11

Mental Health and Recovery-Oriented Mental Health Services

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KEY LEARNING OUTCOMES

When you finish this chapter you should be able to:

- identify the prevalence of mental disorder in the Australian population
- identify the major changes in the delivery of mental health services, including the role of the consumer movement
- outline the components of recovery-oriented mental health practice and services
- differentiate the key mental health professional workforce – consumer peer, carer peer and clinical
- describe the components of the Australian mental health care system.

KEY TERMS AND ABBREVIATIONS

biopsychosocial model
Community Mental Health Services (CMHS)
consumer[1]
deinstitutionalisation
emergency departments (EDs)
general practitioners (GPs)
lived experience
mental disorder
Mental Health Coordinating Council (MHCC)
National Mental Health Commission (NMHC)
National Disability Insurance Scheme (NDIS)
peer worker
personal recovery
social determinants of health (SDH)
stigma
World Health Organization (WHO)

INTRODUCTION

This chapter presents an introduction to mental health and well-being and the prevalence of mental disorders in the Australian population. It explores an overview of Australian mental health services and the major mental health reforms that shaped them, including the role of the mental health **consumer** rights movement, the *National Mental Health Strategy*, and a recovery-oriented model of mental health practice.

[1]Various terms have been adopted by people with lived experiences of mental disorder and using mental health services. These include psychiatric survivors, ex-patients, consumers, lived experience consumers, experts by experience and service users. While no single term is adequate to represent the experiences of everyone, the term 'consumer' will be used in this chapter to refer to people with lived experiences of mental distress and disorder and of using mental health services.

MENTAL HEALTH AND WELL-BEING

The **World Health Organization (WHO)** (2021) refers to mental health as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (p. 1).

The **social determinants of health (SDH)** also affect mental health, and include financial means, living conditions, working environment, long-term health conditions, access to health care, the quality of social relationships and supports, experience of violence and abuse, and geographic and climatic conditions (WHO 2021). Employment, physical activity, strong social relationships and networks, adequate diet, alcohol reduction and green space can act as protective factors (Rickwood & Thomas 2019, p. 22). The promotion of mental health is important in the prevention of mental distress and disorder.

A **mental disorder** refers to 'a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia' (Council of Australian Governments (COAG) 2017, p. 67). Worldwide there are about 284 million people affected by anxiety, 264 million affected by depression, 45 million who have bipolar disorder and 20 million people who have schizophrenia (Abate et al. 2018; WHO 2022). While there are several explanations for the genesis of mental disorders, the **biopsychosocial model** views mental disorder as the complex interactions between biological, psychological and social factors (Papadimitriou 2017). Holistic and person-centred approaches to mental health recovery are vital.

Prevalence of Mental Disorders in Australia

What is the state of Australians' mental health? For many people who experience a mental disorder, it occurs before the age of 25 years (Productivity Commission 2020), a time when young adults are undertaking work and studies, living independently and forming relationships. The *National Study of Mental Health and Wellbeing* provides some insight into the prevalence of mental disorders in Australia (Australian Bureau of Statistics (ABS) 2022). Between 2020 and 2021, over 43% of Australians aged 16–85 years reported experiencing a mental disorder at some time in their life. More than one in five people had symptoms of a mental disorder in the previous 12 months, with the most frequently experienced disorders being anxiety (16.8%), affective (mood disorders) (7.5%) and substance use (3.3%). Women were more likely than men to have an anxiety or affective disorder, while men were more likely than women to have a substance use disorder. Overall, more women than men, and younger rather than older adults, experience a mental disorder (ABS 2022).

The prevalence of psychotic disorders in the Australian population, such as schizophrenia, bipolar disorder and brief psychosis, was estimated at 4.5 per 1000 population. The prevalence for men was higher than for women in every age group (Morgan et al. 2011).

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people have higher rates of mental distress and disorders compared to non-Aboriginal and Torres Strait Islander people. When compared with non-Indigenous Australians, psychological distress was 2.3 times the rate for Aboriginal and Torres Strait Islanders, particularly for people living in non-remote areas, with 24% of Aboriginal and Torres Strait Islander people experiencing a mental disorder or behavioural condition (ABS 2019). Racism has been associated with poor mental health outcomes in Aboriginal and Torres Strait Islander people, with some evidence linking it to the development of anxiety and depression (Kairuz et al. 2021).

