4 MENTAL HEALTH PROFILE

4.1 Diagnostic profile

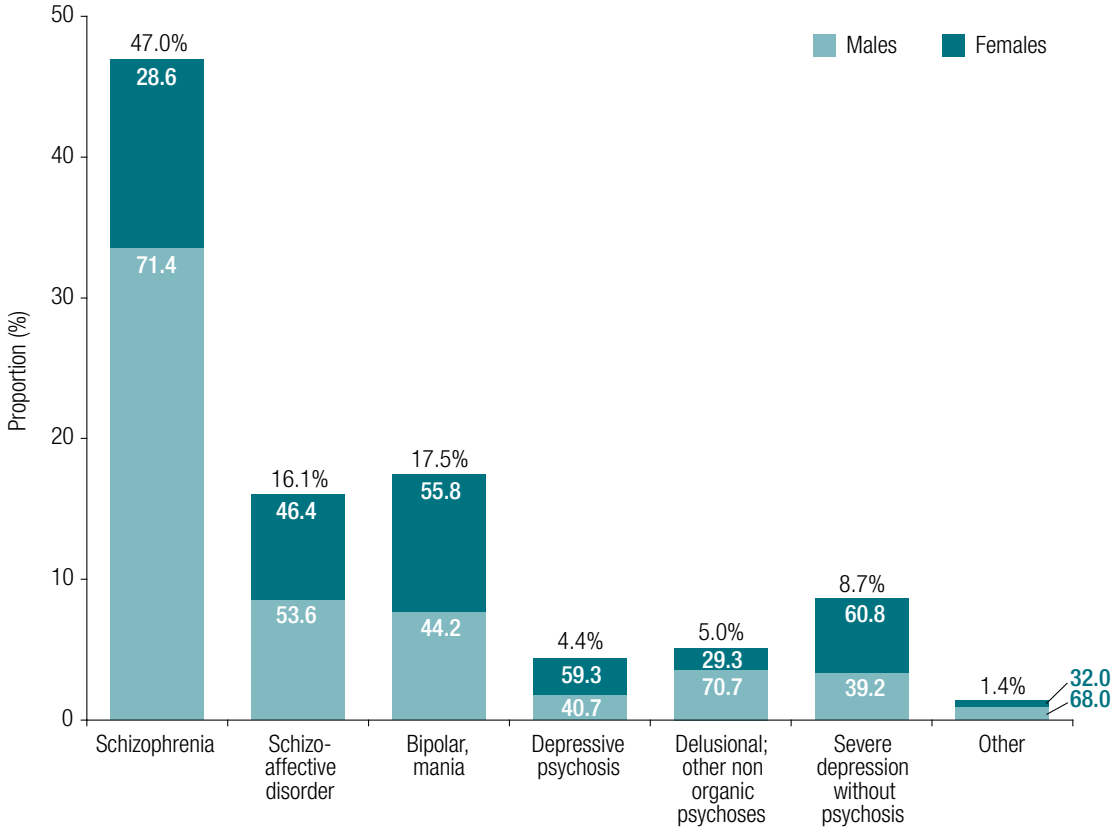
Psychotic illness covers a range of disorders of which schizophrenia is the most prevalent. At interview, 90.0% of the 1,825 screen positive participants randomly selected for interview and assessment were confirmed as meeting full ICD-10 criteria for a psychotic disorder. Almost half of the sample had a diagnosis of schizophrenia (47.0%) and 16.1% had a schizoaffective disorder.

In addition, 17.5% were diagnosed with a bipolar disorder or mania and 4.4% had a depressive psychosis.

A further 8.7% met diagnostic criteria for a severe depression without psychosis. Despite not meeting full criteria for psychosis, two-thirds of these had a lifetime history of psychotic symptoms of hallucinations, delusions or subjective thought disorder (the belief that another's thoughts have been inserted into one's own mind or that one's own thoughts have been inserted into another's mind).

A small proportion, 1.4%, did not meet full diagnostic criteria for diagnoses within the range of interest, despite meeting sufficient criteria before the interview to be rated as screen positive for psychosis (Figure 4-1).

Figure 4-1. ICD-10 lifetime diagnosis by sex



4.2 Age at onset of psychotic illness

The data from the survey provide further evidence that for the majority of people the onset of psychotic disorders is in late teens or early adulthood. The onset of illness has been determined in the survey as the point at which people first experience symptoms that cause distress, impair function or result in medical attention being sought. For many, these will be the more common symptoms of delusions and hallucinations.

