Recovery and Mental Health Care in Australia – A Time of Change

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Policy
Recovery has been acknowledged in Australian mental health care policy since 1992, in which time there have been four five-year National Mental Health Plans; and consultation is currently underway for the fifth. In the federated Australian government system, these Plans outline the shared responsibilities of the Federal and State/Territory governments in the implementation of mental health policy and the provision of services. The primary purpose of the original Plan in 1992 was to restructure mental health services into mainstream health care and progress deinstitutionalization in favour of community-based service delivery.¹ The second Plan incorporated a focus on health promotion, illness prevention, and early intervention.² Notably, the word ‘recovery’ was not evident in the first two Plans, but its essence was emerging with acknowledgement of mental health promotion as “action to maximize mental health and well-being” for both the general population and people with mental illness.³

The term ‘recovery’ was first included in the third Plan and was defined according to William Anthony as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability.”⁴ In 2004, Rickwood argued that recovery was being implemented in Australia, “slowly but surely”.³ The current consultation draft for the Fifth National Mental Health Plan is underpinned by five values, one of which is recovery: “There should be a focus on recovery and enhancing wellbeing, including by recognizing each person’s potential to live a fulfilling life and contribute to their own recovery”.⁵

Action
To aid policy implementation, National Standards for Mental Health Services were released in 1996, initially as voluntary standards, and revised in 2010 to reflect changes in the delivery and focus of mental health services.⁶ These were augmented by National Practice Standards for the Mental Health Workforce 2013, which outline expected...
capabilities for mental health professionals, complementing discipline-specific practice competencies for the professions of psychology, psychiatry, nursing, social work and occupational therapy. These documents articulate the principles and practices of recovery-oriented mental health services. Service providers have reported that the Standards have increased prominence of recovery principles, providing an impetus to focus on good quality clinical care for each person, and noting that these improvements were driven by collaboration with service users.

To add impetus to the the National Mental Health Plans, a National Action Plan on Mental Health was put in place from 2006 to 2011, aiming to build a more collaborative and integrated mental health system. Coordination between government and private services was emphasized, and service delivery was expanded to include providers of housing, vocational, educational, and community services. A component of better integration was a continuum of care approach for people seriously affected by mental illness: mental health services can be broadly categorized as community-based, residential, and acute; and people need to be able to move between these services as their mental health status changes. Recovery has been implemented at different rates and in different ways across this continuum of care.

Within the community setting, recovery-focused care increasingly has become a main priority. Collaborative care has been implemented in many community-based settings; for example, through the Collaborative Recovery Model, which is a comprehensive collaborative care framework promoting a strengths and values approach that has been adopted by many non-government service providers in most Australian jurisdictions. Shared management and self-directed services have emerged in the community setting, with some services providing individualized funds for clients, resulting in practical and psychological benefits for service users from being able to use the funds in ways they felt would be personally most beneficial. Partners in Recovery is a federally funded, community-based recovery-focused program that provides support facilitators for service users, to assist in the coordination of care and integration of services around individual client needs. A final report of an external evaluation of the Partners in Recovery program is currently with the Federal Government; the evaluators concluded that the “initiative has assisted participants in areas such as housing security, physical health, psychological support, and social connection, and there is significant evidence the program has created positive outcomes in a range of domains for individuals.” Peer support programs with a strong recovery focus have also developed within the community sector, enabling people who have a lived experience of a mental illness to encourage and mentor other community members.

At the acute end of the continuum of care, while some inpatient facilities have adopted a recovery orientation, this has been much slower and far less pervasive than for the community sector. It requires a significant shift in the model of care that is provided, and implementation can be challenging for staff. One initiative that has been instigated in some adult inpatient units is the creation of family rooms, providing a fun and intimate space for parents to spend quality time with their children when they come to visit, rather than the previous arrangements of visits being in the foyer or garden. Feedback from
parents and staff indicated the rooms demonstrated to parents that their role as a parent and their relationship with their family was important. Other inpatient units have restructured their delivery of services in response to a movement toward delivering mental health services within mainstream health services. One former psychiatric hospital that became a general hospital offering mental health inpatient care, implemented a comprehensive health care approach and a recovery orientation model of care.\textsuperscript{17} The new general hospital service allowed for a more diverse skillset of nursing care, including mental health and registered nurses. However, these arrangements brought new challenges whereby the nursing staff found the staffing changes and new workforce flexibility resulted in a diversification of roles, competition over the delivery and content of care, and some nurses reporting heavy workloads under the new system.