Pause *for* Reflection ...

Why might more women than men be diagnosed with a mental disorder? Think about the social, cultural, biological and psychological factors that could contribute to these prevalence rates.

Why might men more often than women experience substance use disorders?

How might the social determinants of health explain the higher rates of mental distress and disorders in Aboriginal and Torres Strait Islander people?

SUICIDALITY AND SUICIDE

This section of the chapter discusses suicide. Anyone can be affected by suicide, including health professionals. If the following causes you distress, the suicide and mental health support services in Table 11.1 could assist you.

Suicide can be confronting to discuss, and professional practice can involve interactions with health care consumers who are suicidal. Prevention of suicide is possible, so it is important for health professionals to capably discuss suicidality with health care consumers and those who support them.

Intentional self-harm is deliberately causing physical harm to oneself, with or without the intent to die; therefore, it includes suicide attempts and non-suicidal

Table 11.1 **Suicide and Mental Health Support Services**

Service	Telephone	Website
Lifeline	13 11 14	lifeline.org.au
Suicide Call Back Service	1300 659 467	suicidecallbackservice.org.au
Beyond Blue	1300 22 46 36	beyondblue.org.au
MensLine Australia	1300 78 99 78	mensline.org.au
Q life (LGBTIQ+)	1800 184 527	qlife.org.au
Kids Helpline	1800 55 1800	kidshelpline.com.au

self-harm (Australian Institute of Health and Welfare (AIHW) 2022a). Suicide is the act of deliberately ending one's life, and suicidality refers to thoughts about suicide, making plans for suicide, and suicide attempts (AIHW 2022a). The **Mental Health Coordinating Council (MHCC)** (2018) advises the use of the following non-stigmatising language when speaking about suicide: 'died by suicide' or 'ended their life'. When talking about attempted suicide, they advise this wording: 'an attempt to end their own life'.

Suicide is a complex phenomenon, and several psychological and socio-economic factors are associated with an increased risk for suicide; however, the presence of risk factors in any individual does not predict the future occurrence of suicide. The factors associated with a higher risk for suicide include a personal history of intentional self-harm, being male, being widowed, divorced or separated, living in a lone household, being unemployed and having a lower income (AIHW 2022a).

Prevalence of Intentional Self-Harm and Suicide

Since 2008, the rate of hospitalisation for intentional self-harm has risen, with the rate for Indigenous Australians being three times that of non-Indigenous Australians (AIHW 2022a). Between 2019 and 2020 females made up almost two-thirds of people hospitalised for intentional self-harm, with the highest rate of hospitalisations in those 15–19 years of age (AIHW 2022a). Over ten years, the suicide rate in Australia increased by 13% to 12.1 per 100,000 population, with 3139 deaths by suicide in 2020 (AIHW 2022a). Latest figures suggest that while there has been increased mental distress due to the SARS-CoV-2 pandemic, the pandemic has not been associated with a rise in suspected deaths by suicide (AIHW 2022b).

Across all age groups, the number of suicides by males was higher than for females, occurring at a ratio of approximately 3:1, and rates for Indigenous people are more than twice as high as for non-Indigenous people. Suicide is the leading cause of death among all people aged 15–44, however, males 85 years and older have the highest age-specific rate of suicide at 32.9 per 100,000, and the Northern Territory had the highest rate of all states and territories (AIHW 2022a).

Costs of Mental Disorder and Suicide

The Productivity Commission (2022, p. 9) estimated that mental disorder costs the Australian economy within the range of $200–220 billion per year, including costs of health and other services, lost productivity and economic participation and informal care by families. While the social and emotional costs are less able to be quantified, they can adversely affect individuals and those who support them, and include reduced health and well-being, distress, stigma and discrimination, social isolation, reduced participation in communities and premature death (Productivity Commission 2020, p. 151).

