

Overview of mental illness

This section provides background information on mental illness including definitions, causes, prevalence and the issue of stigma. It provides a brief overview of the National and State plans and protocols on mental health and the classifications used to diagnose mental illness.

Mental health and mental illness

The concepts of mental health and mental illness are related to the beliefs and values of the society in which the person lives. In Western society mental health is generally defined as a positive state in which people are responsible, self-directed, self-aware, reasonably worry-free and can cope with general daily chores and tensions. Three factors influence the development of mental health:

- biological factors
- psychological factors
- sociocultural factors

Biological factors include genetic predisposition, physical health, neurobiology and physiology. Psychological factors include nurturing during childhood, family interactions, intelligence, self-concept, skills, talents, creativity, emotional development level and exposure to trauma. Sociocultural factors include family stability, child rearing patterns, economic resources, housing, religious beliefs and values.

When people are mentally unwell or ill they are generally unable to carry out their normal roles in society. Mental illness may be defined as a set of behavioural or psychological responses that interfere with or inhibit a person's ability to comfortably or effectively meet their needs and function within their culture. The American Psychiatric Association's definition of mental illness (called a mental disorder) is:

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event (APA, 2000, pxxx).

Despite the number of public awareness campaigns aimed at educating the general public about mental illness, stigma remains a significant issue in the mental health sector. Stigma is experienced as social, vocational and recreational barriers in the community due to widespread ignorance and misunderstanding that reinforces shame and isolation. It is very important that workers are aware of the feelings of shame and isolation people with mental illness can feel and thus the reluctance they may have in discussing their difficulties.

Prevalance

The World Health Organisation (2001) note that internationally mental and behavioural health disorders are common, affecting more than 25% of people at some time during their lives. It is also estimated that by 2020 depression alone will constitute one of the largest health problems worldwide (Murray & Lopez 1996).

Estimates confirm that mental disorders are also the leading cause of disability burden in Australia. In 1996 mental disorders were responsible for nearly 30% of the non-fatal disease burden with depression the top-ranking cause (Mathers, Vos, Stevenson and Begg, 2000). Three million Australians will experience a major depressive illness during their lifetime (National Media and Mental Health Group, 2004).

Adults who lived in the most socioeconomically disadvantaged areas experience a higher prevalence of mental or behavioural problems (16%) compared with people who live in the least socioeconomically disadvantaged areas (9%).

In Australia the 2004-5 National Health Survey (ABS, 2006) showed that the prevalence of mental or behavioural problems generally increased with age until the 35-44 year age group then declined in people aged 75 years and over. Females were more likely than males to report a long-term mental or behavioural problem and were also more likely to report high/very high levels of psychological distress than men. However men are at greater risk of suicide, particularly among young men and rural populations.

Specifically in NSW, a snapshot of mental health conducted by NSW Health (2006a) showed that approximately 1.1 million people experienced a mental illness in 2005/6. In 2004-5 mental health units in NSW provided approximately 26,000 overnight admissions and community mental health services provided 2.3 million interventions.

Mental health plans and protocols

National action plan on mental health 2006-2011

The Council of Australian Governments (COAG) agreed to a five-year National Action Plan on Mental Health following its meeting in February 2006. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers. This is in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community. Each jurisdiction is undertaking different actions as part of an Individual Implementation Plan.

To see the National Action Plan on Mental Health 2006-2011 and the Individual Implementation Plan on Mental Health - New South Wales, go to:

- http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf

National mental health plan 2003 - 2008

The current National Mental Health Plan is an ongoing agenda for services and the community. It is the third plan, the first of which was published in 1992 as an initial attempt to coordinate mental health care reform nationally. The broad aims of the plans have been to:

- promote the mental health of the Australian community
- where possible, prevent the development of mental disorder
- reduce the impact of mental disorder on individuals, families and the community
- assure the rights of people with mental disorder.