Inpatient services face a range of barriers to adopting a recovery orientation. The lack of comprehensive recovery-based nursing training within undergraduate curricula has been identified as a key area of concern, with university programs needing to ensure that their nursing students gain the necessary skills and attributes required to provide recovery-based care in the inpatient setting.\textsuperscript{18} Nurses in recovery-oriented settings are very aware of their frontline role in supporting clients in their recovery, using a range of attributes and approaches to assist people in their care, including the incorporation of storytelling, safeguarding, treatment, and responsibility for recovery into their approach.\textsuperscript{19} A further challenge to the implementation of a recovery orientation within inpatient facilities is the design and aesthetics of the facilities. Design is an essential component in assisting people to feel safe in their environment and to feel that they have access to staff and to amenities.\textsuperscript{20}

If a recovery paradigm is to be fully implemented within the inpatient mental health system, then care for service users must be aligned with their cultural background, yet this remains a challenge. To date, there has been little research into how the mental health system meets the needs of Aboriginal and Torres Strait Islander Australians and, in particular, concerns have been raised of how current acute services provide a safe and culturally sensitive environment for Aboriginal and Torres Strait Islander women.\textsuperscript{21} Women, in general, admitted to inpatient units in Australia have expressed a need for hospital units to understand how difficult it is to live in the hospital and that women need to be involved in meaningful activities while they are there.\textsuperscript{22}

A relatively new addition to the mental health service continuum are residential services offering tailored support and care for people with sub-acute symptoms. These services are generally operated by non-government organizations and provide support in a community-based residential setting, with a focus on opportunities for clients to learn daily living skills, symptom management strategies and develop community connections. These services may accept admissions from current inpatients, as a transitional step in preparing to return to community living (step-down), and also from people receiving care in the community who need additional support at a time when their symptoms may be escalating, as an alternative to a hospital admission (step-up).\textsuperscript{23, 24} The services prioritize recovery-based care and psychosocial rehabilitation founded on key principles of recovery that promote hopefulness, personal empowerment, social connectedness, self-determination, and global
well-being. Residential services encourage a collaborative decision-making approach in setting recovery goals, emphasize the development of social connections, assist clients to develop strategies to manage their symptoms, and foster positive mental health. An emerging research base shows that such community-based residential services are an important part of the continuum of care, comprising a valuable support in the recovery journey.

Conceptualization and Measurement of Recovery
A common challenge for recovery-based services in all settings across the continuum of care is the many different understandings of recovery, and this lack of shared meaning and clarity can result in uncertainty for people accessing services. The primary ongoing tension in definition was well-articulated by Slade, Amering and Oades who argued that ‘clinical recovery’ is a perspective that comes from the medical model, which focuses on symptom reduction, functioning, and sustained remission, and is ascertained in a way that is invariant across individuals; whereas ‘personal recovery’ describes the perspective from consumer narratives, emphasizing living a satisfying, hopeful, and contributing life even with limitations caused by the illness, and in a way that varies across individuals. Many argue that the medical model approach still dominates in terms of what is evidence of recovery, particularly of effective service delivery; and multiple interpretations of personal recovery and how to implement such an approach abound. For example, some mental health workers interpret recovery as adopting a ‘hands off’ approach, rather than forging a collaborative relationship with their clients.

A critical current issue is, therefore, how to measure recovery, including both outcome measures of personal recovery and how to determine whether services are implementing a recovery-oriented approach. Outcome measures of service users’ recovery is a complex and much debated field. Australia’s National Mental Health Strategy has promoted the collection of both outcomes and casemix data as a means of monitoring the quality, effectiveness, and efficiency of services. Since 2003, the Australian Mental Health Outcomes and Classification Network (AMHOCN) has reviewed, collated, and reported on outcome data at a national level and undertaken a training and service development role. All public sector mental health services across Australia now routinely report outcomes and casemix data, and this is being expanded to the community and non-government sectors.