Suicide of any individual is a tragedy and has far-reaching effects for family, friends and the wider community, and the importance of accessible mental health and suicide prevention programs and timely support services for people who have attempted suicide cannot be overstated. It is estimated that adequate follow-up after a suicide attempt, and specific support services for Aboriginal and Torres Strait Islanders provided by Indigenous-led organisations, could reduce the number of people presenting to **emergency departments (EDs)** for a suicide attempt by 20% and decrease deaths due to suicide by 1%; that is, 35 people each year who would not die by suicide (Productivity Commission 2020, p. 22).

Pause *for* Reflection ...

How does an understanding of the psychological, social and economic risk factors for suicide contribute to its prevention and the development of effective supports and interventions?

Why do health professionals need to be aware of the prevalence of intentional self-harm and suicide?

STIGMA AND DISCRIMINATION

People living with a mental disorder can experience **stigma** and discrimination, social isolation and violation of their human rights (WHO 2021). Despite mental health reforms and campaigns to address stigma and discrimination, it continues today. Stigma is 'a negative opinion or judgment that excludes, rejects, shames or devalues a person or group of people' (COAG 2017, p. 70) that can lead to public discrimination, internalisation and self-stigma, and non-engagement with mental health services (Carrara et al. 2019; Corrigan et al. 2014; Thornicroft et al. 2007). While programs to address stigma have increased awareness and knowledge of anxiety and depression, the public's understanding of schizophrenia and bipolar disorder are limited and attitudes toward people diagnosed with these conditions are more negative (COAG 2017). But stigma is not confined to the public; stigma by health professionals also occurs and is related in part to beliefs about negative treatment and recovery outcomes (Carrara et al. 2019; Charles 2013; Economou et al. 2019). Acknowledging and actively addressing our own stigmatising attitudes and behaviours and their impact on individuals' recovery and well-being is the responsibility of all health professionals. The **National Mental Health Commission (NMHC)** (2022b) is currently developing a National Stigma and Discrimination Reduction Strategy to reduce structural and public stigma across a range of sectors, including health, social services, legal, and education and training.

DEINSTITUTIONALISATION AND COMMUNITY MENTAL HEALTH

Until the second half of the 20th century, mental health services in Australia were predominantly provided in large psychiatric hospitals or institutions. Originally referred to as asylums in the 19th century, they were often situated on large, secluded grounds, custodial in nature, and funded by governments, with the first institution operating from 1838 (Coleborne & MacKinnon 2006; Lewis & Garton 2017). The 20th century witnessed changing views, with the emerging idea of mental illness as opposed to insanity, a range of new therapies – talking therapies, therapeutic communities and psychotropic medications – and changes to legislation governing the care and control of people in psychiatric hospitals (Lewis & Garton 2017). While there were improvements in some therapeutic practices, criticisms of psychiatric services included overcrowding, abuses of human rights, injuries and death (Lewis & Garton 2017).

By the 1960s with the beginning of community psychiatry, psychiatric services in institutions were reduced. Referred to as **deinstitutionalisation**, the focus of care gradually shifted from hospitals to the community (Smith & Gridley 2006). While the early 1970s saw a rise in community mental health services, many recently discharged people were unsupported in the community (Dunlop & Pols 2022; Lewis & Garton 2017). During the 1980s, the principle of the 'least restrictive care' facilitated community mental health treatment and the establishment of community mental health centres, some with extended hours of service (Smith & Gridley 2006). In the early 1990s, the Burdekin inquiry into human rights and people with a mental illness was a damning account, identifying them as some of the most vulnerable and disadvantaged people (Human Rights and Equal Opportunity Commission (HREOC) 1993). Consequently, the last decade of the 20th century witnessed further deinstitutionalisation and the closure of many psychiatric institutions across the country (Coleborne & MacKinnon 2006).

Pause *for* Reflection ...

Why do you think the public might hold negative views and attitudes about people diagnosed with schizophrenia, bipolar and other psychotic disorders? Consider the role that popular culture plays in informing those views.

