

Understanding MENTAL ILLNESSES



Understanding Mental Illnesses

for Middle / Senior Secondary
Health / Psychology

mind
matters
2005



MindMatters is funded by the Commonwealth Department of Health and Ageing under the National Mental Health Strategy and the National Suicide Prevention Strategy.

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CommunityMatters: Working with Diversity for Wellbeing

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Galen College (Vic)

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ISBN 0642415285

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Design and layout by Education Image Pty Ltd.

Printed by G.T. Graphics Pty Ltd.

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Reprinted with amendments 2002

Reprinted 2005, 2007

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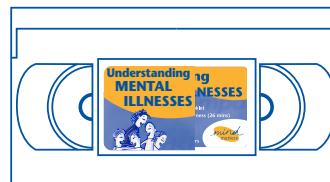
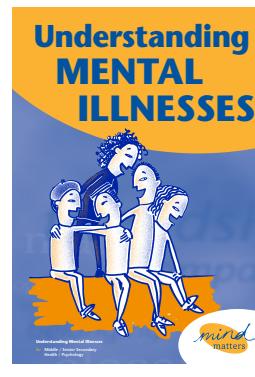
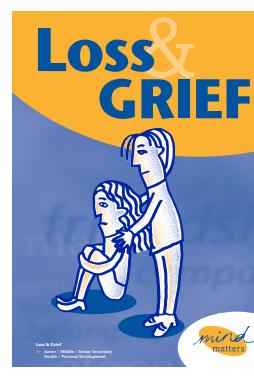
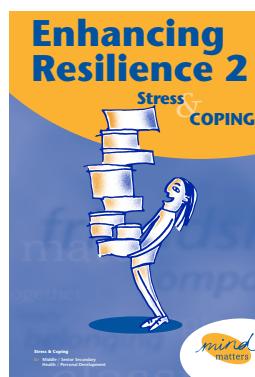
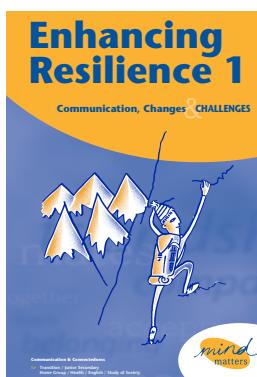
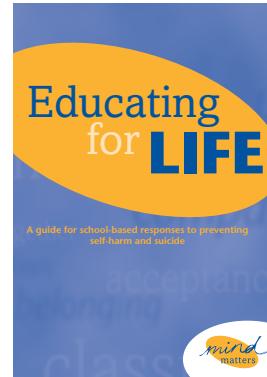
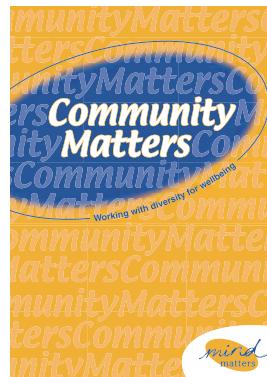
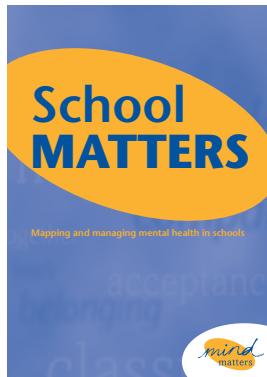
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Use this booklet in conjunction with *CommunityMatters*, which gives a cultural and social context to issues of mental health promotion and mental illness.

The MindMatters materials



This booklet is part of MindMatters: a mental health promotion resource for secondary schools. It is best used as part of a comprehensive whole school approach to the promotion of mental health as outlined in the SchoolMatters booklet.

MindMatters resources

SchoolMatters: Mapping and Managing Mental Health in Schools

This overarching document provides schools with a framework and planning tools to assist them with possible structures, strategies, partnerships and curriculum programs to promote and protect the mental health of all members of the school community.

CommunityMatters: Working with Diversity for Wellbeing

This booklet explores community, culture and identity and suggests strategies for managing the wellbeing needs of diverse groups of students, particularly those who feel marginalised for social reasons, within the contexts of school and broader communities.

Educating for Life: A Guide for School-Based Responses to Preventing Self-Harm and Suicide

This guide outlines the policies, processes and practices that contribute to a comprehensive approach to suicide prevention.

Enhancing Resilience 1: Communication, Changes and Challenges

The curriculum units are designed to enhance resilience via the promotion of communication, participation, positive self-regard, teamwork and a sense of belonging and connectedness to school. They are particularly useful with new groups.

Creating connections

Activities for the Home Group, Personal Development, Pastoral Care or core curriculum teacher, focussing on issues of communication, codes of behaviour and team work.

Games collection

A collection of interactive games designed to promote communication, cooperation and teambuilding. Suitable for use within each of the key learning areas.

Friendship and belonging

Activities for the English class exploring the challenge of making and maintaining friendships.

People, identity and culture

Activities for the Study of Society class exploring personal and social identity, and addressing issues of belonging and culture.

Enhancing Resilience 2: Stress and Coping

This booklet guides schools in their focus on enhancing the resilience and connectedness of their students. It is targeted at middle to senior secondary

students and deals with the importance of providing ongoing opportunities for participation and communication, creating a positive school culture, friendly relationships, and valuing school and community. Two booklets, designed for use in Health, Pastoral Care or Religious Education, address issues of coping with stress and challenge, help-seeking, peer support, stress-management, and goal setting.

Coping

Activities for Health or Pastoral Care in which students identify some of the stresses and challenges young people have to deal with, and explore the range of emotions commonly associated with feelings of stress. They examine a range of coping strategies and consider ways of dealing with a range of challenging circumstances.

Stressbusters

Activities for Health or Pastoral Care in which students explore the role and effect of supportive groups, the role of trust and courage in help-seeking behaviour, and explore conflict resolution and stress-management techniques.

A Whole School Approach to Dealing with Bullying and Harassment

This booklet guides schools in their attempts to take a whole school approach to dealing with bullying and harassment. A comprehensive check list to guide policy and practice is included. Three curriculum units, targeted at junior secondary school students, are provided for use in the Health, English and Drama

class. The Health unit is also suitable for Personal Development and Pastoral Care classes. It is anticipated that schools would choose one of the units for use with a particular class.

Facing facts: a whole school approach to dealing with bullying and harassment for use in the Health class

Students define and give examples of different types of bullying and harassment, and consider the effects of bullying on victims, perpetrators and onlookers. They identify common barriers to seeking help or taking protective action. They are equipped to research bullying in their own school and use interactive exercises to develop help-seeking and assertiveness.

Giving Voice: a whole school approach to dealing with bullying and harassment for use in the English class

Students explore the language of bullying, and look at forms of bullying perpetuated at different levels of society. They use group work and participatory exercises to read, write and discuss poetry, stories and newspaper items, exploring the effects of bullying and possibilities for protective action.

Defining moments: a whole school approach to dealing with bullying and harassment for use in the Drama class

Students explore the body language of status and power, identify and enact common human responses to messages of welcome or rejection. They also use a range of dramatic devices to depict and examine the stories and experiences of oppression, and prepare a performance piece around the theme of bullying.

Understanding Mental Illnesses

This document provides an overview of the issues a school may face in relation to mental illness among students, staff and families. It includes a curriculum unit, aimed at middle to senior secondary students, that intends to increase students' understanding of mental illness, reduce the stigma associated with mental health problems, and increase help-seeking behaviour. A video accompanies this curriculum unit, and this is also relevant for considering mental illness and stigma with any school audience.

Loss and Grief

Issues of loss and grief have been linked to depression, and traditionally such issues have been under-explored in schools. This document provides an overview of school practices relevant to dealing with death and loss within the school, including a sequence of lessons for junior, middle and senior secondary school students.

MindMatters Website:

www.curriculum.edu.au/mindmatters

The website contains background information, a diary of events, case studies, a chat line, an annotated bibliography, PDF copies of all the booklets, links to other sites, state-by-state information on professional development programs, curriculum ideas referenced to curriculum frameworks and stories of how schools are implementing *MindMatters*.

MindMatters is available from:

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Or download from the MindMatters website:

<http://www.curriculum.edu.au/mindmatters>



How to use this booklet

It is intended that the classroom program will be taught as part of a comprehensive whole school approach to mental health promotion as outlined in the *SchoolMatters* and *Educating for Life* booklets. As part of a whole school approach, professional development and collegial support should be available to the classroom teacher.

It is recommended that teachers use, or encompass, the whole unit of work to

enhance student awareness, knowledge and skills. Using one or two sessions from the start of each unit is likely to raise awareness, but allow insufficient time for skill-development. Teachers should read the introductory section of the booklet that outlines some of the key concepts and research relevant to the issues covered in the classroom program.

KEY

SESSION

A session includes a series of activities that may extend over a number of lessons. Time taken to complete any activity can vary greatly from class to class. Teachers may wish to modify activities to suit the needs of their class.

INTENTION

The intention identifies the knowledge and skills to work towards in the session.

RESOURCES

A list of the resources required for the session.

HOW TO

In the 'How to' section, a step by step approach is used to model how the session might be run.

SAMPLE QUESTIONS

Sample questions are provided as a guide to class discussion.

TEACHER TIPS

Assistance and advice is provided for the teacher in the form of teacher tips in boxes in the left column.

TEACHER TALK

This text provides information the teacher may share with the class.

Classroom resources:

 activity sheets are provided as masters

 information sheets are provided as masters

 overhead transparency masters

Rationale

A whole school approach to understanding mental illnesses

In recent years there has been a great deal of interest in the ways young people cope with the circumstances they confront in their lives. Schools are very much aware that just as physical illness can affect a student's performance or capacity to concentrate and engage in study, so too can a challenging personal or family situation, relationship problem or mental health problem.

Schools committed to the welfare and learning of their students are addressing the questions:

- How can we provide a safe and supportive environment in which all students can maximise their learning?
- How can we remain accessible and responsive to their needs?
- How can we assist our students to develop their ability to cope with challenge and stress?
- How can we identify those students in particular need of assistance or support?
- How can we support students who are dealing with experiences of trauma or dislocation?

A whole school approach to understanding mental illnesses models some of the processes schools can use to support students in developing their ability to cope with change and challenge.

A whole school approach to enhancing resilience entails:

- a shift from a focus on fixing individuals, to that of creating healthy systems
- a shift from problems-based needs assessment to a belief in human potential for development, learning and wellbeing
- an acknowledgment that the 'health of the helper' is critical.*

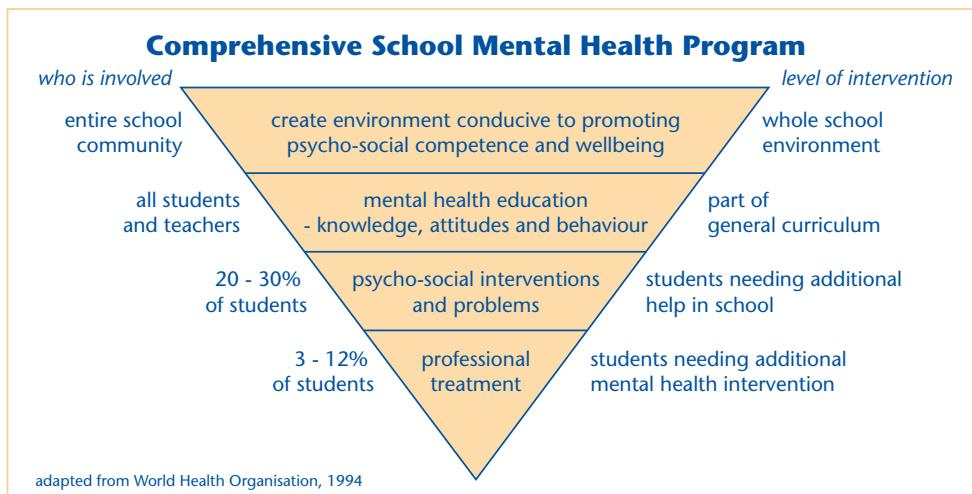
The conceptual model underpinning *MindMatters* is that of the Health Promoting School. This model entails a focus on the interconnecting domains of curriculum, school ethos and partnership (see diagram on page 16). Often when using schools as a setting for health promotion or intervention, only the domain of curriculum has been targeted, forgetting the impact of school ethos and environment, and the power and potential support to be generated through partnerships with parents, carers, community and service providers. (see *SchoolMatters*)

The Health Promoting Schools framework



* Benard (1997) 'A Framework for Practice: Tapping Innate Resilience', in *Resiliency in Action*

Taking a whole school approach to understanding mental illnesses acknowledges those students with particular needs, and seeks to provide for them. In addition it seeks to promote and provide a safe and supportive environment, and an ethos conducive to mental health and learning. The World Health Organisation model of a comprehensive school mental health program is a useful guide in considering the place of school-based efforts.



Understanding mental illness

One in five Australians experience a mental illness at some stage in their lives. Up to 24 per cent of young people experience an episode of depression by the age of eighteen. Some students and staff will experience mental health problems themselves, or be members of families where one or more people suffer a mental illness. A broad range of school operations and practices will affect the wellbeing of these people, influencing their experience of mental health problems and the impact that these problems have on their lives and education.

People who have a mental illness often feel embarrassed or ashamed and are reluctant to talk about it as they would some other medical condition. This often prevents them from seeking support or treatment. They may feel they are not accepted by other people, or that others are uncomfortable in their presence. They may feel at risk in their jobs or feel cut off from society. They are often the victims of some of the myths and stigma that still surround mental illnesses and other mental health problems.

Schools have a role to play in promoting and protecting the mental health of their staff and students, supporting and accommodating those who are experiencing mental health problems.

Promoting optimal mental health entails fostering a supportive social environment for students and staff; promoting resilience, self esteem and social skills; providing feedback and support to teaching staff; and fostering close links between the school and families.

The school may be involved in addressing risk factors in vulnerable groups in the form of providing stress management for senior students; grief and loss counselling; home visits for families at risk; support and coping skills for students experiencing family breakdown; support services for students with alcohol or other drug issues or education programs addressing discrimination.

Schools often play a crucial role in detecting a mental health problem at an early stage and providing access to effective support or treatment through community agencies or services, or adolescent mental health services.

Schools do not usually provide the treatment to reduce the symptoms of a mental illness. However, they do have a role in supporting students and staff returning to school after an episode of mental illness, in recognising the needs of students who have a family member undergoing treatment or rehabilitation for a mental illness and in postvention after an attempted or completed suicide.

(see *Educating for Life*)

Using the Health Promoting Schools framework

(see diagram on page 16)

School policy

Policies in the areas of equity, anti-harassment, staff health and wellbeing, discipline, drug use, and critical incident management are important in dealing with threats to student and staff mental health. The school's physical environment also contributes to mental health promotion. Facilities for private discussion and interview, without interruption or excessive noise, are important. The location of and access to the student counsellor should encourage rather than discourage students to use the services of this person. Some schools have developed specific areas in the grounds or buildings where students can talk together or spend quiet time in reflection, so facilitating peer support and

help seeking / giving behaviour. The social environment and ethos of a school are critical factors in promoting and protecting mental health. An environment which stresses the value and worth of each individual, which accepts and accommodates difference, which stresses team work and cooperation and which promotes participation and social interaction between school members, fosters a sense of connectedness and belonging. Such schools are known to be protective of mental health. They create an environment in which students and staff experiencing mental health problems are more likely to seek assistance and be supported by others.

School practice

Many schools have developed a range of practices and operations specifically aimed at mental and emotional wellbeing. Buddy systems (including targeted systems used for particular students at risk), pastoral care, peer support, students-at-risk committees, activities programs and stress management classes are common.

Support people within the school, such as a student counsellor, pastoral care teachers or a chaplain, can contribute significantly to promoting the mental health of at-risk and all other students. Their work is complemented by an effective referral system for students or staff experiencing mental health problems. This requires professional development of staff to be able to recognise and respond to students at risk, an agreed position on privacy of information relating to these situations, and a well understood approach for deciding how decisions are made about who 'needs to know'. Strategic planning for supporting students and staff with a mental illness is a key aspect of school organisation in this area.

School partnerships

The partnership between school and home is recognised as being important for a broad range of health and learning outcomes for students. However, in the areas of mental health and mental illness – with their associated stigma and fear – this partnership takes on even greater significance. For effective mental health promotion, parents need to be able to approach the school to discuss the learning and health needs of a student experiencing mental health problems or who is a member of a family where there is a mental illness. The stigma of mental illness makes regular communication between home and school essential. Schools that have worked to establish a climate of openness and communication with parents are more likely to be effective in addressing the needs of these students. Also, parent education about mental health through school newsletters and parent information sessions, contributes to the capacity of the school community to respond to mental health problems.

Schools have developed procedures to identify and respond to students who are displaying indicators of mental health problems; for example, drug and alcohol use, self-harm, suicidal or risk-taking behaviours, anxiety, depression or grief and loss. Most responses will make use of psychology and guidance services available within the education system, mental health services in the community, and self-help and /or support groups. Partnerships with these services and agencies are useful in policy development, staff training, development of referral guidelines and case management. In addition, such agencies and services may contribute to the school's curriculum. A comprehensive health education program engaging community

agencies will inform students about a range of health and welfare services such as help lines, gay and lesbian counselling services, drug and alcohol services, youth services, local GPs and community health services.

Curriculum material

This unit of work is designed for use in years 10 and above. It has been developed primarily for teachers of Health and Physical Education.

This unit may need to be modified to ensure cultural sensitivity and inclusivity in different settings. Teachers should be aware that particular groups, including Aboriginal and Torres Strait Islander people, survivors of war and torture, young people experiencing conflict about their sexuality, and same-sex attracted youth, may experience more mental illness and poorer mental health. Factors contributing to this include stigma, isolation, depression, loss experiences, the impact of the Stolen Generation on Aboriginal and Torres Strait Islander people, dispossession, broken family links and discrimination. In some school community settings it will be necessary to seek additional materials and input when dealing with these issues and their implications for mental health and mental illness.