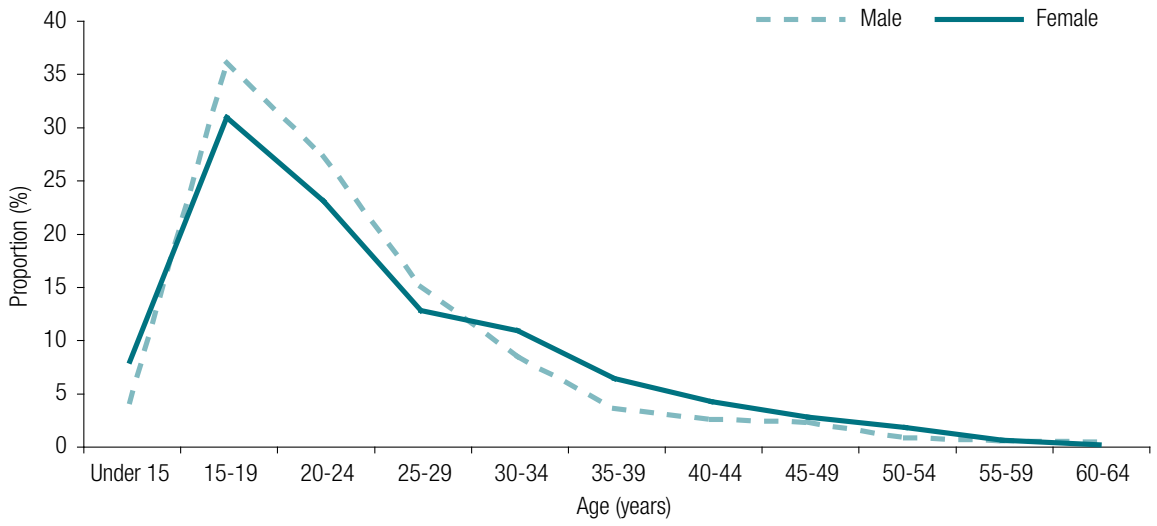
In two thirds of cases (64.8%), onset of illness was before the age of 25 years, with two-fifths (39.4%) first showing psychotic symptoms in their teenage years, that is under the age of 20 years. However, for one third of people (32.3% of males and 38.2% of females), onset was on or after the age of 25 years (Table 4-1 and Figure 4-2).

Table 4-1. Age at onset

	Proportion (%)		
Age (years)	**Males**	**Females**	**Persons**
Under 25 years	67.0	61.5	64.8
25-34	23.1	23.3	23.2
35-64	9.2	14.9	11.5
Not available	0.7	0.3	0.5
Total respondents	**1,087**	**738**	**1,825**

Age of onset was on average 23 years for males and 24 years for females.

Figure 4-2. Age at onset by sex



4.3 Type of onset

For most people (71.3%), onset was considered either gradual, between one and six months in duration (29.1%), or insidious, that is, over a period of more than six months (42.2%). For a smaller proportion, onset was moderately acute, extending between a week to a month (12.6%), acute, taking place over a week (7.2%), or abrupt, within hours or days (8.3%).

Table 4-2. Type of onset

Type	Proportion (%)
Insidious (over six months)	42.2
Gradual (one to six months)	29.1
Moderately acute (one week to one month)	12.6
Acute (within one week)	7.2
Abrupt (within hours or days)	8.3
Missing	0.6
Total respondents	**1,825**

Two thirds (62.8%) of people said that they had experienced a specific life stressor, such as death of a family member or being a victim of crime, in the year prior to the onset of their first episode of illness.

4.4 Family background and developmental history

Over half the participants (58.1%) had a first or second degree relative, that is, an immediate family member or an aunt, uncle, niece, nephew or grandparent, with a history of mental illness. Just over one quarter (27.1%) reported a family history of schizophrenia.

One in ten (11.5%) people reported delayed developmental milestones, that is, delays in starting to walk or talk.

Almost three out of five (57.2%) said they had experienced distressing or traumatic events in childhood, with 16.1% of the total sample reporting that they had been sexually abused in childhood.

4.5 Course of illness

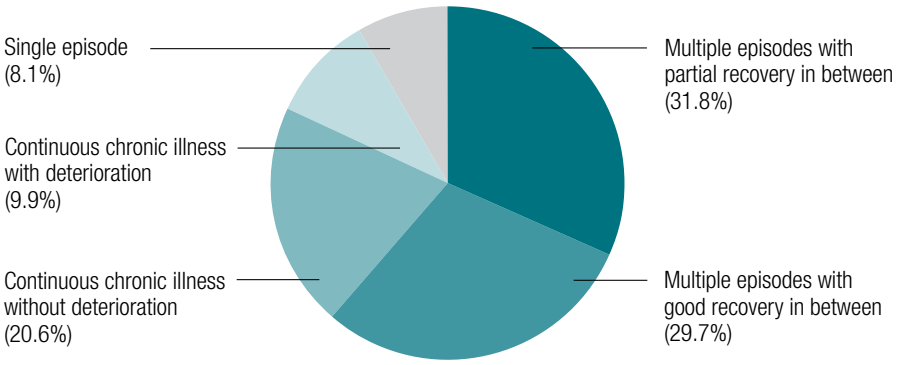
Course of illness was assessed and rated by the interviewers who had professional mental health backgrounds and who based their judgements on participant responses throughout the course of the semi-structured diagnostic interview. It refers to the number of episodes of mental illness that a person experiences and the degree of recovery after each episode.

At the time of interview, 8.1% of people had experienced just a single episode of psychosis with good recovery. While a proportion of these may remain symptom free with treatment, for others this episode will be the start of a more enduring illness.