A review of outcome measures in Australian community mental health organizations, completed in 2013, revealed at least 136 different measures in use. These were across seven domains, categorized as: recovery, cognition and emotion, functioning (activities of daily living and interpersonal relationships), social inclusion, quality of life, experience of service provision, and multidimensional measures.

Measures in the domain of cognition and emotion, where 40 measures were listed, and the functioning domain, where there were 18 measures, constitute those typically used as clinical outcome measures, many of which are relevant to clinical recovery. Of interest, the AMHOCN has recently undertaken a further review of functioning measures alone, identifying 20 measures for use with adults in specialized mental health services.
Investment in this review may reflect a growing focus on functioning as an outcome of particular interest to those evaluating and funding services.\textsuperscript{31}

In the recovery domain, which was defined as “the personal process of individual recovery”, 25 measures were identified in the AMHOCN review.\textsuperscript{30} The earliest measure was published in 1995 and 19 were developed in the United States. The large number of measures highlights the diversity of views regarding the components of personal recovery. A systematic review of recovery measures similarly found 22 instruments that measured the recovery of individuals but also identified 11 that assessed the recovery orientation of services or providers.\textsuperscript{32} Williams undertook a systematic review of measures specifically developed to assess the recovery orientation of services.\textsuperscript{33} They concluded that comparisons between the measures were compromised by the very different conceptualizations of recovery that were applied and variation in the organizational level at which services were assessed. Clearly, much work still needs to be done to determine appropriate measures of recovery, but both aspects are essential to assess: individuals’ experiences of personal recovery must be a focus for routine outcome monitoring in service provision and as a service evaluation indicator; and measures of the recovery orientation of services are essential process indicators for program evaluation and quality improvement.

A new measure was developed under the Fourth National Mental Health Plan to address its first priority area of ‘social inclusion and recovery’. This was in response to calls from consumers and carers for national measures that were better aligned with recovery concepts.\textsuperscript{34} The *Living in the Community* measure is a self-report instrument that asks consumers about recovery-related aspects of life, such as social activities, and work and study. It takes a holistic approach with a focus on indicators of social inclusion. Notably, this measure mentions the lifestage of youth and includes aspects relevant to young people from the age of 16 years. However, it has not been widely implemented to date.

**Young People and Early Intervention**

A critical issue for the recovery field is the lack of attention that has been given to what recovery means for young people and for those in the earlier stages of mental illness. Almost all the recovery literature, recovery-relevant research, and the recovery measures that have been developed derive from an adult focus, and generally from a focus on those with well-established mental ill health. Yet, in Australia there has been significant attention on youth mental health and early intervention, particularly targeting those aged 12 to 25 years.\textsuperscript{35} This is in response to recognition that this is the time of life when most mental illnesses first emerge,\textsuperscript{36} and when there are major barriers to engagement with professional mental health care.\textsuperscript{37} The language of recovery is not a good fit for services to young people (or children), and child and youth services are at risk of being marginalized in current mental health reforms if the fundamental value of recovery is not translated appropriately for these sectors.

There are many reasons why recovery is incongruous for younger people, as well as for those with emerging mental illness. Young people are in a period of constant change and growth, so the notion of recovering to a previous state is not relevant. While the concept of
personal recovery means transformation rather than returning to a previous state.\(^{38}\) The term itself still implies recovery of something that was previously lost. Moreover, young people, fortunately, should not have a history of damaging and traumatic service use, which many people with long-term lived experience have a need to recover from. If the Australian mental health strategy has been at all effective, then recent and current generations of service users should not be negatively impacted by the mental health system itself, in the way that people have been in the past.

One of the few attempts to consider a recovery framework in the context of young people is a discussion paper funded by the NSW Ministry of Health.\(^{39}\) Overall, recovery and recovery-oriented practice were reported to be consistent with the principles of appropriate care for young people with mental health problems; but it was argued that special consideration was needed to ensure that such principles are implemented in ways that are developmentally and contextually appropriate, and that recovery concepts needed to be discussed in youth-friendly language. The paper concludes that the CHIME conceptualization of recovery, which incorporates the processes of connectedness, hope, and optimism about the future, identity, meaning, and empowerment and purpose, is relevant for young people, but that how these are expressed depends on age and developmental stage. It may be that the language needs to be reframed within a child, young people and early intervention context.