MENTAL HEALTH CONSUMER MOVEMENT: 'NOTHING ABOUT US WITHOUT US'

Historically, people diagnosed with a mental disorder had few opportunities to influence decisions about the treatment they received, or the services provided. The gross

violations of the human rights of people in psychiatric hospitals, and their subsequent discharge to unsupported communities, led to the rise of the mental health consumer movement, born from the 'ground up', by those who had direct experiences of psychiatric treatment and abuse (Dunlop & Pols 2022). In Australia, the 1980s saw the burgeoning of the mental health consumer movement, a rights-based movement informed in part by the health consumer rights movement, that viewed consumers as having rights to adequate services and choices about the services they used. Further, the term 'consumer' was considered non-stigmatising as it was not linked to a diagnosis, and it implied active participation in medical and other treatments (Dunlop & Pols 2022). The rights statement 'Nothing about us without us' that evolved from the disability rights movement in reaction to the oppression of people living with disabilities, recognition of their human rights and their knowledge of what was best for them (Charlton 1998), was adopted by mental health consumers. Today, central to decision-making about the development of mental health policy and mental health services is the inclusion of the people affected by those decisions: consumers (COAG 2017).

The development of organisations to assist people discharged from psychiatric hospitals focused on what people needed to recover, well before it was incorporated in mental health policy. Initially comprising health professionals and community members, they developed alliances with consumers to influence decision-making about mental health policy and services (Dunlop & Pols 2022; Smith & Gridley 2006). These partnerships contributed to the de-stigmatisation of people living with mental disorders, facilitated consumer advocacy and created the opportunity to affect change in the mental health system (Dunlop & Pols 2022). Many consumer advocates have leadership roles within mental health organisations and government departments, including Mary O'Hagan who was appointed as the first Executive Director of Lived Experience in the Victorian health department (Victoria Health 2021). The mental health consumer movement demonstrated that recovering from mental disorder and leading a meaningful life were achievable.

MENTAL HEALTH REFORM

National Mental Health Strategy (1992)

The *Mental Health Strategy* was established by the Australian Government to guide the development and delivery of mental health services by each of the state and territory governments (Australian Health Ministers 1992). It comprises the *National Mental Health Policy, National Mental Health Plan* (National Plan), the *Mental Health Statement of Rights and Responsibilities*, and the *National Standards for Mental Health Services.* Each of the National Plans are for a period of five years (COAG 2017).

The first *National Mental Health Policy* (1992) and the *First National Plan* (1993–98) provided the impetus for the transfer of mental health services from psychiatric institutions to the community sector, protected consumers' rights and integrated mental health services within general health services (Whiteford 1993). The reforms of the first three National Plans (1993–2008) were not without criticism, including inadequate funding of services, limited consumer advocacy and little focus on prevention of mental disorder (Rosen 2006; Whiteford et al. 2002). The current *National Mental Health Policy* was released in 2009 (Department of Health and Ageing 2009), and the National Mental Health Commission was established in 2012 (NMHC 2022a). Key to the work of the NMHC is the notion of a 'Contributing Life', which views an individual's recovery as living as fulfilling and complete a life as possible. The NMHC independently monitors and evaluates the implementation of the National Plan (NMHC 2022a).

The *Fifth National Mental Health and Suicide Prevention Plan* promotes consumer and carer participation at all levels of service design, delivery and evaluation: 'nothing about us, without us' (COAG 2017, p. 4). It focuses on services for people who experience complex mental disorders, a national approach to the prevention of suicide, particularly Aboriginal and Torres Strait Islander suicide prevention, and reduction of stigma and discrimination (COAG 2017).

Productivity Commission Inquiry 2020

The Productivity Commission, an independent research and advisory body to the federal government, recently undertook a whole-of-system and whole-of-life inquiry into mental health and social and economic participation. The cost benefits of reforming the mental health system and the subsequent improved quality of life and social participation equated to $18 billion annually, with a further benefit of $1.3 billion related to increased economic participation (Productivity Commission 2020, p. 2). The reforms prioritised five areas: prevention and early intervention for mental health issues and suicide

risk; a person-centred mental health system adaptable to changing consumer needs; access to community support services beyond the health care system; participation in education and employment; and integration of services adopting a whole-of-governments approach: federal, state and territory. Moreover, the Inquiry proposed that the NMHC lead the development of the *National Mental Health Strategy* and the next *National Mental Health Plan* (Productivity Commission 2020).

