to feel supported in their loss, not judged or criticised.
- Help them to understand that healing takes time.
- Accept that silence is helpful sometimes. You can offer comfort by a squeeze of the hand or a reassuring hug. Silence can offer them a time to gather their thoughts and reflect on times gone by.
- Be patient. Sit and listen quietly as they share their stories of loss.
- Do not launch into your own stories of grief and loss.

Provide ongoing support



- Understand that life may never feel the same. They may learn to accept the loss and the pain may lessen, but the sadness may never completely go away.
- Let them know it is okay to share their grief. They are not alone.
- Ask them how you can help. Make suggestions if they are reluctant to receive help or are just unsure what they need. A few home-cooked meals, doing the shopping, helping to receive guests or perhaps offering to go walking or do something enjoyable with them can all help someone through their grief.
- Encourage them to slowly return to activities or social events that they enjoy.
- Keep supporting them. They will need support throughout their time of grief, not just immediately after the loss.
- Be understanding and accept that they may act or say things differently from you.
- Offer extra support on special days. Certain times and days of the year may be particularly hard, such as holidays, family milestones, birthdays, and anniversaries, as they often reawaken grief.
- Encourage them to get help if their grief does not seem to be easing over time, particularly if they have suicidal thoughts, self-harm or appear to be giving up on life.
- Look after yourself. Helping a grieving person can be a heavy burden. Take care of your own physical and emotional health. Talk about your feelings with someone during this stressful time.³⁵

REFLECTING RECOVERY LANGUAGE WRITTEN IN WORDS, NOTES AND CONVERSATIONS

A recovery approach should underpin all interactions and communications in a mental health context.

This approach includes writing about a person in notes, support workers or clinicians talking to colleagues or supervisors and discussing referrals with other services and teams. It should also be considered when writing papers and policy submissions. Recovery principles should also be reflected in the language lawyers and clinicians use in tribunal hearings and in other human service settings that work with people with mental health and coexisting conditions.

The principles of recovery practice should be reflected in attitude, words and actions. This means being respectful and non-judgmental, and avoiding terms that are not easily understood (no jargon!).

An easy way to be accountable and embed recovery language in all aspects of your work is to speak and write as though the people you are speaking about will hear or read what you have conveyed.

Language changes over time

Language is dynamic and evolves over time. What might have been appropriate for one generation may no longer be acceptable twenty years later.

Change may also be viewed as political correctness or vogueish. There is no satisfying everyone. We urge that you practice reflectively and consider what is being written about people might be read by them.

Understand and ensure that their perspectives will be listened to, respected and valued, and not add to the distress they may experience in and with the system, or perpetuate the stigma and discrimination they may have experienced.

Tips for finding the right words



- Characteristically, each field has its own language and use of terminology. It may be necessary to make an opening statement about the language you will use, why you have used those particular terms, and what they reflect.
- You may also want to draw attention to the fact that in a piece of written work you may be directly referencing papers that use terminology that not everyone will be comfortable with.
- You might need to decide on a particular word for consistency throughout a document, but acknowledge that others may prefer alternative terms. An example of this in the literature is about people who have experienced trauma. Some may prefer to be described as 'victims of abuse' while others prefer to be described as 'survivors'.
- People with lived experience of mental health conditions often prefer just to be called 'people' rather than a 'consumer', 'service user', 'client' or 'patient'. Frequently they say they dislike being referred to as a 'case' and would rather see their stories reflected as narratives about their experiences.

KEY TERMS IN MENTAL HEALTH

Some terms are commonly used by clinicians, as well as being used in policy directives or legislation. Some of these words may be interpreted by people living with mental health conditions as stigmatising. Always consider what it would be like to walk in another person's shoes and have certain terms used, and things said about oneself. Reframe your words in such a way as to minimise stigmatising and discriminatory language.

A Consumer is a person living with a mental health condition who is using or has previously used a mental health service.³⁶ Where possible, describe consumers as 'people accessing services' or 'with lived experience of a mental health condition'. Many people do not relate to the terms 'consumer', 'client', 'person with psychosocial disability', 'patient' or 'service user'.

Capacity is a term frequently used in legislation, policy directives and clinical notes, and it refers to a person's ability to make their 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 not have capacity in some areas, but still be able to make other decisions, especially when they are supported.

Cognitive function or impairment is language frequently used in reports, assessments, research and clinical notes as well as in policy or legislation. 'Function' 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 in policy and case notes to refer to individuals who present with an inter-related mix of diverse mental health and physical health issues, developmental and psychosocial difficulties, sometimes described as bio-psychosocial.

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.³⁷

Peer Work is a growing occupational group in the mental health and psychosocial disability workforce. Peer services are a core component of recovery-oriented services and programs. The peer workforce includes workers in mainstream public or community-managed mental health, psychosocial support and rehabilitation services or initiatives. Peers are employed to openly identify and use their lived experience of mental health conditions and recovery as part of their work. Peer workers provide personal and social recovery support to other people living with mental health conditions in hospital settings, supported accommodation, employment, education, other community-based services, and more.³⁸



Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities. It is often used to describe the negative outcomes a person living with a mental health condition may experience when attempting to interact with a social environment and that results in multiple barriers to their equality with others. Psychosocial disability may also describe the restricted participation a person may experience in their daily life because of reduced functionality, poor physical health, and the stigma and discrimination they face because of social, emotional and economic exclusion. Psychosocial disability is not a diagnosis and many people with mental health conditions do not identify as having psychosocial disability.

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 a mental health condition.³⁹

Supported decision-making is a skill and an approach designed to build capacity and support people make significant decisions, exercise their legal capacity, maximise their choice and control, and make day-to-day decisions that affect how they live. It is an approach that draws on a person's 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 and provided with the acknowledgment of 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. The most contemporary recovery-oriented practice is trauma-informed.

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