In the curriculum unit students will explore the language of mental health and mental illness and learn about the causes, symptoms and treatments of different mental illnesses such as depression, anxiety, bipolar mood disorder and schizophrenia. Students will consider the effect that labels and stigma have on people dealing with mental illnesses. Students will identify and practice a range of behaviours related to self-help and seeking help for others.

National curriculum framework

Most states and territories have recently developed or refined their curriculum documents in response to the Statements and Curriculum Profiles developed as part of the National Collaborative Curriculum project.

The sequence of lessons in *Understanding Mental Illnesses* can be used to assist students to meet a number of the outcome statements in the Health and Physical Education curriculum profile. Listed below are examples of the processes, skills and understanding relevant to the level 6 outcomes.

Health of individuals and populations – level 6

Outcome: A student plans strategies to meet the health needs of particular population groups.

Evident when students, for example:

- examine community attitudes to, and knowledge of, mental illnesses
- identify the health needs of people experiencing a range of mental illnesses and suggest ways in which these needs can be met
- identify the health needs of friends, families and acquaintances of people experiencing a mental illness and ways in which these needs can be met
- plan for effective action to address mental health issues at personal, school, local and health-system levels.

Outcome: A student develops a health plan for a specified period.

Evident when students, for example:

- identify mental health as an area where they may experience, directly or indirectly, personal health needs

- describe and demonstrate skills related to help-seeking and supportive behaviour
- map the range of personal and community resources they could use if a mental illness affected their lives.

Safety – level 6

Outcome: The student can evaluate community initiatives that promote safety.

Evident when students, for example:

- examine community attitudes to mental illness
- examine community attitudes to personal safety in relation to the location of mental health services in local communities
- identify personal safety issues relevant to people experiencing a mental illness
- identify ways in which mental health services address the safety of consumers and the local community.

Human relations – level 6

Outcome: A student analyses the ways in which individuals and groups seek to influence the behaviour of others.

Evident when students, for example:

- consider the stigma associated with mental illness and how this impacts on personal feelings and actions towards people with a mental illness
- identify some major issues related to the rights of people with a mental illness, where social attitudes and / or government policy may affect their employment opportunities, rights to privacy, treatment options
- identify the main messages and methods used by the Federal Government in its work to change community attitudes to mental illness.

Outcome: A student analyses how different contexts and situations influence personal values, attitudes, beliefs and behaviours.

Evident when students, for example:

- identify conflicts in values and attitudes between people fearful of those with a mental illness and people who have direct experience of a mental illness
- demonstrate ways of maintaining personal beliefs and standards related to respect for others when among people who are hostile or derogatory to those with a mental illness.

Outcome: A student explains how social and cultural factors influence what people feel and do about their personal identity.

Evident when students, for example:

- identify one of the main messages of the '*One in Five*' campaign as being about how community attitudes often determine how much a person with a mental illness achieves
- consider the impact of social stigma and fear on people experiencing mental health problems in terms of feelings of self-worth, guilt, employability, hope for the future
- examine the change in mental health services from institutional care to community based care and consider how this could have impacted on the personal identity of people with a mental illness.

State and territory curriculum frameworks

Refer to the *MindMatters* website for details of how *MindMatters* fits with state or territory curriculum frameworks.

www.curriculum.edu.au/mindmatters

Teacher professional development

Professional development for staff is important in the area of mental illness and most likely has been lacking or non-existent. Usually the teachers who are familiar with mental illness are those who have some personal or family experience themselves. Unlike other areas of mental health – such as bullying, non-violent conflict resolution, and grief and loss – mental illness and mental health problems are still highly stigmatised, poorly understood and associated with fear. Teachers need information relevant to the issues raised in the curriculum and teaching strategies appropriate to these issues. In addition, information on early warning signs of mental health problems, risk factors for suicide, referral procedures, ways of dealing with personal disclosure or distress in the classroom, and parent communication are important if a school is to develop whole school approaches to understanding and responding to mental illness.

The introduction of a study of mental illnesses into the school curriculum will raise the issue of staff mental health and related mental health problems. Schools

should consider appropriate forums for professional development. These could include: proactive sessions on coping with stress; use of language which labels and stigmatises students and staff who may be different; information and awareness raising sessions about specific mental illnesses; ensuring that staff know where to refer students for support and how to seek support for themselves or colleagues.

The video and print materials from the curriculum unit can be used to provide professional development sessions for teachers.

- develop and maintain partnerships with health and counselling services
- engage in school-wide activities to destigmatise mental illness
- design curriculum activities to promote help-seeking skills
- provide private places for students to talk
- maintain a culture in which privacy is respected
- provide professional development for staff on the issue of suicide prevention
- communicate with parents
- provide access to counselling staff.

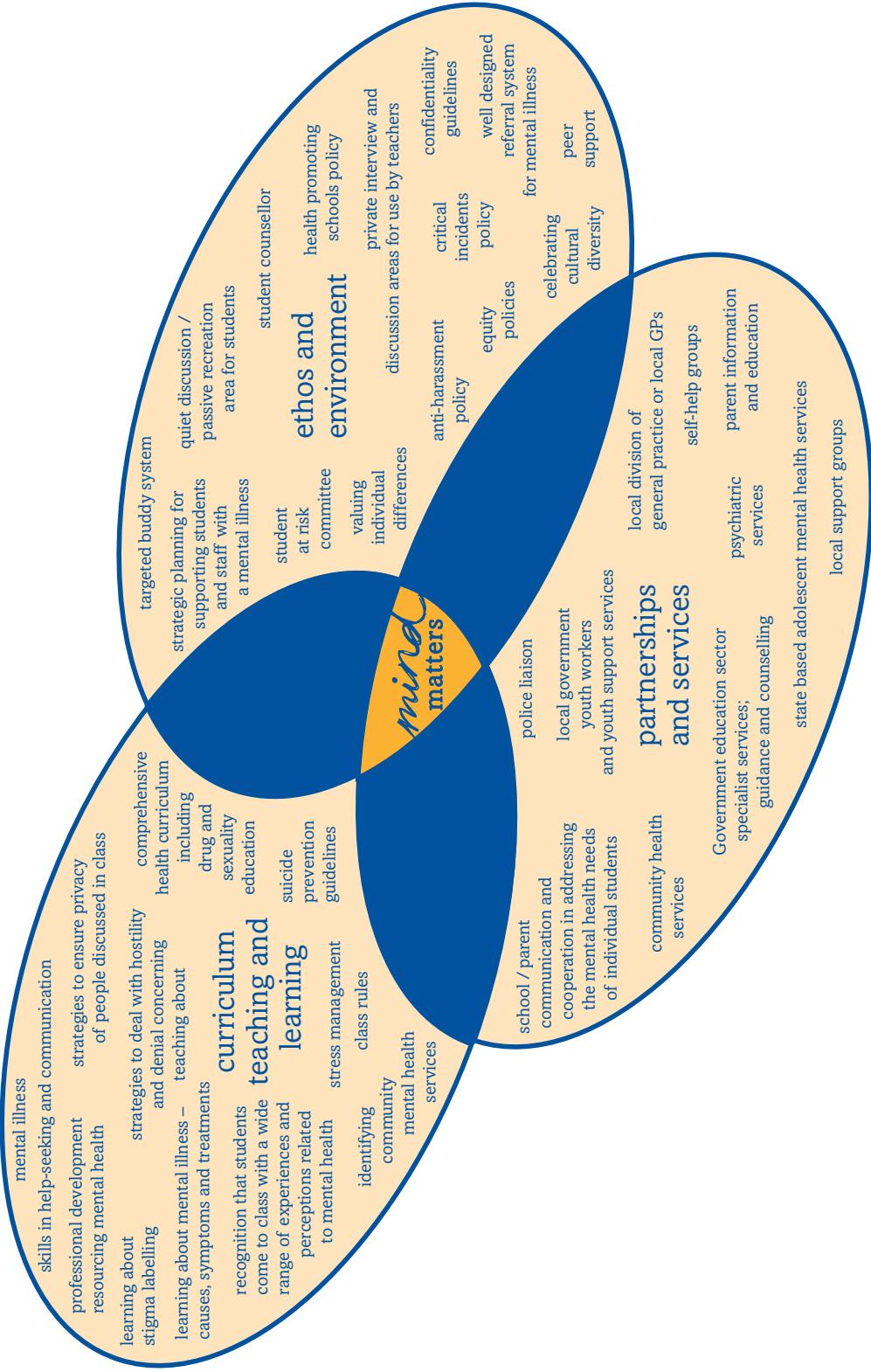
Check list of strategies for promoting mental health and destigmatising mental illness:

- provide professional development to increase staff awareness about the prevalence and signs of mental illness
- provide structured school-wide pastoral care
- promote mental health via a supportive school culture
- engage in strategic planning for the support and integration of staff or students dealing with mental illness
- develop an in-school referral system for staff, students and parents to pass on concerns about students

Community Matters

Chapter 3 ('Diversity and wellbeing') provides a social and cultural context for issues of mental health promotion and mental illness.

A whole school approach to dealing with mental illnesses



Understanding

mental illnesses

Intention

In this session it is intended that students:

- explore their current understandings of mental health and mental illnesses and identify gaps in their knowledge
- consider the negative connotations related to both the area and language of mental illness
- be introduced to the mental illness unit
- begin to explore and use the language of mental health and mental illnesses.

Resources

- *Information sheet: Mental illness – the facts*
- *Activity sheet: Learning the language of mental health*
- Butchers' paper, pens, Blu-tac
- Flexible seating arrangement for group work

How to

ACTIVITY 1: Exploring understandings of mental health / illness

1. Divide the class into four groups.
2. Give each group a piece of butchers' paper with one of four terms on it: 'physical health', 'mental health', 'physical illness', and 'mental illness'.
3. Ask groups to brainstorm all the words that come to mind when they see their term.
4. Ask groups to put sheets on a wall for all groups to see.
5. Get one student from each group to read out their list for the whole group.

Classroom rules

Be vigilant in tackling any 'jokey' or derogatory comments. Have this as a rule for every class. Act when you hear infringements on this rule. Ignoring breaches can be interpreted as condoning the action.

Establish rules about use of language, and encourage students to use correct terminology explaining that many words related to mental illness can be used in a derogatory way. Stress that using the language is one way to demystify the area. Psychiatrists have developed rather complex systems for classifying and understanding mental illness, and some of the terminology also seems a little scary at first. It is normal to be frightened of things that we don't know about.

Students may use very different words for physical health and physical illness.

- The distinction between the terms for mental health and the terms for mental illness may be more blurred than for the physical health equivalents.
- Students are likely to list more physical illnesses than mental illnesses.
- The words associated with mental health and illness may be more negative, and suggest issues of guilt, shame or blame. Physical health may have very positive words as opposed to mental health.
- If students confuse intellectual disability and other conditions with mental illness, be sure you distinguish the difference (see page 27).

Brainstorming

Brainstorming is a way to generate thinking and collect as many ideas or responses as possible. Do not judge or evaluate offerings during the brainstorm, just gather as many as possible. Return to the list later to complete the task.

6. Ask students what they notice about the type of words used on each sheet.
7. Discuss the similarities and differences in student responses to mental and physical aspects of people's health.
8. Ask students to suggest some reasons for these differences.

ACTIVITY 2: Introducing the *Understanding Mental Illness* unit

1. Explain to students that the next six to eight lessons will be about understanding mental illnesses and mental health problems.
2. Make the point that mental health includes a whole range of states: from positive wellbeing through to mental health difficulties (such as feeling sad or unhappy); through to mental health problems and illnesses such as schizophrenia and bipolar mood disorder (manic depression). Although mental health problems are as common as one in five, many people in the community know very little about mental illness.
3. Invite students to ask questions. A main aim is to have open and honest dialogue.

ACTIVITY 3: Language brainstorm

1. Refer to the activity 1 brainstorm. Ask students to add any words they have heard of or used with regard to mental illnesses. (These may include: psycho, loony, schizo, crackers, off the air, nutter, fruit loop, loopy, loony bin, weirdo, crazy, space cadet.)
2. Write the words up on the board.
3. Ask students:
'What feelings do these words evoke in people? Is it fear, a sense of the ridiculous, shame, embarrassment, disdain, distrust, better than them, failure, not taken seriously.'
4. Are any of these feelings associated with other illnesses?
5. Why do individuals respond in this way?

ACTIVITY 4: Understanding what we mean by mental illness

1. Read through the *Information sheet: Mental illnesses: the facts* with the class, until the end of the section on non-psychotic illness.
2. Facilitate a whole group discussion around the sample questions below.
3. Go over unfamiliar terms.
4. Hand out and explain the *Activity sheet: Learning the language of mental illness*. Some definitions are provided. For others, students are to develop their own and write them in the space provided.

Sample questions

- What are the two types of mental illness?
- How common is mental illness?
- What is known about the causes of mental illness?
- What are some of the personal costs associated with a mental illness?
- Why do you think there has been more focus on mental health recently?

Teacher talk

A psychosis is a condition caused by any one of a group of illnesses that are known, or thought, to affect the brain, causing changes in thinking, emotion and behaviour. People experiencing an acute stage of a psychotic illness lose touch with reality. Psychosis is most likely to occur in young adults and it is quite common. Around three out of every hundred young people will experience a psychotic episode, making psychosis more common than diabetes in young people.

A Mental Health Promotion strategy

Raise staff awareness of mental health problems for young people

Mental illness - the facts

One in five Australians will experience a mental illness.

Mental illness is a general term that refers to a group of illnesses, in the same way that heart disease refers to a group of illnesses affecting the heart.

Episodes of a mental illness can come and go in periods through peoples lives. Some people experience their illness only once and fully recover. For others, it recurs throughout their lives.

Most mental illnesses can be effectively treated.

Though we know that many mental illnesses are caused by a physical dysfunction of the brain, we do not know exactly what triggers this.

Stress may trigger some mental illnesses or may prolong episodes. Stress can also result when a person develops a mental illness.

People who have a mental illness often suffer a great deal. They can be disturbed and frightened by their illness.

Not only do they and their families have to cope with an illness that can radically alter their lives, they often experience rejection and discrimination.

People with a mental illness need the same understanding and support given to people with a physical illness. A mental illness is no different – it is not an illness for which anyone should be blamed.

It is rarely possible for someone with a mental illness to make the symptoms go away just by strength of will. To suggest this is not helpful in any way.

Mental illnesses can be separated into two main categories: psychotic and non-psychotic.

Psychotic illnesses

A psychosis is a condition caused by any one of a group of illnesses that are known, or thought, to affect the brain causing changes in thinking, emotion and behaviour.

People experiencing an acute stage of a psychotic illness may lose touch with reality. Their ability to make sense of thoughts, feelings and external information is seriously affected, and they may become very frightened.

Psychotic illnesses include schizophrenia and some types of depression.

During an episode of these disorders, people perceive their world differently from normal. During an episode, what they see, hear and feel is real to them, but people around them do not share their experiences.

People with psychosis might develop delusions (false beliefs of persecution, guilt or grandeur) or they may experience hallucinations where they see, hear, smell, taste or feel things which are not there. They may be depressed or elated out of all proportion to their life circumstances.

To those around them, these episodes can be threatening and perplexing. People who are not familiar with this behaviour may find it difficult to understand the fear and confusion with which people with these conditions live.

Effective medication and support from medical health professionals and counsellors mean that most people who experience a psychotic illness are able to live productive and rewarding lives.

Non-psychotic illnesses

Everyone has experienced strong feelings of depression, sadness, tension or fear.

Some people's feelings can become so disturbing and overwhelming that they have difficulty coping with day-to-day activities such as going to work, enjoying leisure time, and maintaining relationships.

These states describe a group of mental illnesses that are called non-psychotic illnesses. They are a common experience for many people and include phobias, anxiety, some forms of depression, eating disorders, physical symptoms involving tiredness or pain, and obsessive-compulsive disorder.

Though the symptoms of these disorders are often not evident to others, they cause considerable personal distress.

Most non-psychotic illnesses can be effectively treated, usually with a combination of medication and therapy, which help the person understand their illness, manage their symptoms, and lead satisfying lives.

Myths, misunderstanding and facts about mental illness

Myths, misunderstanding and negative stereotypes and attitudes surround mental illness. They result in stigma, isolation and discrimination.

Common questions about mental illness include:

Are mental illnesses a form of intellectual disability or brain damage?

No. They are illnesses just like any other, such as heart disease, diabetes, and asthma. Yet the traditions of flowers, sympathy and support provided to people with a physical illness are often denied to those with a mental illness.

Are mental illnesses incurable and lifelong?

No. When treated appropriately and early, most people recover fully. A mental illness is like many physical illnesses which require on-going treatment (such as diabetes and heart disease), but which can be managed so that the individual can participate in everyday life.

A mental illness can come and go in people's lives. Some people have only one episode and recover completely. For others, it recurs throughout their lives and requires on-going treatment.

Though some people become disabled as a result of a chronic mental illness, many who experience even major mental illnesses manage to live full and productive lives.

Are people born with a mental illness?

The causes of mental illnesses are unclear. A predisposition to some mental illnesses, such as schizophrenia, can run in families. Many other factors can contribute to the onset of a mental illness in people with a predisposition such as stress, bereavement, relationship breakdown, child abuse, unemployment, social isolation, times of accidents, and life-threatening illness.

Can anyone develop a mental illness?

Yes. In fact, as many as one in five Australians may develop a mental illness at some stage in their lives. Everyone is vulnerable to mental health concerns.

Many people feel more comfortable with the notion of having 'a breakdown' than the notion of having a mental illness. Reluctance to talk openly about mental illnesses is a barrier to seeking early treatment.

To many, explaining away a mental illness as a nervous breakdown is preferable to being branded 'mentally ill'.