The principles underpinning the plan are:

- All people in need of mental health care should have access to timely and effective services, irrespective of where they live
- The rights of consumers, their families and carers must shape reform
- Mental health care should be responsive to the continuing and differing needs of consumers, families and carers, and communities
- The quality and safety of mental health care must be ensured
- A recovery orientation should drive service delivery
- Investment in the workforce is essential
- Innovation must be strongly encouraged and supported
- Sustainability of effective interventions must be ensured
- Resources for mental health must recognise the impacts of mental health problems and mental illness
- Mental health reforms must occur in concert with other developments in the broader health sector
- Mental health reforms require a whole-of-government approach.

The four priority themes for this plan are:

1. Promoting mental health and preventing mental health problems and mental illness
2. Increasing service responsiveness
3. Strengthening quality
4. Fostering research, innovation and sustainability.

National standards for mental health services

The National Standards for Mental Health Services document was produced to provide standards for mental health services across Australia. The guiding principles for the standards are:

- the promotion of optimal quality of life for people with mental disorders and/or mental health problems
- a focus on consumers and the achievement of positive outcomes for them
- an approach to consumers and carers that recognises their unique physical, emotional, social, cultural and spiritual dimensions
- the recognition of the human rights of people with mental disorders as proclaimed by the United Nation's Principles on the Protection of People with Mental Illness and the Australian Health Minister's Mental Health Statement of Rights and Responsibilities
- equitable access to appropriate mental health services when and where they are needed
- community participation in mental health service development
- informed decision making by individuals about their treatment
- continuity of care through the development of intersectoral links between mental health services and other organisations
- a mental health system that emphasises comprehensive, coordinated and individualised care
- accountability to consumers, carers, staff, funders and the community

- adequate resourcing of the mental health system
- equally valuing the various models and components of mental health care.

— AHMAC National Mental Health Working Group (1996).

To view the National mental health plans and protocols go to:

- <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>

NSW – a new direction for mental health 2006 - 2010

This document outlines a five year programme of additional expenditure on new and existing initiatives across a range of key focus areas in NSW:

- Promotion, prevention and early intervention
- Integrating and improving the care system
- Participation in the community and employment, including accommodation
- Increasing workforce capacity

NSW Mental Health Act

The Mental Health Act establishes the legislative framework within which care, control and treatment can be provided for people with a mental illness in NSW. The Act acknowledges that although people with mental illness need to have the same rights as everyone else in NSW, there are times in which mental illness results in behaviour that leads to those rights being curtailed. The Act sets out the circumstances in which these rights can be curtailed and ensures that the interference to the client's rights is kept to a minimum.

The Act makes provisions for the care of people who:

- are admitted to hospital voluntarily
- are admitted to or detained in hospital against their wishes
- are required to receive treatment in the community
- have committed an offence and are mentally ill (i.e. forensic clients).

The Mental Health Act lists a number of ways in which an involuntary admission to hospital can be initiated:

1. A medical practitioner (or in regional areas an accredited mental health practitioner) completes a particular form, this is called Schedule 2
2. Police can take a person appearing to be at risk of causing themselves serious bodily harm to hospital
3. (In remote areas only) a request by a relative or friend, along with a written request by a medical superintendent of the hospital
4. An order of the court
5. An accredited person or welfare officer
6. A magistrate can authorise a doctor with backup from the police to schedule a person (this is rarely used).

Clients may be placed on a Temporary Order for up to three months or a Community Order (either a Community Treatment Order or Community Counselling Order).

The Mental Health Review Tribunal has the following responsibilities under the Act:

- Renewing and approving Community Orders
- Looking into the care of voluntary clients who have been hospitalised for a year
- Accessing applications for Electro-Convulsive Therapy (ECT).

The Mental Health Act is currently being reviewed. Due to its complexity it is advisable to access more detailed information from the local Area Mental Health Services regarding the application of the Act in each area. Information about the Mental Health Review Tribunal can also be accessed at <http://www.mhrt.nsw.gov.au/>

To view the NSW Health mental health publications go to:

- <http://www.health.nsw.gov.au/pubs/>

Classifications of mental illness

This section contains background information to the different classifications of mental illness including anxiety, mood, psychotic and personality disorders. Each of these classifications is examined in detail including the criteria mental health professionals use to assess these illnesses in clients.