Three-fifths (61.5%) had multiple episodes of psychotic symptoms, with full or partial remission of symptoms in between. Roughly half of this group (29.7%) experienced virtually no impairment in between the episodes, while the other half (31.8%) reported ongoing symptoms and impairment in between episodes.

One in three (30.5%) had a continuous chronic course of illness with persistent symptoms. For some (9.9%) there was no remission and increasing levels of impairment in their course of illness (Figure 4-3).

Figure 4-3. Course of illness



4.6 Symptom profile

Psychotic disorders are a diverse group of illnesses that impact on aspects of brain functioning involved in thinking, perception, emotion and communication. Two prominent symptoms are:

- Delusions (incorrect beliefs out of keeping with shared beliefs and values in the culture); and
- Hallucinations (perceptions without stimuli, for example, hearing voices).

People with psychotic illness also experience a range of other symptoms including:

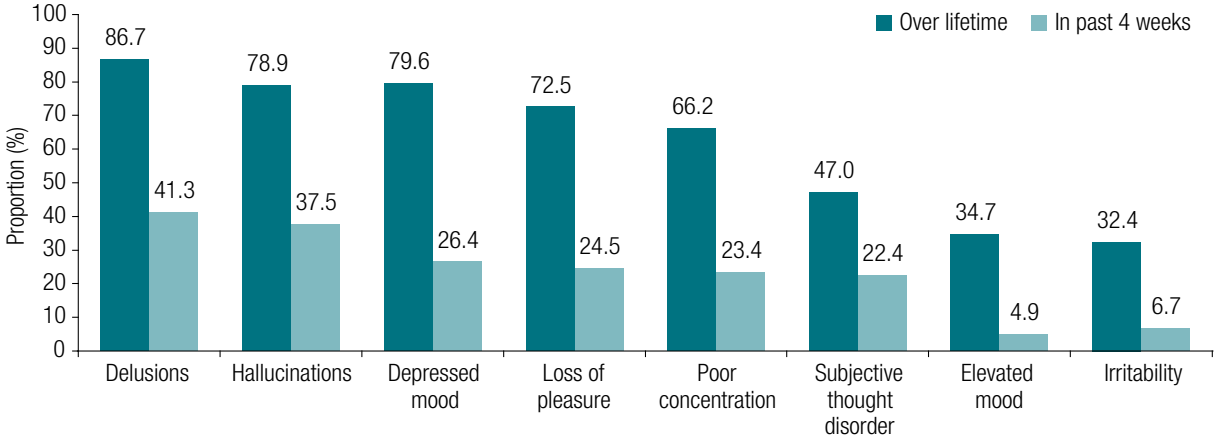
- Depression and elevated mood
- Lack of motivation and planning ability
- Subjective thought disorder – the abnormal experience of having thoughts that are not their own, of thoughts being inserted into their mind by some external agency, their own thoughts being directly accessible to others or thoughts being extracted from their mind.
- Disorganised communication – difficulty in understanding other people, in pursuing a logical train of thought and in expressing thoughts and feelings in speech and 'body language'.

The current and lifetime profiles of some of the key symptoms of psychotic illness are provided in Figure 4-4.

The majority of people had experienced at some time delusions (86.7%) and hallucinations (78.9%), as well as key symptoms of depression including depressed mood (79.6%) and loss of pleasure (72.5%). Two thirds (66.2%) reported poor concentration, one half had experienced subjective thought disorder (47.0%) while one third of people reported they had experienced elevated mood (34.7%) and one third pervasive irritability (32.4%).

The current symptom profile was also dominated by delusions (41.3%) and hallucinations (37.5%). In addition, depressed mood, loss of pleasure, poor concentration and subjective thought disorder were each reported as being experienced in the past four weeks by one quarter of participants (26.4%, 24.5%, 23.4% and 22.4% respectively). Smaller proportions were currently experiencing elevated mood (4.9%) and pervasive irritability (6.7%).

Figure 4-4. Key symptoms of psychotic disorders over lifetime and in past four weeks



For one quarter (23.9%) the experience of psychotic symptoms was accompanied by a sense of reality so compelling that it resulted in poor insight into the abnormal nature of what they were experiencing.

4.7 Other psychiatric comorbidity

Symptoms of depression and anxiety, which are commonly experienced by the general population, are also common among people with psychosis. Overall, 59.8% of participants reported symptoms of anxiety in the past year and just over half (54.5%) reported one or more symptoms of depression (Figure 4-5).

So-called negative (or deficit) symptoms are also common in psychotic illness. These include a diminished sense of purpose, loss of motivation and interest in the things around them, diminished emotional range or a reduction in the variety or intensity of emotions expressed, restricted affect indicated by reduced facial and vocal expression, poverty of speech, and impairment in socialising. Four-fifths (85.2%) of participants reported at least one negative symptom over the past year, or were observed to have restricted affect or poverty of speech at the time of interview. Two thirds (63.2%) reported dysfunction in socialising. Almost one-quarter (22.0%) of people were experiencing five to six different types of negative symptoms.

Figure 4-5. Other symptoms in the past year