Are people with a mental illness usually dangerous?

No. In fact, this false perception underlies some of the most damaging stereotypes. People with a mental illness are seldom dangerous. Even people with the most severe mental illness are rarely dangerous when receiving appropriate treatment.

Should people with a mental illness be isolated from the community?

No. Most people with a mental illness recover quickly and do not need hospital care, or have only brief admissions. Treatment discoveries of recent decades have removed the need for isolation and confinement as was common in the past. A small number of people with a mental illness – one in a thousand – need hospital care, sometimes against their will. It is important to recognise that this is not the situation for the vast majority of those who might have an episode of illness.

The attitudes of family, friends and the community towards people with a mental illness play a critical part in determining their quality of life.

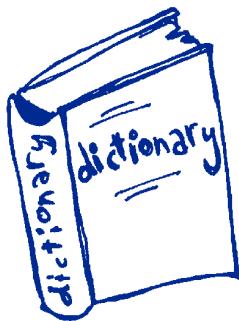
One of the biggest hurdles for people trying to get well is confronting the attitudes that their family, friends, employers and neighbours hold towards them because of their illness.

Sadly, this often means that people with a mental illness face isolation and discrimination just for having an illness.

What can be done about the stigma of mental illnesses?

- Bring mental illness into the open and think about it like other illnesses or conditions.
- Educate the community to overcome attitudes based on misconceptions and stereotypes.
- Promote mental health by nourishing healthy attitudes through early childhood and adult life, and learn ways to deal with trauma in relationships, situations and events.
- Encourage research into mental illnesses to assist understanding of how these illnesses affect people and how they can be prevented.
- Assist friends and relatives with a mental illness to obtain care and treatment.
- Talk about mental illnesses openly with people you meet – it is surprising how many people are affected by mental illness, but have been too afraid of rejection to discuss it openly.
- Provide high-quality support and treatment services that enable people with a mental illness to participate fully in all aspects of community life.
- Address discrimination in every area of life, including employment, education and the provision of goods, services and facilities.

Learning the language of mental illness



Anxiety

Bipolar mood disorder (previously called manic depression)

A specific mental illness which results in swings of mood between highs and lows of emotion.

Clinical diagnosis

A decision about what mental illness a person has, based on scientific and medical information.

Delusion

A mistaken belief that is strongly held even when there is evidence or proof that the belief is incorrect, for example, a false belief of being famous, highly important, being persecuted, followed, or spied upon.

Depression

At its most severe, a mental illness associated with biological and chemical imbalances of the brain and resulting in long lasting feelings of deep anxiety and unhappiness, poor sleep, loss of interest, energy, enjoyment and appetite.

Episodic

Many mental illnesses come and go. Some people may have only one experience (or episode) of mental illness and recover fully. Other people have periods of being ill and periods of being well. Some people recover: others learn to live with and manage their mental illness.

Grieving process

The process of experiencing a loss. This may include periods of sadness, anger, despair and possibly depression.

Hallucinations

Hearing, seeing, smelling, tasting or feeling things that are not there.

Mental health

Mental illness

Medication

Medication can relieve the symptoms of mental illness, and may help prevent mental illness recurring. In the case of depression, there is a range of antidepressant medications available. Similarly, in the case of psychosis or schizophrenia many new medical drugs are available.



Non-psychotic disorders

An on-going pattern of inner experience and behaviour which deviates markedly from more common social norms and cultural expectations, and leads to significant distress and /or impairment. This can include uncontrollable or exaggerated feelings of depression, sadness, tension or fear. These disorders include phobias, anxiety, some forms of depression and obsessive compulsive disorder.

Paranoia

Mistaken beliefs or delusions that include fear, suspicion of others and a feeling of being got at, for example, people trying to kill, hurt, or poison you.

Predisposition

A susceptibility to mental illness because of a pre-existing factor like family history.

Psychological treatment

Psychological treatments such as counselling and therapy deal with the underlying reasons for depression and other mental illnesses. These treatments may include talking about reactions to life events, and developing better ways to deal with stress, correcting negative patterns and learning new ways to deal with negative feelings.

Psychosis

Schizophrenia

A group of specific mental illnesses, where disorder of the brain causes people to lose touch with reality. It has nothing to do with the long-held idea of split personality. For a person with schizophrenia the major symptom is a loss of reality. The disease takes them into another world. Hallucinations and delusions are common.

Treatment

An action or intervention designed to decrease the symptoms or impact of a mental illness. Since a mental illness may be the result of both psychological factors and changes in brain chemistry, treatment can involve both medication and psychological treatments.

Experiences

of mental illness

Intention

In this session it is intended that students:

- be exposed to and consider a cross section of personal experiences of a mental illness
- develop a greater understanding of the personal pain and costs associated with a mental illness
- understand that mental illnesses are real illnesses and not the fault of the individual
- appreciate that mental illnesses are usually episodic and most people recover.

Resources

- *MindMatters* video – section 1
- *Activity sheet: Video discussion*
- *Information sheets: Eating disorders; Depression; Anxiety; Bipolar mood disorder; Schizophrenia.*

Teachers should view the video and read the range of information sheets before students commence activity 3, and view the video.



What if this topic or the video upsets a student?

Acknowledge that some people have upsets in relation to this topic. Invite students who wish to speak to you privately to do so. Follow-up with a one-to-one conversation rather than in front of the class. Offer a buddy to accompany if immediate comfort is required. Be prepared to offer referral according to school protocols. Be aware of mandatory reporting requirements – refer to SchoolMatters.

Discussion of the video may raise the issue of youth suicide. This is appropriate within the broader context of a study of mental illness but it is important that the discussion does not become focussed on suicide. Any discussion of suicide should:

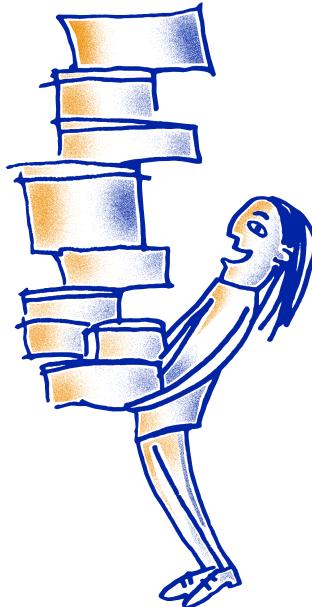
- avoid portraying suicide as romantic, heroic or tragic
- avoid increasing knowledge about methods of suicide
- avoid alienating individuals or groups
- encourage help-seeking behaviour
- promote positive attitudes, coping strategies and healthier options.

(see *Educating for Life* for more information on suicide prevention in schools)

How to

ACTIVITY 1: Video – group discussion of section 1

1. Inform the class that section 1 of the video is a montage of young people and their families talking about their experience of mental illnesses.
2. Prior to showing video put class into groups of three or four and distribute the video activity sheet.
3. Allocate each group one of the following characters or pairs of characters to follow during the video.
 - Sue (schizophrenia)
 - Natalie (obsessive compulsive disorder)
 - Sharon and Tina (anorexia – eating disorder)
 - Mark, Martin and Alysia (depression)
 - Angela and Angelo (bipolar disorder)
4. Give students a few minutes to read through the questions on the video activity sheet. Explain that although they will focus on a specific character, they need to be aware of the experience of all characters.
5. Show section 1 of the video.
6. Groups are to discuss the video activity sheet, complete questions one to four within the group, and then questions five to nine as a whole class.



Community Matters

Chapter 3 addresses some of the wellbeing issues for students with disabilities.

Teacher talk

What constitutes mental illness?

Research indicates that there is a level of confusion within the community about what constitutes mental illness. In particular, distinction should be drawn between mental illnesses, and brain injury, intellectual impairment, intellectual disability, and physical illnesses, like epilepsy, which affect the brain.

There is some debate as to whether Attention Deficit and Hyperactivity Disorder (ADD or ADHD) is a mental illness or not. Children who suffer from ADHD can have disturbed functioning in activity levels. This may include being overactive or restless, or having no particular goal. They may also be unable to pay attention to any one object, person or activity. Causes are varied and may be a combination of biological factors, environmental factors and psychological factors.

Epilepsy is another area of confusion. Epilepsy has been defined as any condition that causes recurrent seizures. It is not a psychological disorder, even though it causes unpredictable behaviour. A brain infection, brain degeneration, or a lack of a certain chemical may cause it, and some people are born with the disease.

Intellectual impairment occurs as the result of injury or disease, and is not a mental illness. Intellectual disability is the concurrent existence of significant, sub-average, general intellectual functioning and significant deficits in adaptive behaviour. Each manifests in the developmental period, that is, before the age of 18 years. In addition intellectual disability excludes intellectual impairment that occurs as a result of injury or disease suffered after early development. In contrast mental illness usually occurs after childhood and adolescence, and does not involve ongoing diminished intellectual capacity.

Homework

The language that teachers use in the classroom and in their interpersonal relationships with students is very powerful. Definitions of normal or inferences about what is normal behaviour in terms of emotional responses, gender stereotypes or sexual preferences can be stigmatising in themselves.

Divide the class into five, equal sized groups (it is important that each group is the same size, or close to it).

Allocate each group one specific mental illness topic listed below and hand out the relevant information sheet to each student.

Ask students to read the information sheet related to their topic. Stress this is important because the follow up lesson relies on input from the whole group.

Group 1 Eating disorders

Group 2 Depression

Group 3 Anxiety

Group 4 Bipolar mood disorder (manic depression)

Group 5 Schizophrenia

A Mental Health Promotion strategy

Well designed referral system for mental illness





Video discussion sheet

WHOLE CLASS DISCUSSION

GROUP QUESTIONS

- 1 Describe the mental health problems experienced by your character in the video? What were they feeling?

- 2 Describe your reaction to the character:

- 3 Explain your reactions and discuss different reactions:

- 4 Develop a list of questions that you would like to ask your character in order to better understand their illness:

- 5 What specific mental illnesses were mentioned in the video?

- 6 Describe how some characters appear to have lost touch with reality:

- 7 What help or treatment did any of the characters access?

- 8 Which of the characters have recovered? Discuss what you mean by *recovered*:

- 9 Are there other mental illnesses that you have heard about? What mental illnesses are you aware of that were not mentioned in the video?

Eating disorders

What are eating disorders?

Anorexia nervosa and bulimia nervosa are the two most serious eating disorders.

Each illness involves a preoccupation with control over body weight, eating and food.

- People with anorexia are determined to control the amounts of food they eat.
- People with bulimia tend to feel out of control where food is concerned.

Anorexia may affect up to one in every hundred teenage girls, although the illness can be experienced earlier and later in life. Most people who have anorexia are female, but males also develop the disorder.

Bulimia may affect up to three in every hundred teenage girls. More females than males develop bulimia.

While these rates show that few people meet the criteria for eating disorders, it is far more common for people to have unrealistic attitudes about body size and shape. These attitudes may contribute to inappropriate eating habits or dieting practices.

Both illnesses can be overcome and it is important for the person to seek advice about either condition as early as possible.

What are the symptoms of anorexia?

Anorexia is characterised by:

- a loss of at least 15 per cent of body weight resulting from refusal to eat enough food, despite extreme hunger
- a disturbance of perceptions of body image in that the person may regard themselves as fat, overestimating body size the thinner they become
- an intense fear of becoming 'fat' and of losing control
- a tendency to exercise obsessively
- a preoccupation with the preparation of food
- making lists of 'good' and 'bad' food.

Usually, anorexia begins with a weight loss, either resulting from a physical illness or from dieting.

Favourable comments cause the person to believe that if thin is good, thinner is better.

The body does not react well to starvation, and erratic eating behaviour begins to dominate the person's life.

About 40 per cent of people with anorexia will later develop bulimia.

What are the symptoms of bulimia?

Bulimia is characterised by:

- eating binges, which involve consumption of large amounts of calorie-rich food, during which the person feels a loss of personal control and self disgust

- attempts to compensate for binges and to avoid weight gain by self-induced vomiting, and /or abuse of laxatives and fluid tablets
- a combination of restricted eating and compulsive exercise so that control of weight dominates the person's life.

A person with bulimia is usually average or slightly above average weight for height, so is often less recognisable than the person with anorexia.

Bulimia often starts with rigid weight reduction dieting in the 'pursuit of thinness'. Inadequate nutrition causes tiredness and powerful urges to binge eat.

Vomiting after a binge seems to bring a sense of relief, but this is temporary and soon turns to depression and guilt.

Some people use laxatives, apparently unaware that laxatives do not reduce kilojoules or fat content, and serve only to eliminate vital trace elements and to dehydrate the body.

The person can make frantic efforts to break from the pattern, but the vicious binge /purge /exercise cycle, and the feelings associated with it, may have become compulsive and uncontrollable.

A person with bulimia may experience chemical imbalances in the body which bring about lethargy, depression and clouded thinking.

What causes anorexia and bulimia?

The causes of anorexia and bulimia remain unclear. Biological, psychological and social factors are all involved. For

some people, some of the following may compound low self-esteem, and contribute to the onset of anorexia or bulimia.

Social influences

This includes media and other presentations of the ideal shape in Western societies as slim and fit, and a tendency to stereotype fat people in a negative manner.

Personal factors

- changes in life circumstances such as the onset of adolescence, breakdown of relationships, childbirth or the death of a loved one
- fear of the responsibilities of adulthood
- poor communication between family members or parental reluctance to allow independence as children mature
- a belief that love from family and friends depends on high achievement.

Biological factors

This includes chemical or hormonal imbalances (perhaps associated with adolescence).

What are the effects of anorexia and bulimia?

Physical effects

The physical effects can be serious, but are generally reversible if the illnesses are tackled early. If left untreated, severe anorexia and bulimia can be life-threatening. Responding to early warning signs and obtaining early treatment is essential.

Both illnesses, when severe, can cause:

- harm to the kidneys
- urinary tract infections and damage to the colon
- dehydration, constipation and diarrhoea
- seizures, muscle spasms or cramps (resulting from chemical imbalances)
- chronic indigestion
- loss of menstruation or irregular periods
- strain on most body organs.

Many of the effects of anorexia are related to malnutrition, including:

- absence of menstrual periods
- severe sensitivity to the cold
- growth of down-like hair all over the body
- inability to think rationally and to concentrate.

Severe bulimia is likely to cause:

- erosion of dental enamel from vomiting
- swollen salivary glands
- the possibility of a ruptured stomach
- chronic sore throat and gullet.

Emotional and psychological effects

These are likely to include:

- difficulties with activities which involve food
- loneliness, due to self-imposed isolation and a reluctance to develop personal relationships

- deceptive behaviours relating to food
- fear of the disapproval of others if the illness becomes known, tinged with the hope that family and friends might intervene and provide assistance
- mood swings, changes in personality, emotional outbursts or depression.

What treatment is available?

Changes in eating behaviour may be caused by several illnesses other than anorexia or bulimia, so a thorough physical examination by a medical practitioner is the first step.

Once the illness has been diagnosed, a range of health practitioners can be involved in treatment, as the illnesses affect people physically and mentally. These may include psychiatrists, psychologists, physicians, dietitians, social workers, occupational therapists and nurses.

Outpatient treatment and attendance at special programs are the preferred method of treatment for people with anorexia. Hospitalisation may be necessary for those severely malnourished through lack of food.

Treatment can include medication to assist severe depression, and to correct hormonal and chemical imbalances.

Dietary education assists with retraining in healthy eating habits.

Counselling and specific therapies are used to help change unhealthy thoughts about eating, and educating the person that family and friends are supportive.

Depression

What is depression?

The word *depression* is often used to describe the feelings of sadness which all of us experience at some stage of our lives. It is also a term used to describe a form of mental illness called clinical depression.

Because depression is so common, it is important to understand the difference between unhappiness or sadness in daily life and the symptoms of clinical depression.

When faced with stress, such as the loss of a loved one, relationship breakdown or great disappointment or frustration, most people will feel unhappy or sad. These are emotional reactions which are appropriate to the situation and will usually last only a limited time. These reactions are not regarded as clinical depression, but are a part of everyday life.

The term *clinical depression* describes not just one illness, but a group of illnesses characterised by excessive or long-term depressed mood which affects the person's life. Clinical depression is often accompanied by feelings of anxiety. Whatever the symptoms and causes of clinical depression, treatment is very effective.

What are the main types of depressive illness?

Adjustment disorder with depressed mood

People with this illness are reacting to distressing situations in their lives (for

example, the failure of a close relationship or loss of a job) but to a greater degree than is usual.

This depression is more intense than the unhappiness experienced in daily life, it lasts longer and the symptoms often include anxiety, poor sleep and loss of appetite.

The time which this form of depression lasts may vary from weeks to years.

It usually goes away when the cause is removed or when the person finds a new way to cope with the stress. Many people require intensive professional help and treatment to overcome this type of depression.

Postnatal depression

The so-called 'baby blues' affect about half of all new mothers. They feel mildly depressed, anxious, tense or unwell, and may have difficulty sleeping even though they are tired and lethargic most of the time. This type of depression may last only hours or for a few days, then disappear.

However, in about 10 per cent of mothers this feeling of sadness develops into a serious disorder called postnatal depression. Mothers with this illness find it increasingly difficult to cope with the demands of everyday life.

They can experience anxiety, fear, despondency and sadness. Some mothers have panic attacks or become tense and irritable. There may be a change in appetite and sleep patterns.

A severe, but rare form of postnatal depression is called puerperal psychosis. The woman is unable to cope with her everyday life and can be disturbed in her thinking and behaviour.

Depressive episode

This is, in general, a more severe form of clinical depression. It can come on without apparent cause, although in some cases a distressing event might trigger the condition.

The cause is not well understood but is believed to be associated with a chemical imbalance in the central parts of the brain.

A depressive episode can develop in people who have coped well with life, who are good at their work and happy in family and social relationships.