Classification is vital to the correct treatment of mental illness although there is the possible misuse of diagnostic labels and the stereotyping of individuals. Classification was developed within the field of psychiatry and is used to group various disorders on the basis of their similarities and differences. It is important because it:

- makes for effective communication between mental health professionals, clients and families
- provides a framework for the study of the mental illness, which provides information to clients and families on what to expect
- allows for prediction of the effects of treatment and helps clients to understand why one treatment is chosen over another
- facilitates scientific research into possible causes of psychiatric disorders and their treatment.

Disorders are described as a mixture of signs (what is objectively visible about the client, e.g. muscle tremor) and symptoms (what the client describes, e.g. flat mood). The combination of signs and symptoms is called a syndrome. If a particular cluster of symptoms and signs occur regularly and show a distinct pattern of progression and response to treatment then this syndrome is called a disorder.

There are two main classification systems.

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association (APA) and is in its fourth edition, text revised (DSM-IV-TR). It uses the term mental disorders rather than mental illness. The DSM is the classification system predominantly used within NSW and thus is the system which is utilised and cited within this document. The second system is the *International Classification of Diseases and Related Health Problems* published by the World Health Organisation and is in its tenth edition (ICD-10). It groups disorders into neurotic disorders (anxiety and depression) and psychotic disorders (the schizophrenic spectrum).

Both systems classify people as being mentally unwell by listing a variety of signs and symptoms called criteria. A certain number of criteria needs to be met within a certain time frame for the person to be diagnosed as having a disorder. There are exclusion criteria related to each category which preclude diagnosis as they are deemed as possibly causing the signs and symptoms instead of the disorder. Preclusion criteria include the person having a medical condition or substance use issue.

Only a qualified medical practitioner can make a clinical diagnosis. It is therefore unethical for non-trained workers to use the diagnoses in clinical notes unless they have received written confirmation of diagnosis from someone qualified to make such a diagnosis. Instead, generic workers are encouraged to note signs and symptoms without labelling the client as having a specific disorder.

Anxiety disorders

Having an anxiety disorder is not just a matter of being too anxious. Anxiety is considered a disorder when a person's symptoms of fear or worrying are grossly disproportionate to reality. The symptoms restrict and hamper the person's normal life, don't lessen with reassurance and may be accompanied by thoughts and actions that are exaggerated.

There are many anxiety disorders described in the DSM. Common to most anxiety disorders are:

- Panic symptoms or "attacks" such as shortness of breath, hyperventilation, heart palpitations or chest tightness, light headedness, sweating, shaking, nausea and/or vomiting. Panic attacks, although common amongst many of the anxiety disorders, are not a specific mental illness
- Fearfulness, distress, agitation, restlessness and/or sleep disturbance.

Please note the following regarding how mental health services would diagnose anxiety disorders:

- general medical conditions, intoxication with or withdrawal from drugs or alcohol precludes diagnosis
- anxiety or worry related to another disorder precludes diagnosis
- significant distress or impairment of the person experiencing the symptoms is required for a diagnosis.