RECOVERY-ORIENTED MENTAL HEALTH SERVICES

The most recent paradigm shift in Australian mental health practice and service delivery was the implementation of a recovery-oriented model (Australian Health Ministers' Advisory Council (AHMAC) 2013). Underpinning this model is the notion of personal recovery.

Personal Recovery

Historically, mental health services have focused on clinical recovery, a term that refers to the reduction or remission of the symptoms of a mental disorder. **Personal recovery** is not restricted to symptom remission (Roosenschoon et al. 2019; Van Eck et al. 2018), and personal recovery occurs in people who have ongoing symptoms (Van Eck et al. 2018).

The concept of personal recovery originated from the consumer movement. A leader in the international mental health consumer movement, psychologist Pat Deegan described her recovery from schizophrenia as the **lived experiences** of finding a new sense of self and purpose in life despite and beyond any disabling effects of the disorder (Deegan 1988). She highlights that personal recovery – what individuals do to recover, rather than what health professionals and systems do – infers personal responsibility and control. Personal recovery is captured in the following often-quoted definition, based on consumers' lived experiences:

> *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 even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*
>
> ***(Anthony 1993, n.p.)***

A National Framework for Recovery-Oriented Practice and Services

In Australia, the *National Framework for Recovery-oriented Mental Health Services* guides recovery-oriented mental health practice in the public, private and non-government health sectors (AHMAC 2013). Uppermost are consumers' human rights of autonomy and self-determination, an environment of hope and optimism, and a person-centred, collaborative approach that is supportive of personal definitions of recovery and personal responsibility for decision-making (AHMAC 2013).

Recovery-Oriented Practice

Health professionals cannot recover individuals, but they can facilitate an environment in which recovering occurs. Supporting the mental health workforce to develop the requisite knowledge and skills, however, is essential (Meadows et al. 2019; NMHC 2022c).

Importantly, the language of recovery-oriented practitioners should convey hope and optimism (AHMA 2013). Using non-stigmatising language, such as referring to the person rather than the diagnosed mental disorder, focusing on strengths rather than deficits and conveying an expectation of recovering are necessary (Mental Health Coordinating Council (MHCC) 2018).

Many consumers have experienced trauma in their lives, and recovery-oriented practice must also be trauma-informed. Trauma-informed practices and services are cognisant of the pervasiveness of trauma in our society (Kezelman & Stavropoulos 2019). Doing no harm, asking what has happened to the person rather than what is 'wrong' with them, and working with, rather than doing to, the person are trauma-informed practices that all health professionals can adopt (Blue Knot Foundation 2021, p. 1).

Lived Experience Workforce

Instrumental to recovery-oriented services are the lived experience workforce, including the consumer peer workforce, or peer workers, and the carers of people living with a mental disorder – the carer peer workforce. **Peer workers** 'are employed to openly identify and use their lived experience of mental illness and recovery' in their support of consumers of mental health services (MHCC 2018, p. 11). Peer workers are a unique discipline employed in public mental health services and

community-managed mental health organisations (Scanlan et al. 2020). The supportive role of peer workers, and reductions in ED presentations and mental health inpatient admissions, attest to their value (Byrne et al. 2021; Productivity Commission 2020).

Pause *for* Reflection ...

The recovery movement has changed the mental health landscape in Australia. How does a biomedical approach differ from a recovery-oriented approach to mental health practice and service provision?

MENTAL HEALTH SERVICE SYSTEM

The funding and regulating of mental health services is provided by the federal, state and territory governments (APH 2019). Responsibilities of the federal government include Medicare-subsidised mental health care provided by **general practitioners (GPs)**, allied health professionals and psychiatrists, prescription medications under the Pharmaceutical Benefits Scheme and primary care from Primary Health Networks (APH 2019). The state and territory governments have responsibilities for specialised mental health in public hospitals with a mental health unit and standalone psychiatric hospitals, community mental health services and residential services (AIHW 2022b; APH 2019). They also have responsibilities for non-specialised health services in EDs of public hospitals and supported accommodation (AIHW 2022b). During 2019 and 2020, $11 billion was spent on mental health related services or 7.6% of total government health expenditure (AIHW 2022b).