They become low-spirited, lose their enjoyment of life and suffer disturbed sleep patterns. People experiencing a depressive episode lose their appetite, lack concentration and energy, and may lose weight. Feelings of guilt are also common.

Sometimes their feelings of hopelessness and despair can lead to thoughts of suicide.

The most serious form of this type of depression is called psychotic depression. During this illness, the person loses touch with reality, may stop eating and drinking and may hear voices saying they are wicked or worthless and deserve to be punished.

Others develop false beliefs (delusions) that they have committed bad deeds in the past and deserve to be punished, or that they have a terminal illness such as cancer, despite there being no medical evidence.

A depressive episode or a psychotic depression are serious and painful illnesses with real risks to the person's life

and wellbeing. Professional assessment and treatment is always necessary and, in severe cases, hospitalisation may be required initially.

Bipolar mood disorder (previously called manic depression)

A person with bipolar mood disorder experiences depressive episodes alternating with periods of mania involving extreme happiness, over-activity, rapid speech, a total lack of inhibition and, in more serious instances, delusions of grandeur.

Sometimes only periods of mania occur, without depressive episodes.

For more information on bipolar mood disorder, read the mental health information brochure 'What is bipolar mood disorder?'.

What causes depression?

Often there are many interrelated factors associated with depression.

Heredity

It is well established that the tendency to develop depression runs in families. This is similar to a predisposition to other illnesses, such as heart disease and high blood pressure.

Biochemical imbalance

As already stated, depressive episodes are thought to be due in part to a chemical imbalance in the brain. This can be corrected with anti-depressant medication.

Stress

Depression is associated with stress after personal tragedies or disasters. It is more common at certain stages of life, such as at childbirth, menopause and retirement, and common in young adults, women, and people with physical health problems.

Personality

People with certain personality characteristics are more prone to depression.

Depression occurs more commonly in people who are sensitive, emotional and prone to experience feelings which are upsetting to them.

Perfectionists who set high standards for themselves and others, and who find it difficult to adjust their ideas and standards to changing circumstances, are often easily depressed. Also, those who are very dependent on others are susceptible to depression if they are let down.

Learnt response

In some cases, people exposed to repeated losses or stress throughout their lives lose their optimism and feel helpless and depressed.

What treatment is available?

People experiencing feelings of sadness which have persisted for a long time, or which are affecting their life to a great extent, should contact their family doctor or community health centre.

Modern treatments for depression can help the person return to more normal feelings and to enjoy life. Treatment depends on each person's symptoms, but will take one or more of the following forms:

- psychological interventions help individuals understand their thoughts, behaviours and interpersonal relationships
- general supportive counselling assists people to sort out practical problems and conflicts, and helps them understand the reasons for their depression
- antidepressant medications relieve depressed feelings, restore normal sleep patterns and appetite, and reduce anxiety. Unlike tranquillisers, antidepressant medications are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects
- specific medications help to manage mood swings
- lifestyle changes such as physical exercise assist people who suffer from depression
- for some severe forms of depression, electroconvulsive therapy (ECT), or shock treatment, is a safe and effective treatment. It may be lifesaving for people at high risk of suicide or who, because of the severity of their illness, have stopped eating and drinking, and will die as a result.

Anxiety disorders

What is anxiety?

Anxiety is a term which describes a normal feeling people experience when faced with threat or danger, or when stressed.

When people become anxious, they typically feel upset, uncomfortable and tense.

Feelings of anxiety are caused by experiences of life, such as job loss, relationship breakdown, serious illness, major accident or the death of someone close. Feeling anxious is appropriate in these situations and usually we feel anxious for only a limited time. These feelings are not regarded as clinical anxiety, but are a part of everyday life.

What are the anxiety disorders?

The anxiety disorders are a group of illnesses, each characterised by persistent feelings of high anxiety. There are feelings of continual or extreme discomfort and tension, with the fear of panic attacks, usually without discernible cause.

People are likely to be diagnosed with an anxiety disorder when their level of anxiety and feelings of panic are so extreme that they significantly interfere with daily life and stop them doing what they want to do. This is what characterises an anxiety disorder as more than normal feelings of anxiety.

Anxiety disorders affect the way the person thinks, feels and behaves and, if not treated, cause considerable suffering and distress.

They often begin in early adulthood, and are often triggered by a series of significant life events.

Anxiety disorders are common and affect one in 20 people at any given time.

What are the main types of anxiety disorders?

Most types of anxiety disorder are characterised by heightened anxiety and fear of panic. Obsessive compulsive disorder and post-traumatic stress disorder are considered types of anxiety disorder, as both feature high levels of anxiety, which people try to control.

Generalised anxiety disorder

People with this disorder worry constantly about themselves or their loved ones being harmed by, for example, financial disaster, their health, work or personal relationships. These people experience continual apprehension.

Agoraphobia

Agoraphobia is a fear of being in places or situations from which it may be difficult or embarrassing to get away, or the fear that help might be unavailable if needed.

Agoraphobia is the most common anxiety disorder and constitutes about half those with anxiety disorders who seek professional help.

People with agoraphobia most commonly experience fear in a cluster of situations: in supermarkets and department stores, crowded places of all

kinds, confined spaces, public transport, lifts, freeways and heights.

People experiencing agoraphobia may find comfort in the company of a safe person or object. This may be a spouse, friend, pet or medicine carried with them.

The onset of agoraphobia is common between the ages of 15 and 20, or between 30 and 40, but we do not understand why this is. Many more women than men seek treatment.

Panic disorder (with or without agoraphobia)

People with this disorder experience extreme panic attacks in situations where most people would not be afraid.

The attacks are accompanied by all the unpleasant physical symptoms of anxiety, with a fear that the attack will lead to death or a total loss of control.

It is because of this that some people start to experience a fear of going outside (agoraphobia) and of being in places where help is not at hand.

Specific phobia

Everyone has some irrational fears, but phobias are intense fears about particular objects or situations which interfere in our lives. These might include fear of heights, water, dogs, closed spaces, snakes or spiders.

Someone with a specific phobia is fine when the feared object is not present. However, when faced with the feared object or situation, the person can become highly anxious and experience a panic attack.

People affected by phobias can go to

great lengths to avoid situations which would force them to confront the object or situation which they fear.

Social phobia

People with social phobia fear that others will judge everything they do in a negative way. They believe they are permanently flawed and worthless if any sign of poor performance is detected.

They cope by either trying to do everything perfectly, limiting what they do in front of others, especially eating, drinking, speaking or writing, or they withdraw gradually from contact with others.

Obsessive compulsive disorder

This disorder involves constant unwanted thoughts, and often results in the performance of elaborate rituals in an attempt to control or banish the persistent thoughts.

The rituals are usually time consuming and seriously interfere with everyday life. For example, people may be constantly driven to wash their hands or continually return home to check that the door is locked or the oven is turned off.

People with this disorder are often acutely embarrassed and keep it a secret, even from their families.

Post-traumatic stress disorder

Many people who have experienced major traumas such as war, torture, vehicle accidents, fires or personal violence continue to feel terror long after the event is over.

They may experience nightmares or flashbacks for years. The flashbacks are often brought about by triggers related

to the experience, but not necessarily central to it.

What causes anxiety disorders?

The causes of each disorder may vary and it is not always easy to determine the causes in every case.

Personality

People with certain characteristics are more prone to anxiety disorders.

Those who are easily aroused and upset, and are very sensitive and emotional, are more likely to develop anxiety disorders.

People who, in childhood, were inhibited and shy may also be prone to develop certain anxiety disorders, such as social phobia.

Learnt response

Some people exposed to situations, people or objects that are upsetting or anxiety-arousing may develop an anxiety response when faced with the same situation, person, or object again, or become anxious when thinking about the situation, person, or object.

Heredity

The tendency to develop anxiety disorders may run in families, or a person may also 'learn' anxious responses from their family or parents.

Biochemical processes

Although there is no clear evidence, it is possible that some anxiety disorders result from chemical processes in the brain.

In all cases, there is a need for a thorough examination of the person to help determine the nature of the problem and how it may best be treated.

What treatment is available?

Anxiety disorders, if they are not managed, continue to interfere significantly with the person's thinking and behaviour, causing considerable suffering and distress.

Many professionals such as your general practitioner, psychologists, social workers, counsellors or psychiatrists can assist in the treatment of anxiety disorders.

Treatment will often include education and counselling to help the person understand their thoughts, emotions and behaviour. People develop new ways of thinking about their anxiety and how to deal more effectively with feelings of anxiety.

Medication is sometimes used to help the person control their high anxiety levels, panic attacks or depression.

The benzodiazepines (like diazepam or valium) are used for the temporary relief of anxiety, but care has to be taken as these medications may cause dependence.

Antidepressants play an important role in the treatment of some anxiety disorders, as well as associated or underlying depression. Contrary to common belief, antidepressants are not addictive.

Bipolar mood disorder

What is bipolar mood disorder?

Bipolar mood disorder is the new name for what was called manic depressive illness.

The new name is used as it better describes the extreme mood swings – from depression and sadness to elation and excitement – that people with this illness experience.

People with bipolar mood disorder experience recurrent episodes of depressed and elated moods. Both can be mild to severe.

The term 'mania' is used to describe the most severe state of extreme elation and overactivity.

Some people with bipolar disorder only have the episodes of elation and excitement.

What are the symptoms of bipolar mood disorder?

Mania

Common symptoms include varying degrees of the following:

- elevated mood – the person feels extremely high, happy and full of energy. The experience is often described as feeling on top of the world and being invincible
- increased energy and overactivity
- reduced need for sleep
- irritability – the person may get angry and irritable with people who disagree

or dismiss their sometimes unrealistic plans or ideas

- rapid thinking and speech – thoughts are more rapid than usual. This can lead to the person speaking quickly and jumping from subject to subject
- lack of inhibitions – this can be the result of the person's reduced ability to foresee the consequences of their actions, for example, spending large amounts of money on buying items which are not really needed
- grandiose plans and beliefs – it is common for people experiencing mania to believe they are unusually talented or gifted or are kings, film stars or prime ministers. It is common for religious beliefs to intensify, or for people with this illness to believe they are an important religious figure
- lack of insight – a person experiencing mania may understand that other people see their ideas and actions as inappropriate, reckless or irrational. However, they are unlikely to recognise the behaviour as inappropriate in themselves.

Depression

Many people with bipolar mood disorder experience depressive episodes.

This type of depression can be triggered by a stressful or unhappy event, but more commonly occurs without obvious cause.

The person loses interest and pleasure in activities enjoyed before. They may withdraw and stop seeing friends, avoid social activities and cease simple tasks such as shopping and showering.

They are overwhelmed by a deep sadness, lose their appetite, subsequently lose weight, cannot concentrate, and may experience associated feelings of guilt or hopelessness.

Some attempt suicide because they believe life has become meaningless or they feel too guilty to go on.

Others develop false beliefs (delusions) of persecution or guilt, or that they are evil.

For more information on depression and its treatment, see the mental health information brochure, 'What is depression?'.

Normal moods

Most people who have episodes of mania and depression experience normal moods in between. They are able to live normal lives, manage household and business commitments and hold down a job.

Everyone experiences mood swings from time to time. It is when these moods become extreme and lead to a failure to cope with life that medical attention is necessary.

What causes bipolar mood disorder?

Bipolar mood disorder affects two people in every hundred of the Australian population.

Men and women have an equal chance of developing the disorder. It is most common in people in their twenties.

It is believed that bipolar mood disorder is caused by a combination of factors including genetics, biochemistry, stress and even the seasons.

Genetic factors

Studies on close relations, identical twins and adopted children whose natural parents have bipolar mood disorder strongly suggest that the illness is genetically transmitted, and that children of parents with bipolar mood disorder have a greater risk of developing the disorder.

Biochemical factors

Mania, like major depression, is believed to be associated with a chemical imbalance in the brain which can be corrected with medication.

Stress

Stress may play a part in triggering symptoms, but not always. Sometimes the illness itself may cause the stressful event (such as divorce or a failed business), which may then be blamed for the illness.

Seasons

Mania is more common in spring, and depression in early winter. The reason for this is not clear.

What treatments are available?

Effective treatments are available for depressive and manic episodes of bipolar mood disorder.

For the depressive phase of this illness, antidepressant medications are effective. Antidepressants are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects.

Medication should be adjusted only under medical supervision, as some people may experience a switch to a manic phase.

It may be necessary to admit a person with severe depression to hospital for a time.

When people are in a manic phase, it can often be difficult to persuade them that they need treatment. It may sometimes be necessary to admit the person to hospital if the symptoms are severe.

During acute or severe attacks of mania, several different medications are used. Some are specifically used to calm the person's manic excitement: others are used to help stabilise the person's mood.

Medications such as lithium are also used as preventive measures, as they help to control mood swings and reduce the frequency and severity of depressive and manic phases.

Psychotherapy and counselling are used with medication to help the person understand the illness and better manage its effects on their life.

With access to appropriate treatment and support, most people with bipolar mood disorder lead full and productive lives.

Schizophrenia

What is schizophrenia?

Schizophrenia is a mental illness which affects one person in every hundred.

Schizophrenia interferes with the mental functioning of a person and, in the long term, may cause changes to a person's personality.

The first onset is usually in adolescence or early adulthood. It can develop in older people, but this is not nearly as common.

Some people may experience only one or more brief episodes in their lives. For others, it may remain a recurrent or life-long condition.

The onset of illness may be rapid, with acute symptoms developing over several weeks, or it may be slow, developing over months or even years.

During onset, the person often withdraws from others, gets depressed and anxious and develops extreme fears or obsessions.

What are the symptoms of schizophrenia?

Major symptoms of schizophrenia include:

Delusions – false beliefs of persecution, guilt or grandeur, or being under outside control. People with schizophrenia may describe plots against them or think they have special powers and gifts.

Sometimes they withdraw from people or hide to avoid imagined persecution.

Hallucinations – most commonly involving hearing voices. Other less common experiences can include seeing, feeling, tasting or smelling things, which to the person are real but which are not actually there.

Thought disorder – where the speech may be difficult to follow, for example, jumping from one subject to another with no logical connection. Thoughts and speech may be jumbled and disjointed. The person may think someone is interfering with their mind.

Other symptoms of schizophrenia include

Loss of drive – where often the ability to engage in everyday activities such as washing and cooking is lost. This lack of drive, initiative or motivation is part of the illness and is not laziness.

Blunted expression of emotions – where the ability to express emotion is greatly reduced and is often accompanied by a lack of response or an inappropriate response to external events such as happy or sad occasions.

Social withdrawal – this may be caused by a number of factors including the fear that someone is going to harm them, or a fear of interacting with others because of a loss of social skills.

Lack of insight or awareness of other conditions – because some experiences such as delusions and hallucinations are so real, it is common for people with schizophrenia to be unaware they are ill. For this and other reasons, such as medication side-effects, they may refuse to accept treatment which could be essential for their wellbeing.

Thinking difficulties – a person's concentration, memory, and ability to plan and organise may be affected, making it more difficult to reason, communicate, and complete daily tasks.

What causes schizophrenia?

No single cause has been identified, but several factors are believed to contribute to the onset of schizophrenia in some people.

Genetic factors

A predisposition to schizophrenia can run in families. In the general population, only one per cent of people develop it over their lifetime. If one parent suffers from schizophrenia, the children have a 10 per cent chance of developing the condition – and a 90 per cent chance of not developing it.

Biochemical factors

Certain biochemical substances in the brain are believed to be involved in this condition, especially a neurotransmitter called dopamine. One likely cause of this chemical imbalance is the person's genetic predisposition to the illness.

Family relationships

No evidence has been found to support the suggestion that family relationships cause the illness. However, some people with schizophrenia are sensitive to any family tension which, for them, may be associated with relapses.

Environment

It is well recognised that stressful incidents often precede the onset of schizophrenia. They often act as precipitating events in vulnerable people. People with schizophrenia often become anxious, irritable and unable to concentrate before any acute symptoms are evident. This can cause relationships to deteriorate, possibly leading to divorce or unemployment. Often these factors are then blamed for the onset of the illness when, in fact, the illness itself has caused the crisis. It is not, therefore, always clear whether stress is a cause or a result of illness.

Drug use

The use of some drugs, especially cannabis and LSD, is likely to cause a relapse in schizophrenia.

Myths, misunderstanding and facts

Myths, misunderstanding, negative stereotypes and attitudes surround the issue of mental illness and, in particular, schizophrenia. They result in stigma, isolation and discrimination.

Do people with schizophrenia have a split personality?

No. Schizophrenia refers to the change in the person's mental function, where thoughts and perceptions become disordered.

Are people with schizophrenia intellectually disabled?

No. The illness is not an intellectual disability.

Are people with schizophrenia dangerous?

No. People with schizophrenia are generally not dangerous when receiving appropriate treatment. However, a minority of people with the illness become aggressive when experiencing an untreated acute episode, because of their fears. This is usually expressed to family and friends, rarely to strangers.

Are people on medication for schizophrenia addicted to the medication?

No. The medication helps to reduce the severity of the symptoms. The specific medications for treatment of schizophrenia are not addictive.

Is schizophrenia a lifelong mental disorder?

Not necessarily. Most people, with professional help and social support, learn to manage their symptoms and have a satisfactory quality of life. It is also a fact that about 20 to 30 per cent of people with schizophrenia have only one or two psychotic episodes in their lives.

What treatment is available?

The most effective treatment for schizophrenia involves medication, psychological counselling and help with managing its impact on everyday life.

The development of anti-psychosis medications has revolutionised the treatment of schizophrenia. Now, most people can leave hospital and live in the

community. Not all people with schizophrenia have to go to hospital and care can be delivered in the community.

These medications work by correcting the chemical imbalance associated with the illness. New but well tested medications are emerging which promote a much more complete recovery with fewer side effects.

