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Connecting through Clinical Quality, Recovery, and Resiliency

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Creating a Resiliency Agenda for Ohio's Youth

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The Ohio Department of Mental Health has taken a lead role in the development and dissemination of a statewide mental health resiliency model that informs policy and practice across the developmental life stages of a youth (from infancy to the transition to adulthood).

This model should be grounded in current resiliency research, including research on risk and protective factors, developmental assets, and other relevant research. While this model should complement the current recovery model for adults, it should by necessity be different and uniquely matched to the complex, multiple-system lives of children. This article will briefly outline the current definition of resiliency and its major components as supported by the research literature. The challenges of developing and implementing such a resiliency model will also be presented with the purpose of generating an ongoing dialogue.

Historically, the term resiliency referred to a child's static traits and abilities that served as protective factors against life challenges. Friedman (2003), however, believes that it is important to get past the traditional definition of resiliency, which focuses only on protective factors. Masten (2001) agrees and believes that resiliency is not the result of special children with special qualities but instead arises from ordinary processes and conditions. Currently, resiliency is more commonly defined as a dynamic process, which takes into account the interaction of risk and protective factors, contextual conditions, as well as the individual's traits and abilities (Luthar, Cicchetti, & Becker, 2000; and Masten, 2001).

In reviewing the research literature on resiliency Masten (2001) lists the following as global resiliency factors: connection to competent and caring adults in the family and community, cognitive and self-regulation skills, positive views of self and motivation to be effective in the environment. Friedman (2003) cites five major components of resiliency: connections to individuals and institutions, competencies (social, problem solving and abilities), hope and optimism, giving to others or a sense of contribution and high expectations and standards. To summarize, it is the supportive conditions and expectations, and the individual skills, abilities and attitudes that interact to create a resilient youth or situation.

While this information is presented as a starting point for future discussions it is not an end point. In the next section, some talking points are listed that will hopefully generate future discussions that will assist in clarifying resiliency both as a construct and as a potential model of care for our at-risk youth and families.

Challenges: Questions for future discussion

- First, what does the evidence say? We need to review the research on resiliency and reach a consensus on what this literature tells us.
- Next, we need to define best practice principles of care that support the resiliency philosophy and that are consistent with current research findings.
- We need to create a diverse partnership between children and their families and professionals from the initial stages of model development. How do youth and families view resiliency? What is salient and meaningful to the youth, family, and community? How do different cultural, spiritual, ethnic and family values inform best practice standards for a resiliency model?
- How does a resiliency framework inform our practice? How does a resiliency model inform our therapeutic relationships? We need to have an ongoing dialogue on how to best utilize and apply a resiliency framework in our assessments, treatment and overall approach to care.
- How do we promote public policies that build competencies and positive environments for at-risk youth and their families both at the prevention and intervention levels?
- How will we disseminate this model? What is the best vehicle for training providers in a resiliency model? What training efforts are needed to disseminate research-supported information on assets, risk factors, and protective factors?
- How do current evidenced-based practices fit into a resiliency model framework? And conversely, how can resiliency be utilized within these programs?
- How does resiliency fit into the system of care framework? What are the common aspects?
- How is resiliency uniquely applied to the different developmental stages? We need to develop a model that is flexible enough to match the needs across the developmental stages and ages of children from birth to adulthood.

The above list is only meant to be a starting point for discussion and hopefully will generate fruitful dialogue and possible next steps for developing a resiliency model. As we move forward with a statewide resiliency agenda there will be many challenges in its implementation, but the potential rewards are significant to the youth, family, and greater community. We have many questions that still need to be answered on our way to building a resiliency paradigm in our state. But if we utilize what we know from the current resiliency literature, adult recovery models, and current evidence-based treatment we are well on our way to building a foundation for a dynamic resiliency model for our youth and families.

References

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