Also jointly funded by the federal and state and territory governments, the **National Disability Insurance Scheme (NDIS)** supports the recovery of people living with a mental disorder who have psychosocial disabilities (NDIS 2021). The NDIS reflects a move to a market model of disability support, via individual funding packages to purchase necessary support, which can be empowering for many but not all due to various personal and program barriers (Wilson et al. 2022).

Medicare-Subsidised Services

Mental health care is integrated in general health services. Psychologists provide most services, followed by GPs, psychiatrists and other allied health professionals (AIHW 2022b). Recommendations to increase the consumer peer workforce in primary health care is warranted (Lawn et al. 2021). Better Access is a Medicare Benefits Schedule initiative available for people diagnosed with a mental disorder to receive support from health professionals, including telehealth services (Department of Health 2022).

Specialised Mental Health Facilities

Specialised mental health care is provided in a variety of health services. The majority are community mental health services (1321), followed by government and non-government residential mental health services (181), public hospitals (161) – predominantly mental health units of general hospitals – and private hospitals (68) (AIHW 2022b). Nurses comprise 50% of staff, followed by allied health professionals (20%), and medical officers, psychiatrists, and psychiatry registrars and trainees. Almost half of all specialised mental health organisations employ consumer peer workers and about a third employ carer peer workers (AIHW 2022b).

***Community mental health services* (CMHs)** are government-funded, operate in the community, and include mental health centres and hospital-based ambulatory care services, such as outpatient clinics (AIHW 2022b). The majority of people using the services have ongoing conditions and contact with health professionals of 5–15 minutes duration (AIHW 2022b).

CMHs are provided by multidisciplinary teams, offering a range of therapeutic interventions, including assessment, crisis intervention, and pharmacological, or specialist, such as early psychosis, and assertive community treatment (Williams & Smith 2019). Assertive case management with psychosocial interventions is considered superior for recovery (Lau et al. 2017). Current debate about CMHs focuses on continuity of care across inpatient and community settings and increasing the opportunities for co-designed services (Williams & Smith 2019).

Residential care services are provided by government and non-government services. The majority of people using services are 18–24 years of age and have an ongoing mental health condition. Over half of the residents used a service for two weeks or less, and 30% for 2–4 weeks (AIHW 2022b).

Pause *for* Reflection ...

What role do community mental health services play in the early intervention for people with mental health issues? Given that most community mental health contacts are of 5–15 minutes in duration, what therapeutic interventions are most likely provided? Do you think this is adequate for a recovery-oriented approach? Why or why not?

EMERGENCY DEPARTMENTS

Young adults experiencing mental distress frequently present to emergency departments (EDs) of hospitals (AIHW 2022b); however, people experiencing a mental health crisis have reported extended waiting times and care that was traumatising and unwelcoming (Allison et al. 2021; Judkins et al. 2019). Services provided in a lower stimulus setting, utilising multidisciplinary teams, inclusive of peer workers (Judkins et al. 2019), are developing throughout New South Wales. Known as Safe Havens, they are co-designed, confidential, safe, alternative services to EDs for people experiencing mental distress or suicidality, and are staffed by peer workers (NSW Health 2022; South Eastern Sydney Local Health District (SESLHD) 2022).

Another initiative is the Mental Health Acute Assessment Team, a collaboration between paramedics and mental health clinicians (Faddy et al. 2017; Queensland Cabinet & Ministerial Directory 2021). The teams assess people experiencing mental crisis and determine the most appropriate care setting, including remaining at home, rather than the automatic transfer to an ED. This initiative demonstrated a reduction in ED transfers for people without physical health concerns and increased transfers to specialist mental health services in the community (Faddy et al. 2017). Another initiative in New South Wales, the Mental Health Intervention Team, is a collaboration between NSW Health and Police NSW. It aims to facilitate access to appropriate mental health services for people who are experiencing a mental health crisis and to increase advocacy for mental health issues. This initiative demonstrated reduced community stigma related to mental distress (Police NSW n.d.).