Schizophrenia is an illness, like many physical illnesses. For example, just as insulin is a lifeline for a person with diabetes, anti-psychosis medications are a lifeline for a person with schizophrenia.

As with diabetes, some people will need to take medication indefinitely to prevent a relapse and keep symptoms under control.

Though there is no known cure for schizophrenia, regular contact with a doctor or psychiatrist and possibly a multidisciplinary team of mental health nurses, social workers, occupational therapists and psychologists can help a person with schizophrenia organise and do the important things in life.

Sometimes specific therapies directed towards symptoms such as delusions may also be useful.

Counselling and support can be helpful for problems with finances, accommodation, work, interaction with others and loneliness.

Effective treatment can assist the person in leading a productive life.

Mental illnesses

– the same but different

Intention

In this session it is intended that students:

- gain a better understanding about symptoms, causes and treatment for specific mental illnesses
- increase their knowledge about one mental illness and share this knowledge with others
- work cooperatively within a group
- talk openly about mental illness using the language related to mental illness.

Resources

- *Information sheets from session 2: Eating disorders; Depression; Anxiety; Bipolar mood disorder; Schizophrenia.*
- *Activity sheets: Understanding anxiety; Understanding depression; Understanding schizophrenia; Understanding eating disorders; Understanding bipolar mood disorder; Mental illness – how much do you understand?; Community attitude survey.*
- Flexible seating arrangement

Why do these activities in groups?

Students get practice in talking with others, they build social skills and working together is a way to energise a class.

How to

Explain to students that a jigsaw activity will be used during this lesson. This means that students will continue working in small groups formed in session 2 and will become ‘experts’ about one mental illness (one piece of the jigsaw). They then form mixed groups where students will share their specific information so that all pieces of the jigsaw are put together.

ACTIVITY 1: Specialist groups

1. Students join others who have studied the same area of mental illness as they have.

Hand out the relevant activity sheets to each group.

1. Eating disorders
 2. Depression
 3. Anxiety
 4. Bipolar mood disorder
 5. Schizophrenia
2. Ask them to talk about the nature of the mental illness the group has been allocated.
 3. Allow students a few minutes to scan written material again.
 4. In groups, they are to discuss information for their particular activity sheet and answer the questions.
 5. Students record the information on their activity sheet to share during next activity.
 6. Allocate a letter (A, B, C, and so forth) to each group member in each specialist group. Then direct all the A's to create a new group, all the B's to form another group, and so on. This should result in groups with one 'expert' from each of the five areas of mental illness.

Depression is the most common mental health problem experienced by school students. Be sure you stress avenues for help.

The social context

When considering depression, teachers should ask students to consider how issues such as loss and grief, dispossession of land, removal from families and discrimination, may impact on individual and group feelings of mental health and wellbeing.

Teachers should select either activity 2 or 3 as a way of groups sharing their information.

ACTIVITY 2: Sharing the pieces

1. Allow each student two minutes to report to the newly formed group about their specific area of mental illness, highlighting at least two important aspects.
2. After all students have reported back encourage students to ask questions of each other.

ACTIVITY 3: Follow up quiz

1. Give each student *Activity sheet: Mental illness - how much do you understand?* and run the quiz with the whole class, giving them limited time to share answers within the group to get correct answers. The 'expert' knowledge from specialist groups should allow at least one member in each group to have some idea of the answer.
2. Alternatively you may give only one quiz answer sheet per group and award a small prize to the winning group. Something mentally healthy like a chocolate bar might be in order.



Answers for quiz

Be aware that different cultures and family groups have different views about what is honourable or appropriate as a response. Be prepared to acknowledge that different views exist about what is right and wrong. Ask questions about the effects of actions on others. Seek opportunities for inquiry rather than judgement.

Discuss with students the sensitive nature of the questionnaire and the possibility that some people may not want to answer it.

1. C
2. C
3. B
4. C
5. D
6. schizophrenia
7. anorexia and bulimia
8. A
9. obsessive compulsive disorder is linked to anxiety
10. A
11. D (all of the above)
12. adjustment disorder, post natal depression, depressive episode and bipolar mood disorder
13. Most people are sad or unhappy at some time. But this lasts only a short time. Depression, however, involves excessive or long-term distress that significantly affects the person's lifestyle
14. 90 per cent
15. T
16. F
17. F
18. Delusions are false beliefs of guilt or persecution or beliefs of grandeur (believing they are a king, queen, medical doctor, famous person). Hallucinations are when people see, hear, smell, taste or feel things that are not there .
19. B
20. Discrimination and community misconceptions (see *Information sheet: Mental illness – the facts*)

Homework

In preparation for session 4, students need to survey five to ten people about their attitudes to mental health problems and people with a mental illness.

Hand out *Activity sheet: Community attitude survey* and request students survey a minimum of five people and a maximum of 10 people who share their house, school or local community.

A Mental Health Promotion strategy

Engage in health promotion activities which destigmatise mental illness



Understanding anxiety disorders

'If I went outside I couldn't breathe. I had trembly legs. So I stayed in for four years, and never went out. It was very gradual at first. I noticed that in crowds I couldn't go out or I got panicky and if I went shopping for food and the shop was full, I used to walk out.'

(NSW Mental Health Information Services Material, 1997)

What are anxiety disorders?

Who gets anxiety disorders and how common are they?

Describe some of the symptoms of anxiety disorders

List and briefly explain some of the main types of anxiety disorders

What type of treatment is available for people experiencing anxiety disorders?

What support services are available?

Understanding depression



'It was the worst period of my entire life. I'm normally a very optimistic person, but I felt listless, pessimistic, and apathetic about everything. I saw no point in going on. I felt like an orphan. There was nothing and no-one for me. I remember crying and crying and crying. I had an ocean of tears. I recall wondering where all the fluid came from. At times I thought I'd never stop crying: it was like I was developing an involuntary habit. I thought I'd tumbled into a deep hole and I couldn't climb out.'

(NSW Mental Health Information Services Material, 1997)

What is depression?

List and briefly explain some of the main types of depression

Who gets depression and how common is it?

Describe some of the symptoms of depression

What type of treatment is available for people experiencing depression?

What support services are available?



Understanding schizophrenia

'I know that there are really not any voices but I feel as though there are, and that I should listen to them or something will happen to me. I see things...in crowds. I see people looking at me, and talking about me. Sometimes I hear them planning to kill me. I don't want to die. I want to be like everyone else.'

(NSW Mental Health Information Materials, 1997)

What is schizophrenia?

List and briefly explain some of the factors believed to contribute to the onset of schizophrenia

Who gets schizophrenia and how common is it?

Describe some of the symptoms of schizophrenia

What type of treatment is available for people experiencing schizophrenia?

What support services are available?

Understanding eating disorders



'The more you starve yourself, the more in control you feel, and the more of that euphoric feeling you get. You get more light headed and you feel this is a good feeling. I've really got control. I'm better than everybody else because I've got such strict control.'

(From *Flipping Out and Hanging On*, video)

What are eating disorders?

Who gets eating disorders and how common are they?

Describe some of the symptoms of anorexia

What are the physical, emotional and psychological effects of bulimia?

What type of treatment is available for people experiencing anorexia or bulimia?

What support services are available?



Understanding bipolar mood disorder (or manic depression)

'I remember this voice, this beautiful voice saying to me you know everything is going to be all right...and I was just getting high, high, high. You know nothing seemed to go wrong in life. I could cope with anything. Everything seemed to be perfect, like I was in paradise.'

(Attitude, World of the Mentally Ill, ABC)

What is bipolar mood disorder?

**Who gets bipolar mood disorder
and how common is it?**

**Describe some of the symptoms
of bipolar mood disorder.**

**What combination of factors
are believed to cause bipolar
mood disorder?**

**What type of treatment is
available for people experiencing
bipolar mood disorder?**

**What support services are
available?**



1 Which of the following statements is correct?

- a) Mental illness refers to five specific diseases of the brain.
- b) Only people with a family history of mental illness will suffer from a mental illness themselves.
- c) Many mental illnesses are caused by a physical or chemical dysfunction of the brain.

2 Hallucinations are:

- a) drugs that suppress elevated moods
- b) drugs that heighten depressed moods
- c) seeing, hearing, smelling, tasting or feeling things that are not there
- d) seeing, hearing, smelling, tasting or feeling things that are there

3 Someone experiencing an acute stage of a psychotic illness is likely to:

- a) be in touch with reality
- b) perceive their world differently from ours
- c) be able to make sense of thoughts, feelings and external information without these processes being affected

4 A person experiencing a non-psychotic illness may be characterised as someone who:

- a) is coping with day-to-day activities but experiencing depression
- b) is suffering from a disorder not related to mental illness
- c) suffers from phobias, anxiety, some forms of depression or obsessive compulsive disorder

5 Which of the following symptoms have been identified with bipolar mood disorder (or manic depression)?

- a) increased energy and overactivity
- b) lack of inhibitions
- c) reduced need for sleep
- d) all of the above

6 What is the mental illness where thoughts and perceptions become disordered?

7 What are the two most recognised and common eating disorders?

8 People with a generalised anxiety disorder:

- a) worry constantly about harm befalling them, their loved ones, their work, and their relationships
- b) experience fear when confronted with a particular object or situation
- c) try to do everything perfectly
- d) all of the above

9 What do the letters OCD stand for and what mental illness do you think it relates to?



10 A phobia is _____

- a) intense extreme fears which interfere in our lives, and usually involve acute anxiety about a particular object or situation
- b) something people fake to get attention
- c) just a nightmare or bad dream

11 Which of the following is a symptom of anxiety? _____

- a) difficulty sleeping
- b) sweating
- c) hyperventilation
- d) all of the above

12 List four different types of depression _____

13 What is the difference between 'feeling down' and being seriously depressed? _____

14 What is the chance of people with one parent who suffers from schizophrenia not developing it? _____

Circle true or false for the following three questions

15 Medication is helpful for most mental illnesses T/F _____

16 Post natal depression affects about 50 per cent of mothers after childbirth T/F _____

17 Clinical depression is another term for unhappiness T/F _____

18 What is the difference between a delusion and an hallucination? _____

19 Which of the following is not a symptom of the eating disorder anorexia? _____

- a) loss of at least 15 per cent body weight
- b) eating binges
- c) intense fear of becoming fat and losing control
- d) exercising obsessively

20 What are two significant barriers that people with a mental illness face? _____

Community attitude survey



Tick the most appropriate answer:

	Agree	Disagree	Not sure
1 People should generally sort out their own mental health problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 Once you have a mental illness you have it for life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 Females are more likely to have a mental illness than males.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 Medication is the best treatment for a mental illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 People with a mental illness are generally violent and dangerous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 Adults are more likely than teenagers to have a mental illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 You can tell just by looking at someone whether they have a mental illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 People with a mental illness are generally shy and quiet.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9 Mental illness can happen to anybody.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 You would be willing to have a person with a mental illness at your school or employed at your place of work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11 You would be willing to have a person with a mental illness marry into your family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12 You would be happy to have a person with a mental illness become a close friend.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13 It would be safer for the community for people with a mental illness to be kept in hospital.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14 It's okay for people with a mental illness to have children.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 People see mental illness in the same way they see physical illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





Survey record sheet

COMMUNITY ATTITUDE SURVEY RECORD SHEET

Response

Please write appropriate response: **1, 2 or 3** (**1** = Agree; **2** = Disagree; **3** = Not sure)

Gender **Age** Please tick

	M	F	≤14	15-25	26-40	>40	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15
1	<input type="checkbox"/>																				
2	<input type="checkbox"/>																				
3	<input type="checkbox"/>																				
4	<input type="checkbox"/>																				
5	<input type="checkbox"/>																				
6	<input type="checkbox"/>																				
7	<input type="checkbox"/>																				
8	<input type="checkbox"/>																				
9	<input type="checkbox"/>																				
10	<input type="checkbox"/>																				

Changing

people's minds and attitudes

Intention

In this session it is intended that students:

- explore the attitudes of people in the local school community to mental illnesses
- draw distinctions between myth and fact relating to the capabilities and capacity of people with a mental illness, and the causes and symptoms of mental illnesses
- challenge their own attitudes and values around mental illnesses
- explore differences between the label and the reality of mental illness
- consider underlying reasons for current community attitudes and values related to mental illnesses.

Resources

- Survey data collected by students for homework in session 3
- *MindMatters* video section 2
- *Activity sheet: The kindness of strangers*
- Butchers' paper and textas
- *Overhead: Key communication messages*
- Overhead projector

How to

ACTIVITY 1: Survey collation

1. In groups of four to five, students share survey responses to ascertain what the attitudes of their bigger sample were. If time permits, students could use a computer to collate and graph results.

2. Students should come up with some generalised statements from the group survey findings to report back to class, for example:
 - our sample was not well informed about mental illnesses
 - the women in our sample were more tolerant than the men about mental illnesses
 - only half the people surveyed agreed that they would have someone with a mental illness as a close friend.
3. Facilitate a whole class discussion as part of this reporting back, highlighting what the results tell us about people's attitudes to mental illnesses. Use the sample questions as a guide.
4. Use the *Overhead: Key communication messages* to summarise key information for the details.

Teacher talk

Stress the range of reasons which may underlie damaging, stigmatising and discriminatory attitudes:

- lack of information
- lack of exposure to people with mental illness in the past due to institutionalisation
- prior media coverage of mental illness in a negative or scary light
- mental illness as an area not completely understood so there is associated fear.

Sample questions

- On what basis do people form their attitudes?
- Do the responses indicate an understanding of mental illnesses within the community? Suggest some reasons why this understanding or lack of understanding exists.
- Is it necessary to change the community's attitudes?
- How difficult is it to change people's attitudes?
- Do you think that some groups are more or less informed or tolerant (for example women or men, young people your age or the elderly)? Suggest possible reasons for these differences.
- Which groups within the community would be most difficult to influence? Why?

- Do you think your results reflect the Australian community attitude? Why, or why not?
- Do you believe it is possible to change the community's attitudes toward mental illness?
- How might this be done?

Teacher talk

A major Australian survey measured community attitudes, beliefs, opinions and knowledge about mental illness. Generally, it showed women tend to be better informed about mental illnesses than men. Women report more exposure to, and experience of, mental illness and indicate more tolerance, sympathy and acceptance. Extremes of age are least informed about mental illnesses, while young people are both tolerant and keen to know more. Personal exposure to a mental illness was the most significant factor in people's level of knowledge and attitudes.

Similarly, a 1994 American survey by the National Association of Mental Illness found that 71 per cent of respondents thought that severe mental illness was due to emotional weakness, 65 per cent thought bad parenting was to blame, 35 per cent cited sinful behaviour, and 45 per cent believed that the mentally ill bring on their illness and could will it away if they wish. Further, 43 per cent believed mental illnesses are incurable, and only 10 per cent thought that severe mental disorders had a biological basis and involved the brain.
 (ref: <http://www.proaxis.com/~irisproject/94-08.html>
URL valid during 2002)

Teachers should draw on state and local initiatives that are best known to students.

Have students think back to a time when they or someone they knew changed their opinion or attitude. What caused this?

ACTIVITY 2: Video – Changing people's attitudes

1. Ask students if they can recall seeing media campaigns about mental illness.
2. Question them as regards to the content of the ads and posters.
3. Explain briefly that there was a national Community Awareness Program (CAP) which addressed mental health and illness and included three television advertisements (see Teacher talk next page).

4. Tell students that there is a set of key messages which are common to the three advertisements. Ask them to try to identify these messages when watching the video and other messages portrayed in the same segment.
5. Remind students the video segment is short – only five minutes.
6. Show section 2 of the video to students and then ask them the sample questions.
7. If appropriate, show the video again to highlight the key messages.

Sample questions

- What did you identify as the key messages in the advertisements?
- What is your opinion of the advertisements?
- Did any advertisement appeal to you specifically? Give reasons.
- If you were in the band and you had to decide if Sarah could join, what other questions might you want to ask her before deciding?
- Do you think the ‘One in Five’ advertisements would have changed people’s attitudes? Explain.
- What is the point Anne Deveson is trying to make?
- Apart from media campaigns what else could be done to help educate the community about mental illness?

Teacher talk

As part of the National Mental Health Strategy, a Community Awareness Program (CAP) operated in Australia between 1994 and 1997. As part of the CAP, a mass media campaign known as ‘One in Five’ was used to raise people’s awareness of mental health and mental illness, and challenge some of the attitudes and beliefs in the community. In developing the components of the strategy, five key communication messages were intended.

Key communication messages

- All people have a dimension of mental health (as well as physical health) that can be protected and promoted.

Activity 3 is student directed.
Students find this an effective approach to learning about mental illness.

- Ordinary people (just like you) experience mental health problems.
- Mental health problems are common (one in five suffer at some stage in their life).
- Mental health problems can be effectively treated and managed.
- There are help services available for those people who feel they may be experiencing mental health problems.

ACTIVITY 3: Script your own advertisement

1. Working in pairs students will develop the next 30-second advertisement for the 'One in five' series.
2. The end of their advertisement should use the same words as the campaign:
'One in five Australians suffer from a mental illness.
How much they suffer depends on our attitude'.
3. Students choose one of the following situations (or one of their own) and develop their script using the situation as the basis.

Situations

For each of these situations it is assumed that one character has a mental illness:

- older people at bowls discussing team membership
 - committee meeting at a sporting club considering decisions about who should be on the new committee
 - you're supposed to be going shopping with a family member or relative who is coming to stay
 - a student returning to school after an episode of mental illness.
4. Outline the four elements that each script must have to ensure the message of understanding and acceptance gets across.

Elements in script

1 Situation set up

'Hey, guys, my friend Sarah said she'd do vocals for the band.'