Table 3.1 Symptoms of anxiety disorders

Anxiety Disorder	Symptoms
Generalised Anxiety Disorder	Excessive anxiety or worry felt for at least 6 months that is difficult to control and focuses on a number of events or activities. Symptoms include feeling restless, fatigue, difficulty concentrating, irritability, muscle tension and sleeping problems
Obsessive Compulsive Disorder (OCD)	OCD is made up of either (and sometimes both) obsessions or compulsions. Obsessions are recurrent, persistent, intrusive and inappropriate thoughts, impulses or images. Compulsions are repetitive behaviours acted out in response to an obsession. The person recognises that his/her obsessions and/or compulsions are excessive and they cause distress or anxiety, are time consuming or interfere with the person's normal routine
Panic Disorder (with or without Agoraphobia)	This disorder involves the person having unexpected panic attacks followed by persistent concern or worry about having and the implications of having another attack. As a result the person changes their behaviour in relation to the attacks. Panic disorder is sometimes accompanied by agoraphobia which involves having anxiety about being in places or situations from which escape might be difficult or embarrassing or in which help may not be available. Symptoms involve the person avoiding such situations, or if such situations are endured there is considerable distress or anxiety, or a need for a companion
Social Phobia	Social phobia involves a marked and persistent fear of social or performance situations, exposure to unfamiliar people, possible scrutiny of others or fear of acting in a way that will be humiliating or embarrassing. Exposure to these things causes anxiety and/or panic attacks and hence the person usually avoids the situations. The avoidance may make this disorder appear to be agoraphobia but the feared event differs
Specific Phobia	This phobia is related to marked, persistent and excessive fear of a specific object or situation causing immediate anxiety and/or panic attacks. Phobic cues may include animals; blood, injury or injections; situations involving the natural environment such as heights or storms; or other specific situations such as aeroplanes, lifts or enclosed spaces
Post Traumatic Stress Disorder	PTSD results from the person having experienced a traumatic event where they perceived they (or others) are in threat of loss of life or physical integrity leading to intense fear, helplessness or horror. Following the event, for at least one month, the person re-experiences the event in ways such as having dreams or recollections that increase arousal (e.g. causing sleep problems, anxiety, anger, difficulty concentrating, hypervigilance). The person thus avoids situations reminding them of the event or may become numb
Acute Stress Disorder	This disorder is similar to PTSD but lasts for less than a month

Mood disorders

The Mood disorders, sometimes called the affective disorders, are characterised by a disturbance in mood. The most common in Australia is depression and is frequently seen in clients with chronic problems such as illness, pain or disability. A recent study from the National Drug and Alcohol Research Centre (NDARC) showed that of heroin users entering treatment one in four had current major depression.

The word 'depression' is now used regularly by many people, often to describe sadness or feeling 'flat'. Depression in terms of a disorder involves more severe symptoms:

- Psychological symptoms such as feeling worthless, hopeless, distress, lacking motivation and/or loss of interest in what was previously interesting and being withdrawn
- Physical symptoms such as fatigue, sleep disturbance, headaches, gastro-intestinal disturbances, aches and pains, loss of appetite and weight loss
- Suicidal ideation or thoughts of self-harm

The mood disorders involve having 'episodes' of dysfunction. Episodes themselves are not diagnosable mental illnesses. They are included to aid understanding of the disorders.

Table 3.2 Symptoms of mood disorders

Anxiety Disorder	Symptoms
Major Depressive Episode	Involves at least a two week period in which the person regularly (nearly every day) experiences some of the following: a depressed mood, loss of interest or enjoyment in activities, change in weight and appetite, sleeping problems, fatigue, feelings of worthlessness or inappropriate guilt, difficulty concentrating and/or recurrent suicidal ideation, attempts or plans
Manic Episode	Involves at least one week of abnormally or persistently elevated, expansive or irritable mood where the person experiences some of the following: inflated self-esteem; decreased need for sleep; increased talkativeness, distractability and/or agitation; racing thoughts and/or excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. buying sprees, sexual indiscretions)
Mixed Episode	In a mixed episode criteria are met for both a manic episode and major depressive episode for at least one week
Hypomanic Episode	A hypomanic episode is the same as a manic episode but can be noted after four days but unlike a manic episode does not require the episode to be severe enough to cause impairment in social or occupational functioning

Each of the mood disorders are listed separately and are split into depressive (unipolar) disorders and bipolar (a mixture of episode types) disorders. Please note the following regarding how mental health services would diagnose these disorders:

- general medical conditions, intoxication with or withdrawal from drugs or alcohol precludes diagnosis
- mood changes related to another disorder precludes diagnosis
- significant distress or impairment of the person experiencing the symptoms is required for a diagnosis.