Criticisms of specialised mental health services in Australia include resourcing issues, a reliance on ED use and inadequate community services to support people after discharge from hospital services (Allison et al. 2021; Judkins et al. 2019; Perera 2020). The provision of co-designed and adequately resourced specialist mental health and suicide support services, staffed with peer workers, is a vital component of a recovery-oriented mental health care system.

Case study 11.1 presents a young man who experiences a mental health crisis and demonstrates the use of a range of mental health services to support his recovery.

CASE STUDY 11.1 Recovery-Oriented Mental Health Services

Lachlan is a 24-year-old man who lives with his partner and a flatmate in a shared house in a large city. He recently completed a three-year TAFE qualification in electrotechnology, and he is employed as an electrician. He enjoys running, working out at the gym and socialising with his friends.

Lachlan experienced a brief episode of psychosis five years ago. At the time, he used cannabis daily, experienced some paranoid beliefs, was unable to sleep and stopped eating. He was hospitalised for three days in a mental health unit and prescribed antipsychotic medication.

After discharge from hospital, some of his friends reacted negatively and stopped contacting him. He continued taking the medication and was supported by a Community Mental Health Crisis (CMHC) team and then his GP. He stopped using cannabis regularly and gradually ceased the antipsychotic medication with his GP's support.

Three months ago, Lachlan lost his job due to a downturn in work related to the COVID-19 pandemic. He was unable to find work as an electrician, but he obtained casual employment in hospitality. A month ago, after repeated conflict, his partner ended their relationship, and he was left with the total cost of the rent for his room. His parents were supportive and assisted him financially.

Since that time, Lachlan feels anxious about his job and relationship loss. He has difficulty falling asleep and can't stop thinking about what has happened. He can't concentrate at work, and some of his colleagues have expressed a view that 'he has problems and should be let go'. He is smoking cannabis daily to cope with anxiety, and he has lost interest in socialising with his friends. His flatmate has been critical of his changed behaviour, stating that he 'should see a shrink, and take some pills'.

Lachlan told his parents that he was worried about having another psychotic episode and stated that, 'he felt nervous and sick all the time and wanted to sleep and never wake up'. His parents were concerned, and he agreed to go with them to a Safe Haven at a nearby public hospital.

CASE STUDY 11.1 Recovery-Oriented Mental Health Services—cont'd

At the Safe Haven, Lachlan was greeted warmly by peer workers, one of whom was his age and had lived experiences of suicidality and using support services. The peer worker encouraged him to talk about his previous experiences of recovering and what he wanted to happen, now. While he said he didn't want to end his life, he stated the anxiety and fear were overwhelming and he wanted that to end, and that he'd found the CMHC and his GP supportive.

With the peer worker's assistance, Lachlan telephoned the CMHC who met him later that evening. Lachlan discussed his anxiety with the team and stated that he did not want to go to hospital. The CMHC offered Lachlan twice-daily visits to support him at home over the next week, which he accepted. They also discussed the possibility of using the Better Access program.

Over the next few months, Lachlan continued to receive support from the Safe Haven, the CMHC and online mental health support groups. He and his GP developed a mental health treatment plan, which included referral to a psychologist for cognitive therapy. He agreed to the short-term use of medication for anxiety and to improve his sleep, and he has decreased his cannabis use. His parents have continued to support him while recovering, as have his close friends, and he is starting to think about working as a licensed electrician again.

Case Study Questions

1. What precipitating factors might have contributed to Lachlan's mental health crisis, and what are his strengths and some possible protective factors? Consider psychological, physical and social factors.
2. How might peer workers who are of a similar age to Lachlan assist him?
3. Why are peer workers essential for Safe Havens and other mental health and suicide support services?
4. What evidence is there of public stigma towards Lachlan?
5. How is 'Nothing about us without us' demonstrated in the case study?
6. Using examples from the case study, outline how a personal recovery-oriented approach to mental health care is demonstrated.