- 2** *Questioning or concern about mental health*
‘Hasn’t she got a mental illness?’
- 3** *Facts given or myth challenged*
‘Yeah, but she’s on medication. She can look after herself.’
- 4** *Tolerant /accepting positive attitude taken*
‘Let’s get her in, then.’
- 5** Give students time to develop and practice their scripts.
- 6** Get groups or pairs to present their scripts if they want to. You could suggest passing scripts on to another pair so that they feel less inhibited about presenting their own work. Select a few different advertisements for the class to watch and ask for reactions.

ACTIVITY 4: Exploring attitudes

1. This activity is based on the *Activity sheet: the kindness of strangers* by Sandy Jeffs. Either read it out to the class or give students copies to read.
2. Instruction to students
 - You are an observer on a tram or train, in a cafe, park or other public place. Someone is acting strangely or behaving inappropriately, or at odds with normal behaviour, even a ‘bit crazy’.
 - Briefly describe the behaviour you observe.
3. Describe how two different strangers react to this person and their behaviour. In one case you are describing ‘the kindness of strangers’ and in the other ‘the unkindness of strangers’.

A Mental Health Promotion strategy

Ensure all staff are aware of how to pass on concerns about a student’s emotional or mental health

The kindness of strangers



by Sandy Jeffs

There is a marvellous moment at the end of Tennessee Williams' play *A Streetcar Named Desire* where Blanche DuBois, a broken and lost soul, is taken from her sister's house by a doctor and a matron from the asylum. After a forlorn struggle, she is offered a gentle hand by the doctor, who tries to impose a little dignity on the situation, to which she responds with the famous words: 'Whoever you are – I have always depended on the kindness of strangers.'

There is a poignancy about these words that rings all too true when one considers them in the light of the mentally ill and the relationship we have with family, friends and the community at large. I have always maintained that one unpleasant aspect of suffering from schizophrenia was the uncertainty of never knowing when I'm going to embarrass myself next, such is the vulnerability with an illness that does not always obey the rules of society.

There are countless moments when I have said and done things that are simply incomprehensible to outsiders – indeed *strangers* – which have placed me at odds with *normal* behaviour. Whether it's talking to my voices, acting strangely and inappropriately, holding a belief not based in reality, being paranoid without reason – these are but a few examples – all in the gaze of the public eye, I am constantly at the mercy of the kindness of strangers.

The crazy in the street could be me. The crazy in the street **is** me!

In talking about the *kindness of strangers* one could conversely talk about the *unkindness of strangers*, because as we are found in the trams, trains, cafes, parks, indeed anywhere in public, we have to suffer the taunts and gazes of incredulity from unsympathetic people who are often judgmental and dismissive. We are all potential strangers who need to be mindful of the kindness we might one day be required to perform, just as we are all potential sufferers who might one day be in need of an act of kindness to help us on the way.

Extract from 'The kindness of strangers' by Sandy Jeffs from *Poems from the Madhouse* published by Spinifex Press.

Key communication messages

- All people have a dimension of mental health (as well as physical health) that can be protected and promoted
- Ordinary people (just like you) experience mental health problems
- Mental health problems are common (one in five suffer at some stage in their life)
- Mental health problems can be effectively treated and managed
- There are help services available for those people who feel they may be experiencing mental health problems



Labels

are for jars

Intention

In this session it is intended that students:

- understand the effect that labels and stigma have on people's lives
- critically analyse the causes of stigma
- identify behaviours of their own and others, which are stigmatising
- tackle stigma (information to debunk myths; understanding and empathy; legislative protection).

Resources

- *Activity sheet: Labels*
- *Activity sheet: Jam-jars, postcard and shoes*
- *Activity sheet: Fact, furphy, fear or fiction*
- *Information sheet: Mental illness: the facts*
- *Activity sheet: A thesaurus of madness*

How to

ACTIVITY 1: Labels

OPTION A: If the shoe fits?

1. Give students a copy of *Activity sheet: Labels* and ask them to look at the different pairs of shoes. Write one word under each pair of shoes which describes one personal characteristic of someone who might wear these shoes.
2. In pairs students compare their words and talk about similarities and differences.
3. Collect responses from the whole class for one or two pairs of shoes.

- In activity 1 the teacher may choose option 1 or option 2. Both relate to issues of labelling and stigma. Alternatively, the class could split in two, with half doing each activity and then share findings with a partner.
4. Get students to identify words they would feel uneasy or embarrassed to have used in relation to themselves. Why is this?
 5. Discuss the following sample questions with the class.

Sample questions

- Can you tell anything about people by their shoes?
- Do people judge others by the shoes they wear? Why?
- What other dress codes are people judged by?
- What types of labels might be used about odd behaviour?

OPTION B: Labelling jars not people

1. Refer students to the *Activity sheet: Jam-jars*.
2. Individually ask students to label each jam-jar using words that are sometimes given to people experiencing a mental illness, or whose behaviour is different or alternative in some way.
3. In groups of four, students are to select a few of the labels they have placed on the jars and discuss the following sample questions.

Sample questions

- What are some of the words people use to label odd behaviour?
- Which of these labels are used to restrict what we think are people's capabilities? How does this occur?
- Which labels seem to stem from people feeling uneasy or embarrassed by different or odd behaviour?



Teacher talk

Odd behaviour in others might be thought of as:

- illogical, unusual, something we want to explain
- something which makes us uneasy, perhaps frightened
- something we see as unpredictable
- something we want to avoid.

Yet odd behaviour might be easily explained if we understood what caused the behaviour. Perhaps under the circumstances it is not so odd. Perhaps it is not so frightening. Perhaps we focus on the behaviour, not the person and problem underlying the behaviour.

Labels are powerful. Labels define who we are, and how we see others. Labels can be used to scapegoat. Labels can be used to restrict what we think people are capable of. Leave the labels on the jars and open our minds. People are more than their mental illness.

Stigma means a mark or sign of shame and disgrace or disapproval, of being shunned or rejected by others. It emerges when people feel uneasy or embarrassed to talk about behaviour they perceive as different.

ACTIVITY 2: Fact, fear, furphy or fiction – a summary quiz

OPTION: This could be set for homework or as an assessment task

1. Explain to students that the summary quiz has a range of statements about mental illness. Some may be myths, others are misconceptions, some may be true.
2. Each student will need the *Activity sheet: Fact, fear, furphy or fiction* and the *Information sheet: Mental illness: the facts* to help them respond to the statements.
3. Students circle the most appropriate response(s) to each statement and then explain on the sheet why they considered this /these to be the most appropriate word(s) to describe the statement.
4. Discuss responses to the *Fact, fear, furphy or fiction* exercises.

ACTIVITY 3: Creative writing

1. Students are to read *A Thesaurus of madness* and use some of the language from this to develop a short piece of creative writing describing an incident in the author's life.

ACTIVITY 4: Newsletter

1. Have the class develop the *Activity sheet: Fact, fear, furphy or fiction* into a short article for the school newsletter. There could be a '*MindMatters: Myths and Facts*' column which runs for a month or so to educate the whole school community.

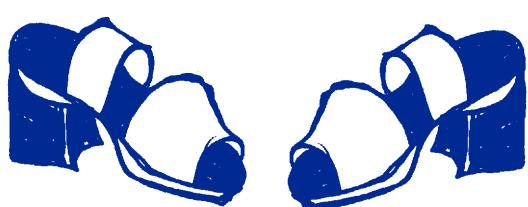
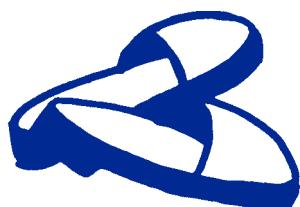
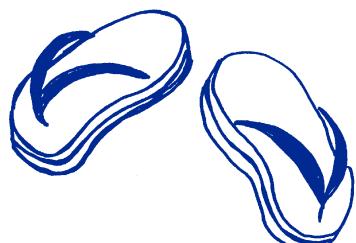
'A thesaurus of madness' is also useful in a staff meeting or in service where teachers are exploring their attitudes to mental illness. Having people read out the poem is powerful.

A Mental Health Promotion strategy

Set up structures for reintegration of students or staff returning to school following a mental illness.

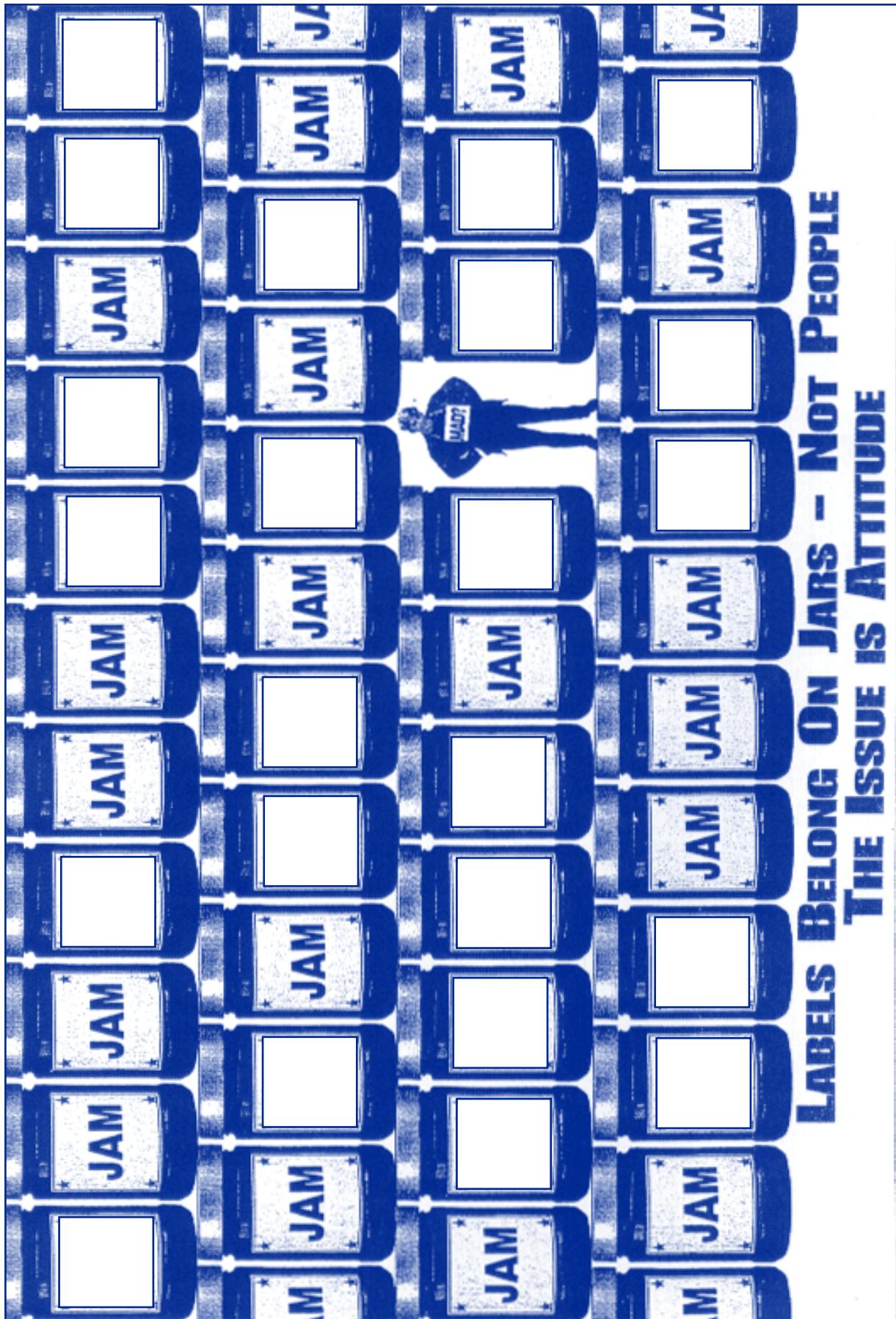


Labels





Jam-jars



Fact, fear, furphy or fiction



Students should read /use Information sheets: Mental illness: the facts from session 1, in explaining their answers to the following statements.

Tick one or more words that best represent your view about each statement. Then explain why you have chosen these words.

1 People are born with a mental illness.

- fair unfair correct sometimes correct incorrect

Why? _____

2 People with a mental illness are usually aware of their illness.

- fair unfair correct sometimes correct incorrect

Why? _____

3 Mental illness is something that comes and goes, but you never recover.

- fair unfair correct sometimes correct incorrect

Why? _____

4 People with a mental illness make poor parents.

- fair unfair correct sometimes correct incorrect

Why? _____

5 People with a mental illness have a flawed or weak character.

- fair unfair correct sometimes correct incorrect

Why? _____

6 People with a mental illness are usually dangerous.

- fair unfair correct sometimes correct incorrect

Why? _____



7 Most people with a mental illness live and work within the community.

- fair unfair correct sometimes correct incorrect

Why? _____

8 People with a mental illness need to stay on medication.

- fair unfair correct sometimes correct incorrect

Why? _____

9 People with schizophrenia are at greater risk of hurting themselves than people in the general community.

- fair unfair correct sometimes correct incorrect

Why? _____

10 People with a mental illness are considerate work mates who are able to hold down a job.

- fair unfair correct sometimes correct incorrect

Why? _____

11 Mental illness is reasonably common within the community.

- fair unfair correct sometimes correct incorrect

Why? _____

12 Mental illnesses are a form of intellectual disability or some type of brain damage.

- fair unfair correct sometimes correct incorrect

Why? _____

13 You can protect yourself from developing a mental illness.

- fair unfair correct sometimes correct incorrect

Why? _____

A thesaurus of madness



Author Sandy Jeffs from 'Poems from the Madhouse', Spinifex Press

(People must think I'm Crazy)

Being the madwoman, I am also: a lunatic, a maddy, a mental case, a bedlamite, a screwball, a nut, a loon, a loony, a madcap, a mad dog, a psychopath, a maniac, an hysterick, a psychotic, a manic depressive, a megalomaniac, a pyromaniac, a kleptomaniac, a crack-pot, an eccentric, an oddity, an idiot, a basketcase, demented, moon-struck, hazy, unhinged, dippy, loopy, distracted, pixy-led, a scatterbrain, certifiable, crazy, loco, psycho, a nutter, possessed, fevered, bonkers, obsessed, bedevilled, troppo, starkers, schizo, potty, nuts, daft, dilly, a crackbrain, a fruit-cake, touched.

Being insane, I suffer from: mental illness, psychiatric illness, brain damage, unsoundness of mind, alienation, lunacy, madness, mental derangement, mental instability, abnormal psychology, loss of reason, intellectual unbalance, mental decay, a darkened mind, a troubled brain, a deranged intellect, nerves, imbecility, cretinism, morosis, feeble-mindedness, queerness, having a screw loose, bats in the belfry, rats in the upper story, nervous breakdowns.

Being as I am, mad that is, I must be: not in my right mind, bereft of reason, deprived of my wits, as mad as a snake, a tinnie short of a slab, diseased in the mind, as mad as a hatter, wildered in my wits, not the full quid, a brick short of a load, off my rocker, round the bend, a candidate for Bedlam, foaming at the mouth, as mad as a meat axe, up the pole, a sandwich short of a picnic, out of my tree, off my face, off my block, over the edge, off my saucer, a shilling short of the pound, as silly as a wheel, off my trolley, as mad as a two-bob watch, a shingle short and I have a kangaroo loose in the top paddock.

Being wild and distraught, I live in a mad house, a mental home, a mental hospital, an asylum, an insane asylum, Bedlam, a booby hatch, a loony-bin, a nut house, a bug house, a psychiatric hospital, the rat house, the giggle factory, the rat factory, the funny farm.

I am many things, in many places.
Fool that I may be, mad that I may be.
I am, in all my precarious guises,
the creation of a cruel mind.

Extracts from 'A thesaurus of madness (People must think I'm crazy)' by Sandy Jeffs from *Poems from the Madhouse* published by Spinifex Press.

Seeking help, finding support

Intention

In this session it is intended that students:

- understand that people need support in dealing with stressful life situations
- differentiate between 'normal' responses to stress and difficulty, and those that may indicate the need for additional support from professionals
- consider who they could talk to if they were concerned about a friend or relative
- identify support personnel within the school relevant to mental health
- map the range of community-based health care services and groups available to support people experiencing mental illness and to support their families and friends
- note changes in the provision of mental health care services across the last 40 years.

Resources

- *Information sheet: Something is not quite right*
- *Activity sheet: Scenario cards*
- Resources to assist students to identify a range of community mental health resources when responding to the given scenarios, such as:
 - list of community mental health associations and services and support groups for particular illnesses
 - directory of community health and /or local government services
 - representatives of local community health agencies
 - internet access
- *Information sheet: Care of the seriously mentally ill in Australia*

Local health agencies often provide resource directories which list mental health support.

How to

ACTIVITY 1: Identifying the need for support

Teacher talk

When and how do we decide that a person is ill and needs assistance from health care workers? The love, friendship and support that usually come from family and peers to help young people through tough times may not always be enough.

1. Divide the class into eight groups. Two groups get set 1 of the scenario cards, two groups get set 2, two groups get set 3, and two groups get set 4. All receive the *Activity sheet: Something is not quite right*. Ask students to differentiate between 'normal' responses to stress and difficulty and those responses that may indicate that something is 'not quite right'.
2. Students discuss their two scenarios. They use the check lists and the first three guide questions in each scenario to identify the issues of concern. They consider whether each situation is one where the help of family and friends would be sufficient, or one where assistance from health professionals should be sought.

ACTIVITY 2: Local services

1. Using local resource lists and directories, each group is to identify a range of services, agencies and groups that each of their characters could use to deal with the situation. The other guide questions after each character will assist students to develop a comprehensive response to this task.
2. For each character, the group produces a summary chart, indicating the issue (for example, eating disorder, depression or anger), and the range of agencies and services available.
3. Each group chooses one of their three characters to present to the rest of the class. They describe the situation, and identify how the character could go about seeking help and the range of supports this person could use.