Table 3.3 Symptoms of depressive disorders

Depressive Disorder	Symptoms
Major Depressive Disorder	Is characterised by one or more major depressive episode/s
Dysthymic Disorder	Dysthymic disorder is a milder more persistent form of depression which is diagnosed after the person has experienced symptoms for at least two years. It can not be diagnosed if any episodes have occurred

Table 3.4 Symptoms of bipolar disorders

Bipolar Disorder	Symptoms
Bipolar I Disorder	Bipolar I disorder is characterised by one or more manic or mixed episodes. Often the individual has also had one or more major depressive episodes
Bipolar II Disorder	Bipolar II disorder is characterised by one or more major depressive episodes with at least one hypomanic episode. The presence of a manic or mixed episode precludes diagnosis of this disorder
Cyclothymic Disorder	Cyclothymic disorder is a chronic (at least two years) fluctuating mood disturbance involving numerous periods of hypomanic and depressive symptoms. The presence of symptoms that meet major depressive, manic or mixed episodes precludes diagnosis of this disorder

Psychotic disorders

The term psychosis refers to the inability to distinguish external reality from internal fantasy. The psychotic disorders are characterised by distortions of thinking and perception, a disorganisation of thought and behaviour, cognitive impairment, disturbances in communication and social and functional impairment. It is usual for people with these disorders to have a sense of being a unique, self-directed individual however they also lack insight and thus may not realise that there is anything wrong with their mental state or behaviour.

The most common of the psychotic disorders is schizophrenia. The symptoms of schizophrenia are grouped within two types: positive and negative. Positive symptoms reflect an excess or distortion of normal functioning and include:

- hallucinations (seeing, hearing, smelling, sensing or tasting things that others can't)
- delusions (false beliefs involving the misinterpretation of perceptions or experiences and may involve persecutory, religious or grandiose themes)

- disorganised speech (not staying on the topic; tangentiality; incomprehensible or thought disturbances such as the person believing that thoughts are being inserted into or withdrawn from the mind or are being broadcast to others)
- motor manifestations such as grossly disorganised behaviour (can include agitation, silliness, difficulty in performing activities of daily living) or catatonia (decreased reactivity to the environment sometimes to the extreme of complete unawareness, maintaining a rigid or inappropriate posture).

Negative symptoms reflect a loss of normal functioning and include:

- avolition (restricted initiation of goal-directed behaviour)
- flat affect (restricted range and intensity of emotional expression)
- alogia (restricted fluency and productivity of thought and speech)
- anhedonia (loss of interest or pleasure).

Schizophrenia has been conceptualised as occurring in three phases:

1. **Prodromal phase** which is often described as 'something is not quite right'. This phase includes subtle changes characterised by general loss of interest; depressed mood; avoidance of social interactions; avoidance of work or study; anxiety, irritability or oversensitivity and odd beliefs and behaviours (such as superstitiousness). These symptoms can be hard to distinguish from normal adolescent behaviour. The prodrome phase does not occur in all people, when it does occur its length is extremely variable.
2. **Acute phase** is when the person experiences positive symptoms along with strong feelings such as distress, anxiety, depression and fear. Risk of suicide increases at this stage, especially during the early years of the disorder. Without treatment this stage may resolve spontaneously or may continue indefinitely, with treatment the symptoms are usually brought under control.

3. **Residual phase** is the period where symptoms are reduced, although they may still be experienced with less severity than in the previous stage. There is significant variability in this phase between one person and the next: some will function well while others will remain considerably impaired.

The latter two phases frequently cycle with repeated acute episodes of illness interspersed by periods of residual negative symptoms of varying degrees of severity. While full remissions from schizophrenia do occur, the majority of people have at least some residual symptoms of varying severity. It is important to recognise that people may be well functioning between episodes although they may have some residual negative symptoms.