SUMMARY

This chapter has presented an overview of mental health, well-being and mental disorder and the development of the Australian mental health service delivery. It addressed the following key points:

- The social determinants of health affect mental health, and therefore overall health and well-being.
- The high-prevalence mental disorders in Australia include anxiety, affective and substance use disorders. The rates of these disorders are higher in Aboriginal and Torres Strait Islander people as compared to non-Aboriginal and Torres Strait Islander people.
- Professional practice can involve interactions with health care consumers who are suicidal. Prevention of suicide is possible, so it is important for health professionals to capably discuss suicidality with consumers and the people who support them.
- Mental health services in Australia were provided in psychiatric institutions until the mid-20th century. Pharmacological and psychosocial treatments, a concern for the human rights of people in psychiatric institutions and the rise of the mental health consumer movement resulted in the closure of many psychiatric hospitals and the development of community mental health services.
- Deinstitutionalisation and closure of psychiatric hospitals did not translate to adequate funding of community mental health services, resulting in inadequate support for many people discharged and reliance on families as informal carers.
- The *National Mental Health Strategy*, initiated in 1992, reformed Australian mental health care, by transferring services from institutions to mainstream health services and the community sector, and including consumers in the development and evaluation of mental health policy and services.
- The fifth *National Mental Health Plan* focuses on addressing the needs of people who experience complex mental disorders and the development of a national approach to the prevention of suicide. The establishment of the National Mental Health Commission ensures an independent evaluation of the implementation of the National Plan.
- The paradigm shift to a recovery-oriented approach has changed the focus of Australian mental health practice and service delivery. Led by the consumer

movement, the rise of personal, rather than clinical only, understandings of recovery, and the development of the lived experience/peer mental health workforce, have contributed to the expectation of living a fulfilling life and increased social and economic participation for consumers.
- Today, mental health care is predominantly provided by health professionals and peer workers in primary health care, and in specialised mental health services, such as community mental health centres, mental health units in general hospitals, and in residential settings.
- Co-designed co-delivered services are vital for a recovery-oriented mental health and suicide support system.

REVIEW QUESTIONS

1. Most people diagnosed with a mental disorder and using mental health services are younger than 25 years of age. How do the social determinants of mental health contribute to the development of mental distress and disorder in younger adults?
2. Identify two examples of each of the following types of stigma towards people living with a mental illness: personal, public/social and professional stigma.
3. How have changes to the mental health system, over the past sixty years, contributed to person-centred, recovery-oriented mental health practice and services?
4. The consumer movement has been influential in the development of mental health policy and services in Australia. How could consumers influence the practice of health professionals? Consider their influence in education, training and research.
5. What is meant by co-design and co-delivery of mental health services? What are the enablers and barriers to co-designed and co-delivered services?

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ONLINE RESOURCES

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Australian Government Department of Health and Aged Care: https://www.health.gov.au/.

Australian Institute of Health and Welfare: http://www.aihw.gov.au.

Being – Mental Health Consumers: https://being.org.au/.

Beyond Blue: https://www.beyondblue.org.au/.

Black Dog Institute: https://www.blackdoginstitute.org.au/.

Flourish Australia: https://www.flourishaustralia.org.au/.

Headspace Australia: https://www.headspace.org.au/.

Lifeline: https://www.lifeline.org.au/.

Mental Health Australia: https://mhaustralia.org/.

Mental Health Carers Australia: https://www.mentalhealthcarersaustralia.org.au/.

Mind Australia: https://www.mindaustralia.org.au/.

Mental Health Coordinating Council: https://mhcc.org.au/.

National Mental Health Commission: https://www.mentalhealthcommission.gov.au/.

National Mental Health Consumer and Carer Forum: https://nmhccf.org.au/.

One Door Mental Health: https://www.onedoor.org.au/.

SANE Australia: https://www.sane.org/.

Suicide Prevention Australia: https://www.suicidepreventionaust.org/.

World Health Organization – Mental Health: https://www.who.int/health-topics/mental-health#tab=tab_2.