ACTIVITY 3: Care of the seriously mentally ill in Australia

Working in small groups, students are to use the *Information sheet: Care of the seriously mentally ill in Australia* to identify changes in mental health care service over the last 40 years. They will consider how the type of institutional care provided for people with a mental illness may have affected community attitudes to mental illness. The following questions will help them to cover these issues.

1. Describe the sort of mental health services provided in Australia 40 years ago:
 - where people with a mental illness were located
 - what their living conditions were like
 - the availability and adequacy of treatment
 - the length of time people spent in institutional care and the factors which determined this.
2. Discuss how locking away people with a mental illness might have influenced community attitudes and beliefs about mental illness, for example:
 - they must be a danger to society if they are locked away
 - they are very different from other members of the community
 - they stay in those places all their lives – their illnesses don't go away.
3. Find out how the move to community-based care came about, and where in the community people with a mental illness were likely to live once they left institutions.
4. Identify some of the difficulties associated with community-based care for people with a mental illness.
5. Find out about services provided in your area for people dealing with mental illness.

A Mental Health Promotion strategy

Provide accessible counselling service

Something is not quite right



Getting help early for mental illness

Something is 'not quite right' about the way someone close to you is behaving. You are worried. Is it serious or is the moodiness, irritability and withdrawn behaviour a stage to grow out of? Are drugs involved? Is medical assessment needed to help you decide if there is a serious problem?

Getting help early

The chances are that there is not a serious problem, and time and reassurance are all that are needed. However, if there is a developing mental illness, then getting help early is very important.

Being unwell for a shorter time means less time lost at school or work and more time for relationships, experiences and activities which help us stay emotionally healthy.

Check list 1

Behaviour which is considered NORMAL although difficult

Difficult behaviour at home, school or in the workplace

People may be:

- | | | | | |
|-----------------------------------|-------------------------------------|--------------------------------------|---------------------------------|----------------------------------|
| <input type="radio"/> rude | <input type="radio"/> irritable | <input type="radio"/> over sensitive | <input type="radio"/> lazy | <input type="radio"/> rebellious |
| <input type="radio"/> weepy | <input type="radio"/> argumentative | <input type="radio"/> over emotional | <input type="radio"/> withdrawn | <input type="radio"/> shy |
| <input type="radio"/> thoughtless | | | | |

These behaviours may also occur as a normal brief reaction to stressful events such as:

- | | | |
|---|---|--|
| <input type="radio"/> breakup of a close relationship | <input type="radio"/> other family crisis | <input type="radio"/> exam failure |
| <input type="radio"/> moving house | <input type="radio"/> death of a loved one | <input type="radio"/> physical illness |
| <input type="radio"/> divorce | <input type="radio"/> other personal crisis | |

Probably no cause for serious concern

It is best if you try not to over react. Try to be as supportive as possible while waiting for the 'bad patch' to pass. If you are experiencing these problems it may be necessary to seek medical assessment.

If the behaviour is too disruptive or distressing for other people, or if the difficult behaviour persists, then you could seek counselling help or advice. Talk this over with your GP, school or workplace counsellor, Community Information and Referral Service, Community Health or Mental Health Centre.

Check list 2

What's the difference between just having a bad day and something more serious?

Signs of clinical depression

- | | |
|---|---|
| <ul style="list-style-type: none">• Feeling miserable for at least a week or two• Feeling like crying a lot of the time• Not wanting to do anything, go anywhere, see anyone• Having trouble concentrating or getting things done• Feeling like you're operating in 'slow-motion'• Having trouble sleeping | <ul style="list-style-type: none">• Feeling tired and lacking energy – unable to get out of bed even after a full night's sleep• Having a change in appetite• Feeling like there's a 'glass wall' between you and the world• Feeling hopeless or thinking of suicide• Putting yourself down and thinking you're no good |
|---|---|

If you often experience a number of these things, you may be depressed. You don't have to be alone with these feelings. Depression is treatable.

Check list 3

Behaviours which are considered ABNORMAL FOR THAT PERSON and may seriously affect other people.

People may:

- withdraw completely from family, friends and workmates
- be afraid to leave the house (particularly in daylight hours)
- sleep or eat poorly
- sleep by day and stay awake at night, often pacing around
- be extremely preoccupied with a particular theme, for example, death, politics or religion
- uncharacteristically neglect household or parental responsibilities, or personal appearance or hygiene
- deteriorate in performance at school or work, or leave jobs
- have difficulty concentrating, following conversations or remembering things
- talk about or write things that do not really make sense
- panic, be extremely anxious, or markedly depressed or suicidal
- lose variation in mood — be 'flat'. Lack emotional expression, for example, humour, friendliness
- have marked changes in mood, for example, from quiet to excited or agitated
- hear voices that no-one else can hear
- believe, without reason, that others are plotting against, spying on, or following them and have extreme fear of, or anger at, those people
- believe that they are being harmed, or influenced to do things against their will, by, for instance, television, radio, spacemen, the devil.
- believe they have special powers, for example, that they are important religious leaders, politicians or scientists
- believe their thoughts are being interfered with or that they can influence the thoughts of others
- spend extravagant and unrealistic sums of money.

Seek a medical assessment as soon as possible

These behaviours are much stronger signs that someone needs to be checked out, particularly if they have been present for some weeks. There may only be a minor disturbance but a mental illness such as a psychotic disorder may be developing.

(Adapted from *Something is not quite right: getting help early for mental illness*, produced by SANE Australia 1998 and from YMAG, 1998)

Scenario cards 1



PETER, 14

Peter is 14-years-old and goes to the local high school. When he was 11 his mum died suddenly. Now his father is always at work and his older brothers and sisters run the household. Everyone is expected to pull their weight and be happy. However, even though everyone thinks he is happy, Peter says that sometimes he goes home, shuts the door to his bedroom and cries on his bed for hours. He does not really know why he gets so sad but often he feels very, very lonely.

- 1 What do you think is happening with Peter?
- 2 Is what's going on here a problem for Peter? Why do you say that?
- 3 If you were a friend of Peter's, who could you discuss your concerns with?
- 4 What could Peter himself do?
- 5 If you were in Peter's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person / place most likely to be able to help with Peter's situation? Why? What might make it harder for Peter to approach that person? What might make it easier?
- 7 Is there anybody or any place that Peter would not approach for help? Why is that? Are there any ways of asking for help which might make things worse for Peter?

GINA, 14

Gina is 14-years-old. She has breakfast at home but, when her mother is out of the room, puts most of it in the bin. When she gets to school she trades the lunches her mother gives her for a piece of fruit. If she goes out with friends she might get a plate of food, but most often gives most of it away to other people. On sports days, she never gets changed in front of anyone else. At school some of the other kids have started to make jokes about how bony she is.

- 1 What do you think is happening with Gina?
- 2 Is what's going on here a problem for Gina? Why do you say that?
- 3 If you were a friend of Gina's, who could you discuss your concerns with?
- 4 What could Gina herself do?
- 5 If you were in Gina's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person / place most likely to be able to help with Gina's situation? Why? What might make it harder for Gina to approach that person? What might make it easier?
- 7 Is there anybody or any place that Gina would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Gina?



Scenario cards 2

NICK, 15

Nick is 15-years-old. He comes from a large family of older brothers who are all now at university. He has never done as well at school as his brothers did and over the last year, his father has been making him bring in his homework after he's finished it and sometimes there are big fights afterwards. Lately, when he goes to do his homework he feels sick, gets headaches and sometimes feels really dizzy. Last week on the way home he had to get off the bus because he got so nervous at the thought of going home that he couldn't breathe and thought he was going to throw up.

- 1 What do you think is happening with Nick?
- 2 Is what's going on here a problem for Nick? Why do you say that?
- 3 If you were a friend of Nick's, who could you discuss your concerns with?
- 4 What could Nick himself do?
- 5 If you were in Nick's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person/place most likely to be able to help with Nick's situation? Why? What might make it harder for Nick to approach that person? What might make it easier?
- 7 Is there anybody or any place that Nick would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Nick?

ALI, 22

Ali is 22-years-old and works with the biggest steel company in town. He started going out with a girlfriend and thought things were going really well. He asked her to marry him. However, she said she wasn't ready for a commitment and instead she went overseas – on her own.

Since then, he can't stop thinking about her and how hurt he feels. He hasn't been able to sleep. He's been at the pub every night. He's been feeling like a 'pent up volcano'. The blokes at work have started to hassle him a bit about 'not being on the job', and last week, when the foreman yelled at him about something, he started screaming back and almost threw a punch. He's been told to take some time off.

- 1 What do you think is happening with Ali?
- 2 Is what's going on here a problem for Ali? Why do you say that?
- 3 If you were a friend of Ali's, who could you discuss your concerns with?
- 4 What could Ali himself do?
- 5 If you were in Ali's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person/place most likely to be able to help with Ali's situation? Why? What might make it harder for Ali to approach that person? What might make it easier?
- 7 Is there anybody or any place that Ali would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Ali?

Scenario cards 3



TONY, 13

Tony is 13-years-old and in his second year of high school. He has a disabled younger brother who is always really sick and takes up most of his parents' attention. He's normally pretty quiet at school and has always done well. He hasn't wanted to make trouble for his parents because there's already enough stress at home. However, a few months ago, he took the day off school and while he was hanging around the shops, stole a baseball cap. Everyone said what a great cap it was when he wore it to school the next day. Since then, he's been stealing from stores in the area on a regular basis. Often he gives presents to his brother, his friends or to his mum.

- 1 What do you think is happening with Tony?
- 2 Is what's going on here a problem for Tony? Why do you say that?
- 3 If you were a friend of Tony's, who could you discuss your concerns with?
- 4 What could Tony himself do?
- 5 If you were in Tony's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person / place most likely to be able to help with Tony's situation? Why? What might make it harder for Tony to approach that person? What might make it easier?
- 7 Is there anybody or any place that Tony would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Tony?

KATE, 19

Kate is 19-years-old, has left home and is looking for a job. Lately, she is finding it really hard to get to sleep at night and then get out of bed the next morning. She has not had a job interview for a long time and has difficulty paying her bills. Her friends have noticed that she doesn't want to come out with them any more. She has been using sleeping pills to help get to sleep at night and has been talking a lot about how hopeless things are and that things are never going to change for her.

- 1 What do you think is happening with Kate?
- 2 Is what's going on here a problem for Kate? Why do you say that?
- 3 If you were a friend of Kate's, who could you discuss your concerns with?
- 4 What could Kate herself do?
- 5 If you were in Kate's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person / place most likely to be able to help with Kate's situation? Why? What might make it harder for Kate to approach that person? What might make it easier?
- 7 Is there anybody or any place that Kate would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Kate?



Scenario cards 4

SONYA, 22

Sonya is 22-years-old. She works at a local coffee shop and says the boss looks over her shoulder all the time and hassles her. She is particularly worried about one incident that happened about six weeks ago. During the busy lunch period, Sonya was hurrying with a tray of plates and glasses. She tripped and dropped the tray, breaking everything on it. The boss started screaming at Sonya in front of all the customers and staff. Since then, Sonya has told this story to her friends over and over. She also says she feels sick in the stomach almost all the time and keeps going over the incident in her head. She can't eat or sleep properly.

- 1 What do you think is happening with Sonya?
- 2 Is what's going on here a problem for Sonya? Why do you say that?
- 3 If you were a friend of Sonya's, who could you discuss your concerns with?
- 4 What could Sonya herself do?
- 5 If you were in Sonya's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person/place most likely to be able to help with Sonya's situation? Why? What might make it harder for Sonya to approach that person? What might make it easier?
- 7 Is there anybody or any place that Sonya would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Sonya?

NIGEL, 20

Nigel is 20-years-old. He's in his second year at university and has found being there a real struggle. He's had trouble sleeping and feels very negative about people and life in general. A few weeks ago he began having some strange experiences. For example, he began seeing people out of the corner of his eye who were looking straight at him but who were not there when he looked again. He was also sure there was someone yelling at him and calling his name loudly in his ear. It seemed like every radio announcer was talking directly to him on the radio and telling him what to think or what to do.

- 1 What do you think is happening with Nigel?
- 2 Is what's going on here a problem for Nigel? Why do you say that?
- 3 If you were a friend of Nigel's, who could you discuss your concerns with?
- 4 What could Nigel himself do?
- 5 If you were in Nigel's situation, who is the first person you might go to for help? Why? How helpful would they be? Are there any reasons why they wouldn't be able to be helpful?
- 6 Who do you think would be the person / place most likely to be able to help with Nigel's situation? Why? What might make it harder for Nigel to approach that person? What might make it easier?
- 7 Is there anybody or any place that Nigel would not approach for help? Why is that? Are there any ways of asking for help that might make things worse for Nigel?

Care of the seriously mentally ill in Australia

Services for the mentally ill have changed radically for the better in the last 40 years, as this excerpt from a recent major survey shows

Schizophrenia Australia Foundation has completed a wide-ranging survey and rating of state and regional services (Care of the Seriously Mentally Ill in Australia, 1994).

The main objectives of the survey were:

- to put information on public record
- to identify good services to learn from
- providing information which can be used to carry out improvements in existing services.

The following excerpt from the survey provides an historical background to mental health services in Australia over the last 40 years.



Historical context: the last 40 years

Dr Eric Cunningham Dax

In 1952, Dr Eric Cunningham Dax arrived from England to take up a position as chairman of the newly-founded Mental Hygiene Authority of Victoria. A decade later, he recalled those times in his book, *Asylum to Community*¹.

Mental health services in Australia owe a tremendous debt to Dr Dax: his energy, ability, dedication and vision led them out of their darkest period into the modern age

'The [Mental Health] Department by 1952 was mostly in a state of utter neglect and far below the standard of the oldest and most backward hospitals at that time in Great Britain or those seen in Europe... The wards were mostly very dirty and little more could be expected from the unsanitary state of affairs. Chamber pots were used nearly everywhere and frequently stored during the day in the same place as the food was prepared. The smell was abominable because straw mattresses were fairly generally used and only periodically refilled, the filthy straw being turned on to a heap. The toilets were without seats and frequently broken and were quite insufficient in numbers, while the totally inadequate washing accommodation was also dreadful. There was a considerable amount of mechanical restraint and solitary seclusion used, and the staff must have been in the greatest possible difficulties to know what to do for the patients, with no facilities available in

most cases for their care. These deplorable conditions were accentuated by an overcrowding in the nature of 1500 people, many of whom were sleeping on mattresses on the floor. The serving of the food and its presentation was revolting.'

On taking up his position, Dr Dax set about raising the standard of mental health services. Three years later, Stoller and Arscott could write, 'Victoria was, in our view, the best-equipped state in the Commonwealth, both in regard to mental health facilities and to planning.'

Mental health services in Australia owe a tremendous debt to Dr. Dax: his energy, ability, dedication and vision led them out of their darkest period into the modern age.

The Stoller and Arscott Report, 1955

The Commonwealth Government commissioned a psychiatrist, Dr Alan Stoller, and an administrative officer, Mr K. Arscott, to survey mental institutions in Australia.

Most of the institutions at that time were mental hospitals: there were few general hospital psychiatric units, and few outpatient clinics. Hospitals everywhere were overcrowded: this phrase comes up constantly.

Western Australia was 'backward psychiatrically'. South Australia was relatively 'backward'. Queensland hospitals were 'not good' and needed to be decentralised. In New South Wales, 'the Mental Hygiene Department has lagged behind world developments in psychiatry. It has been so starved of essential monies, even for adequate maintenance, over so many years...' Callan Park Hospital in Sydney had 1845 patients in residence, with 'floor beds solidly packed to such a degree that any

patient wanting to get to the lavatory at night, had to crawl over patients. Hygiene facilities, especially in dormitories, were appalling.'

Tasmania's mental hospital also had certain parts which 'could only be described as appalling' and maintenance was 'shocking'.

Victoria's mental hospitals were improving, though the words 'appalling', 'shocking' and 'dreadful' were still used to describe the Kew Mental Hospital.

Around the country, staffing levels were ridiculously inadequate.

Goodna Mental Hospital, near Brisbane, had 2 403 patients, making it the largest hospital in Australia: there were seven medical staff, none with full psychiatric qualifications. The hospital had no social workers or occupational therapists.

Bloomfield Mental Hospital in Orange, NSW, had two psychiatrists and one medical officer for 1 655 patients. The Reception Houses had somewhat better staffing but they had a very high rate of turnover, for example, Darlinghurst Reception House in Sydney had 3 000 acute psychiatric admissions a year.

Reading their report today, one can feel the despair that politicians, bureaucrats, mental health professionals, relatives, and most of all, patients, must have felt at this overwhelmingly dreadful situation

Stoller and Arscott concluded, 'Australian standards are generally lower than those existing in the United Kingdom, United States of America, and Canada. They are lower in terms of beds, staffing, excremural activity and research. Yet standards overseas are by no means ideal. There has been a move forward since 1945, certainly in the United States of America and Canada, which has not been paralleled

in Australia.' They added: 'There is, in most states, insufficient central staff to plan adequately for the psychiatric needs of the State and to initiate developmental programs. Mental hospitals are hopelessly overcrowded, poorly maintained and short staffed'. Three states had no qualified psychiatrists in the Mental Hygiene Department.

They stated that clinical psychologists were only employed in any numbers in Victoria: shortages in social workers were 'so chronic, that a relative inertia had been induced': occupational therapists were in short supply.

Reading their report today, one can feel the despair that politicians, bureaucrats, mental health professionals, relatives, and most of all, patients, must have felt at this overwhelmingly dreadful situation.

1955 to the mid 1960s

After the Stoller and Arscott Report, the other states slowly set about following Victoria's lead. The Commonwealth Government gave ten million pounds to the states to improve their mental hospitals.

More staff were recruited, staff training was upgraded, rehabilitation programs were introduced, buildings were renovated and new ones built: out-patient clinics were opened in locations away from the hospitals.