Of special consideration, young people have unique needs regarding awareness of their mental health status.\(^{40}\) Child and adolescent services very often prioritize a strength-based approach and avoid diagnostic labelling, which may be unreliable and inaccurate, and can be unduly stigmatizing and limiting of future options. Identity development is a central concern for adolescents, and awareness and acceptance of mental ill-health needs to be handled in a sensitive and developmentally appropriate way. Opportunities and positive growth must be the emphasis for young people, rather than a focus on accommodating and moving beyond the limitations of illness.

**Recent Reforms**

Most recently in Australia, the Federal Government has acted in response to a major review of the mental health system undertaken by the National Mental Health Commission—*Report of the National Review of Mental Health Programmes and Services*.\(^{41}\) While this review mentions recovery in several places, its strongest focus is on providing ‘person-centred care’, which means matching available resources to identified need.

A fundamental restructure of mental health service delivery has ensued. Key features of this include the provision of many mental health care services through 31 Primary Health Networks (PHNs), which are expected to be responsive to the needs of their local regions across Australia, and accountable to the Federal Government for the planning and commissioning of services. Alongside this, a stepped care approach has been initiated, which aims to match the level of service delivery received to the level of need for an individual, with an emphasis on self-help, digital mental health interventions and low intensity services for people without severe mental illness.\(^{42}\)
Australia has also initiated a *National Disability Insurance Scheme* (NDIS), which aims to provide individualized support to people with disabilities. The *Scheme* is expected to enable an integrated service delivery approach for people with psychosocial disability as a result of mental ill health, through access to funding for the coordinated delivery of eligible services. In general, in the disability sector, the *Scheme* is seen as a positive approach to person-centred support.

However, the eligibility requirement of permanent, or likely to be permanent, impairment is thought by many in the mental health sector to be ‘toxic’. An expectation of permanence is incompatible with a recovery orientation, and also lacks recognition of the often fluctuating nature of symptoms and functioning for people with recurring mental illness. Further, the *Scheme* locks out many younger people and those earlier in the developmental trajectory of mental illness—people with more unreliable diagnoses and prognoses. Notably, ineligibility rates for applicants with mental illness have been shown to be significantly higher than those from people with physical, intellectual and sensory disabilities in the pilot sites, and a number of major challenges have become evident, including apparent inequities between jurisdictions in access rates.

Since mid-2016, the NDIS is being rolled out more widely across Australia, beyond the initial pilot sites. Over time, participants in other major Federal Government schemes, such as the *Partners in Recovery* program, will be required to transition into the NDIS.

**Recovery in a Time of Change**

How the underpinning value of recovery is realized through this rapidly changing environment remains to be seen. There is a considerable way to go before the NDIS is shown to be effective at meeting the needs of people with mental ill health across the continuum of care, and how it can operate in a way that embraces and facilitates a focus on recovery, while providing timely, responsive, and ongoing support. Primary Health Networks will need to demonstrate how they prioritize a recovery orientation in their planning and commissioning. Where accountability sits and how outcomes are determined in this more regionalized, person-centred and hopefully more efficient system, requires clarification.

It has been argued that embedding a recovery focus throughout the mental health system is achieved through consumer leadership, although Happell and Roper caution that improving services must be the responsibility of all leaders, not solely consumer leaders. The central consumer movement values of empowerment, equity, and self-determination are fundamental to a recovery-oriented system, and consumer leadership has the expressed purpose of driving systemic-level change. Such leadership needs to be clearly evident within the PHNs and its scope expanded to represent the broad range of mental health service users.

Australia has decades of well-intentioned strategy and planning, and recovery is a concept that is woven throughout its many policies and plans, at a national and also at many jurisdictional levels. Current national reforms are substantial and comprise more than well-
meaning words; it is a time of change. How a personal recovery orientation fares with these changes, and particularly how person-centred care is transacted within a recovery framework, is unknown. Through national leadership but regional integration, the reforms aim to create a more responsive system that matches the type and level of care to individual needs. Careful monitoring is required to ensure that the reforms truly do improve the quality of care as it is perceived by service users and their families, across the entire spectrum of mental ill health and continuum of mental health care services.

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References