Table 3.5 Symptoms of psychotic disorders

Anxiety Disorder	Symptoms
Schizophrenia	A mixture of positive and negative symptoms <i>most of the time</i> for at least one month (shorter if successfully treated) with some signs of the disorder for at least six months. These signs and symptoms are associated with marked social or occupational functioning
Schizophreniform Disorder	Characterised by a symptomatic presentation that is equivalent to except its duration is limited to less than six months and it is not necessary to have a decline in social or occupational functioning
Schizoaffective Disorder	A disturbance involving acute symptoms of schizophrenia along side a mood episode (depression, mania or a mixture of the two). This disorder may thus be divided into two types: bipolar (mania or mixed episode) and unipolar (depressive episode)
Delusional Disorder	Characterised by at least a month of non bizarre delusions. There is a relative absence of hallucinations or other positive symptoms of schizophrenia
Brief Psychotic Disorder	A disturbance when positive psychotic symptoms are present for less than a month
Shared Psychotic Disorder	Develops in an individual who is influenced by someone else who already has a psychotic disorder with prominent delusions of a similar content

Personality disorders

Generally people with personality disorders seem to be different from the “norm” in the way that they relate to others, moderate their behaviour and emotions and the way they think about the world. The personality disorders involve deeply ingrained and enduring patterns of behaviour manifested as inflexible responses to a wide range of social and personal situations. It is common for people with personality disorders to present with the following symptomatology:

- Inflexible, maladaptive responses to stressful circumstances
- Significant impairments in loving, working and relating
- Impulsivity in most areas of their lives
- Difficulty in accommodating other people’s needs
- Difficulty in accepting responsibility for their own behaviour
- A history of pervasive and persistent anger and resentment
- Concrete thought processes
- A belief in personal uniqueness, deserving special attention and consideration
- Tendency to misperceive feelings as facts or realities
- A pervasive sense of boredom, nothingness or emptiness
- Lack of problem solving ability
- Hypersensitivity to perceived put downs, persistent fear of being discovered as worthless or a nobody.

To be diagnosed with a personality disorder using the DSM-IV-TR the client must have a pervasive and enduring pattern of inner experience and behaviour that deviates from the expectations of the individual’s culture. This pattern must lead to distress or impairment and be stable and of long duration, with onset traced back to at least adolescence or early adulthood. Personality disorders tend to develop in adolescence or early adulthood and are generally lifelong.

It is important to note that even though many individuals may display the traits listed above it is only when these traits are inflexible, maladaptive, persistent and cause significant functional impairment or subjective distress that they constitute a personality disorder. For a formal diagnosis to be made, specific criteria must be met and an evaluation of the individual’s long-term patterns of functioning must be undertaken.

The personality disorders are grouped into three clusters. People with cluster A personality disorders often appear to be odd or eccentric, have significant impairment but relatively infrequently seek out help.

People with cluster B personality disorders tend to be dramatic, emotional and erratic and are generally significantly impaired and of considerable concern to health care providers. Of all the personality disorders people with cluster B disorders are the ones that most commonly present to services.

People with cluster C personality disorders tend to be anxious and fearful and are generally less impaired than cluster B.

Table 3.6 Symptoms of personality disorders

Cluster A Disorders	Symptoms
Paranoid Personality Disorder	Is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent
Schizoid Personality Disorder	Is a pattern of detachment from social relationships and a restricted range of emotional expression
Schizotypal Personality Disorder	Is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions and eccentricities of behaviour
Cluster B Disorders	Symptoms
Antisocial Personality Disorder	Is a pattern of disregard for and violation of the rights of others. They are aggressive, unlawful and impulsive
Borderline Personality Disorder	Is a pattern of instability in interpersonal relationships, self-image and feeling states with marked impulsivity and chaoticness
Histrionic Personality Disorder	Is a pattern of excessive emotionality including being dramatic, attention seeking and seductive
Narcissistic Personality Disorder	Is a pattern of grandiosity and self-centredness and thus lacking empathy for others
Cluster C Disorders	Symptoms
Avoidant Personality Disorder	Is a pattern of social inhibition with feelings of inadequacy and hypersensitivity to negative evaluation. They tend to be needy but scared of relationships. There is some debate that this is a form of long-term social phobia
Dependent Personality Disorder	Is a pattern of submissive and clinging behaviour related to an excessive need to be taken care of. They tend to be indecisive and fear abandonment
Obsessive-Compulsive Personality Disorder	Is a pattern of preoccupation with orderliness, perfectionism and control, thus they are rigid and inefficient