The problem of the awful overcrowding was tackled too, and the numbers in hospitals levelled off and then began to fall gradually.

There were two ways the overcrowding was solved. One method was to discharge long-stay patients from the back wards of the hospitals.

This was relatively easy in that period: many patients gradually lose their symptoms over time, and in the hopelessly staffed mental hospitals prior to the late 1950s, there was no-one to assess them with a view to discharge. This could now begin to happen.

The psychiatrists say they began deinstitutionalisation not to save money, but because they believed it was better for the patients.

What is more, medication was available to control symptoms. Patients were assessed, placed into hostels or boarding houses, and followed up by domiciliary staff from the hospital. As they left the hospital, beds in the ward were reduced.

The other method of alleviating overcrowding was 'non-institutionalisation'. Patients admitted to hospital had their symptoms rapidly brought under control with the new medication.

When they improved, they were discharged back home and given out-patient appointments. It was difficult to get from the admission ward to the long-stay wards because beds were being dismantled.

By the late 1960s, the despair of the past had gone. The walls had come down from around the mental hospitals, the medication seemed to help many individuals to improve: stigma was decreasing: overcrowding was disappearing: staff were plentiful. What had brought about the change?

The commonest answer is that administrators did it to save money. But talking to psychiatrists who were working in the hospitals at the time, there is no support for that allegation.

The appalling nature of the hospitals conflicted with the increased social consciousness and responsibility that had developed during and after the Second World War.

Something had to be done. None of the psychiatrists claimed there was any pressure on them from administrators to discharge patients.

One psychiatrist who was superintendent of a mental hospital recalls a senior administrator expressing concern that caring for people outside hospital was going to cost more.

The psychiatrists say they began de-institutionalisation not to save money, but because they believed it was better for the patients.

Following the 1961 Royal Commission into allegations of cruelty and neglect in Callan Park Mental Hospital, the principles of decentralisation and community orientation were stressed.

Dr Bill Barclay became Director of State Psychiatric Services, and the period when he held that office, and subsequently became one of the five health commissioners for New South Wales, was a time of most rapid decline in that state's mental hospital population – from 12 421 in 1965 to 7 426 in 1975.

When the intellectually retarded are excluded from the statistics, the numbers fall even more sharply – 8 889 in 1965 to 4 382 in 1975, a reduction of 50 per cent. The ratio of inpatients to staff fell from about three to 0.94 over this time.

The total money spent on operating the mental hospitals increased 63 per cent from \$53.6 million to \$87.3 million, but when allowance was made for inflation, the average weekly cost per patient increased 172 per cent, from \$83 to \$226. Total admissions went from 15 689 in 1965 to 23 628 in 1975, an increase of 50 per cent. Shiraev has broken the admission figures down by diagnosis.

Admissions with a diagnosis of schizophrenia increased by 41 per cent; a diagnosis of depression (psychotic and neurotic) increased by 62 per cent; and a diagnosis of alcohol-related disorders increased by 113 per cent.

This last group, from 1973 onwards, exceeded the number of admissions of people with schizophrenia. A new clientele had entered the mental hospitals.

Mid-1960s to mid-1970s

The late 1960s and early 1970s were heady years for mental health staff, and several psychiatrists have written about them as the golden years of public psychiatry.

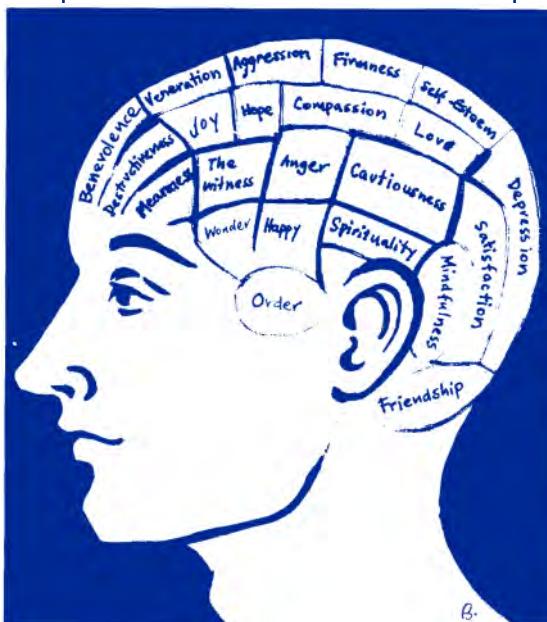
Certainly they were golden compared to the immediate past. Probably the most important ingredient was the feeling of hope that

so-called 'schizophrenogenic mother' would soon disappear.

Prior to 1973, the development of community mental health services was rudimentary and consisted of a few staff, mostly nurses, going out each day from a mental hospital base to a community outpost to provide services for discharged patients.

Following the elections of the Whitlam Government, the Commonwealth poured in money to the states to establish community mental health services: so much money in such a short time that the states had difficulty digesting it and supervising the expansion. Amidst all the euphoria, staff in the new services began to 'do their own thing'.

The task of helping the mentally ill was much more difficult, much more complex than anyone had realised in the 1960s



things were improving and would keep on improving.

Patients were being placed in the community without any worry that the boarding houses were often of poor standard or overcrowded: that could be fixed.

In the meantime, the domiciliary nurses from the hospitals called regularly to see that the patients took their medication. Most individuals with mental illness could get jobs: even if they could not keep them, it did not matter because another one was waiting in the full employment market of the time. Housing was not a major problem: and most patients from the admission wards were going back to their families.

There were senior psychiatric staff in the mental hospitals (private psychiatry was not reimbursed by health insurance, and Medicare had not yet commenced). The idea of the

This usually did not involve spending much time with the mentally ill. The new priorities involved treatment of those with neurotic disorders, or with no diagnosable mental disorder but with marital or family problems.

Community development became popular, and 'prevention' – that ill defined concept – was everybody's goal. Community mental 'health' was going to fix everything.

1975 to the Present

It took only a few years for the euphoria to wear off. Problems which had been smouldering for years now became apparent, and increased, after 1975, with the worsening economic situation.

The dismiss of the families caring for their mentally ill relatives began to emerge (and, in fact, led to the formation of the Association for the Relatives and Friends of the

Mentally Ill, in NSW in 1976, and the first Schizophrenia Fellowship, in Victoria in 1978). Complaints by families about being blamed for causing mental illness were voiced.

The plight of the mentally ill in the boarding houses and special accommodation houses surfaced: although the residents told researchers they preferred the boarding houses to the hospitals, the houses were seen as a form of 'trans-institutionalisation', and calls were made for something to be done.

As the economy worsened, the mentally ill now had greater difficulty obtaining jobs, let alone keeping them.

The Commonwealth Government changed its method of funding for the state governments' health services: moreover, they cut the funding at the same time as the state governments were experiencing financial problems.

As a result, mental health services began to be cut back. The links between community mental health centres and the mental hospitals were severed, and continuity of care became tenuous.

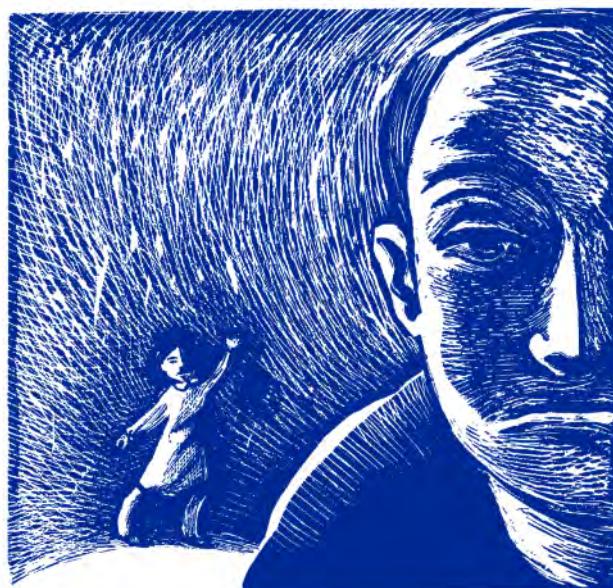
Psychiatrists were leaving the public sector because Medicare guaranteed them a high income and they were free to practice as they wished.

The 1970s ended, and so had the hopes of a decade earlier. The

task of helping the mentally ill was much more difficult, much more complex than anyone had realised in the 1960s.

The early 1980s added another problem as the mentally ill turned up among the homeless populations in the inner cities.

This phenomenon has been popularly attributed to deinstitutionalisation: the term



'back wards to back streets' came into vogue to describe the process.

The evidence shows something different in Sydney. Teesson and Buhrich found 22 men with a diagnosis of schizophrenia in a random sample of 86 men in a large shelter for homeless men.³

Although some of the men had been going in and out of psychiatric

hospitals and clinics for many years, only two had gone to the shelters prior to 1981: most had gone into the shelters for the first time in the period 1981–84.

The peak period of deinstitutionalisation in New South Wales was 1965–1975. Clearly other factors must be involved.

One obvious one was the tightening of the Sydney housing market around 1980. There must surely be others. The whole topic awaits its researcher. (In the United States there was a similar long-time lag between the decrease in the population of the mental hospitals, which began even earlier, and the appearance of the mentally ill among the homeless in the late 1970s.)

The 1980s and 1990s saw the struggle to readjust taking place in a continually worsening economic climate.

The mentally ill had left the mental hospitals, but the money allocated for their care was still back in the hospitals. Attempts by bureaucracies to unlock the money had little success, and in places have resulted in bitter fights with unions.

*From: Care of The Seriously Mentally Ill in Australia
A Rating of State & Regional Programs
March, 1994
Schizophrenia Australia Foundation*

¹ Dax, E.C., 1961, *Asylum to Community: The Development of the Mental Hygiene Service in Victoria*, Melbourne. F.W. Cheshire.

² Stroller, A. & Arscott, K.W., 1955, *Report on Mental Health Facilities and Needs in Australia*, Canberra, Government Printer.

³ Teesson, M. & Buhrich, N., 1990, 'Homelessness in Australia'. Hospital and Community Psychiatry (publisher's details not provided, Ed.).

Taking actions,

creating options

Intention

In this session it is intended that students:

- develop an understanding that mental illness is an issue that may directly concern them
- identify and practice a range of behaviours related to self-help and help for others
- identify barriers and difficulties in taking action in support of people experiencing a mental illness or those affected by it.

Resources

- Section 3 of the *MindMatters* video
- Space for role-plays and class discussion

How to

ACTIVITY 1: Getting help

1. Section 3 of the *MindMatters* video shows the use of role play technology in dealing with two situations involving young people: a suspected eating disorder in a young woman, and a young man who is experiencing depression and withdrawal from his peers.
2. Play section 3 of the video for the class.
3. Rewind and replay the first scenario dealing with the suspected eating disorder. Use the sample questions to guide class/group discussion of the issues.

Sample questions

- Could it happen at this school?
- If it did happen within your group of friends, what would you do, where could you go? Where would you go?
- Why is it possible that the girl's parents had 'done nothing' about her situation?

Setting up role-plays

It helps the actor if they know:

- who they are playing
- what the scene is about
- when the scene is taking place
- where the scene is taking place
- what their character wants.

Managing role-plays

- Try simultaneous role-play first to build confidence and engagement. In a simultaneous role-play all actors are at work, and there is no audience.
- Keep it short. Complete stories are not required.
- Stop and start the action to guide focus of discussion.
- Use replay, discussion and interview techniques.
- Ask reality testing questions, for example, 'Was that more like real life or more like a soap opera/comedy version?
- What would the real life drama look like?

Debriefing

Use the sample questions as part of the debriefing process.

- How easy would it be for you to go to her parents to say that you are concerned about her health?
- How easy would it be to go to a local health service and get help?
- Script out a conversation between yourselves and her parents or the health service. Script out a conversation between yourselves and the girl if she realised that you had been speaking to her parents. Role-play one or both of these situations.

4. Replay the second scenario dealing with the young man who is staying away from school and his friends. Class / group discussion of these issues could focus on the following sample questions.

Sample questions

- Is this situation common among young men at this school? Among young women? Do you think there are differences between young men and women in relation to depression and losing contact with friends? If so, what could explain these differences?
- Is Luke experiencing an episode of mental illness, or is he just going through a 'normal' part of adolescence?
- What could be the results of Luke dropping out of school?
- Who is likely to be able to support him in dealing with his difficulties? What could his friends do if they were concerned about him?
- Are there any resources in your school or the local community that could help Luke? If you can't answer this question, how would you go about finding out this information?
- What other situations are there where you might have to seek help for friends in relation to their mental or emotional health? Each group could sketch out one situation and explain it to the rest of the class, including what action they and others in the local area could take to help the person.

Protective interrupting is where a teacher interrupts a student so that a story is not shared or told. It is a teaching strategy designed to protect:

- **the person telling the story** from disclosing into the public arena, or from damaging their reputation
- **those who the story is told about** they have the right to privacy
- **the class member** from distress at hearing a disclosure, or from covert pressure to be engaged in social activities of ‘high status’ risky behaviours
- **the course and the teacher** from side tracking off the discussion activity, or from allegations that the course is an arena for gossip or intrusion upon the privacy of others.

ACTIVITY 2: Actions and reactions

1. This activity uses role-play in the classroom around other situations. The teacher can select issues that have been raised in earlier work in this unit, that are relevant in the local community, or select from the list below.
2. In each case, the purpose of the role-play is to pose a situation, explore feelings, actions and reactions of the characters, identify options for action, and things that might make it difficult for young people to take action about their own health or that of their friends or relatives. The teacher plays a crucial role in prompting students’ thoughts and moving them forward during the role-play, in using other students to identify what individual characters are thinking or feeling, or in persuading them to take certain actions (even where these ‘persuaders’ play the part of the person’s own mind).
3. **Possible situations**
 - A student returns to school after an episode of mental illness. Lots of rumours are going around the school. You are a friend, and are a bit afraid of how, or even whether, to approach your friend.
 - You find out that Jane’s mother has schizophrenia. Jane is one of your group of friends.
 - One of your teachers has had a ‘breakdown’. He has been on sick leave but is just about to come back to school, and he will be your home group teacher again. You’ll have to see him every day.

ACTIVITY 3: Discussion

1. Use the sample questions to guide discussion of the role-play scenarios.

Sample questions

- How could these characters take action in support of their friends?
- How might the attitudes of others affect this character?
- Where could this person go for help?

Face to face

Intention

In this session it is intended that students:

- be exposed to and consider personal experience of living with mental illness from the perspective of both consumers and carers
- develop an understanding of the impact of mental illness on both consumers and carers.

Resources

- Visiting speakers **or**
- Mental illness videos (see Resource list on the back page)

How to

ACTIVITY 1: Guest speaker

1. Invite as a guest speaker a person who has direct experience of a mental illness and /or a person who has cared for someone with a mental illness.
Community mental health services, relevant support groups, and mental illness associations may be able to supply details of suitable speakers.
2. It is important that the visiting speaker is given a brief on the context within which the visit is occurring, or on the nature of the class group.
3. Students also need to prepare for the visit. Based on what they have learned so far in this unit, they are to develop a list of questions and issues they want covered.
4. Before the presentation begins, establish whether the speaker is happy to have questions asked during the talk or would prefer them left to the end.
5. After each talk it is beneficial for students to be given as much time as possible to interact with the presenter(s), asking questions and discussing issues.

ACTIVITY 2: Reflecting upon the new information

1. This activity may take place after the presenters have left or while they are still there, depending on time available and the needs of particular classes.
2. In groups or as a homework reflection, students are asked to discuss what they learned from the talks, using the sample questions as a guide.

ACTIVITY 3: Selected video

1. Use a video concerning the personal experiences of mental illness. Select from the videos listed in the Resource list on the back page.
2. Watch the video with the class.
3. Use the sample questions to guide discussion about the video.

Sample questions

What did you learn from the talks or video that:

- helped you understand mental illness better?
- you did not know before?
- seemed to you particularly important?
- surprised you?
- contradicted something you had always believed about mental illness?
- made you rethink your previous views on mental illness?
- made you feel more (or less) positive and hopeful about mental illness?
- helped you to understand better how community ignorance and stigma affects carers and consumers?
- made you feel more or less afraid of mental illness?
- made you feel happy or sad or angry or embarrassed or some other emotion?

Be sure that adequate preparation is given to this session so that the presenters and the teacher are clear about:

- time available
- students' prior experience
- context of school
- any special circumstances of students.

It should be made clear to groups that the questions are provided to help them explore their responses. They must not feel limited by them: they must be encouraged to allow discussion to move off the questions, so long as it continues to deal with their responses to the talks.

Resource list

MindMatters bibliography

<http://www.curriculum.edu.au/mindmatters>

Websites

<http://www.nimh.nih.gov/>

National Institute of Mental Health

US Department of Health and Human Services

Comprehensive information on specific mental disorders, their diagnosis and treatment

<http://www.health.gov.au/mentalhealth>

National Mental Health Strategy.

Useful information and brochures on depression, schizophrenia, eating disorders and anxiety disorders

<http://www.kidshelp.com.au>

Kids Help Line

Help line for young people and information on issues such as relationships, prejudice, and suicide

<http://www.reachout.asn.au/>

New Australia Foundation Ltd

Comprehensive information about youth suicide including advice and support

Videos

For copies of the full videos used in the *MindMatters* showreel video, please contact:

Attitude: World of the Mentally Ill

Attitude: Suicide

ABC TV Program Sales

(02) 9950 3173

Flipping Out and Hanging On

Marcom (07) 3340 8900

Spinning Out

Film Australia (02) 9413 8777

One in Five (advertisements)

One in Five (video)

State of Mind

Mental Health Branch

Commonwealth Department of Family and Community Services

1300 653 227

Mental health brochures

Available from:

Mental Health Branch of the Department of Health and Ageing

GPO Box 9848

Canberra ACT 2601

Tel 1800 066 247,

Fax 1800 634 400



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