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Serious mental illness? Categorical measurement for health service systems

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Diagnosis of mental illness has been formally recognised for hundreds of years. Another approach to the categorisation of mental illness has more recently developed to inform the design, resourcing and provision of mental health services. Instead of diagnosis, the characteristic feature is the estimation of need for a type of service predicated on the functional impact of the illness on everyday life. This schema generates categories such as 'serious mental illness' to represent population need for services including acute response, multidisciplinary team-based care, case management and inter-agency coordination. There are a raft of disorders, such as obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), eating disorders and personality disorders, which occur across a spectrum of impact and severity. They all qualify as serious mental illness if sufficiently impairing. However, public mental health systems have predominantly focused on chronic psychosis and acute risk. Set against resource constraints, this has come at the cost of developing the capacity or mandate for treating other conditions. There is a generational opportunity to reset the paradigm. A classification system based on the health service needs of people with mental illness has been developed over the past decade to serve the establishment of a National Mental Health Service Planning Framework in order to assist in the organisation and resourcing of clinical care in Australia.

Looking abroad can frame the context. The US federal definition of serious mental illness followed a mandate from the 1992 Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act which itself used a definition created by the US Department of Health and Human Services to assist state governments applying for grant funds, based on epidemiological estimates, to support clinical services. This definition included any mental illness associated with severe symptoms and functional impact. The establishment of the 'serious mental illness' category, determinant of clinical service funding, appears to have influenced the very research activity that generates the prevalence and clinical need data used to determine funding allocation. For instance, a PubMed search for 'serious mental illness' relative to the 1992 US Federal legislation reveals 25 publications before and 5495 since. It should not be a surprise that research aiming to inform policy and improve service provision uses terminology set out by the funding agency. However, the research activity should, among other things, test the validity and reliability of this type of categorisation of mental illness in addition to the effect of its implementation which determines whether people with mental illness can access treatment.

Despite the proliferation of 'serious mental illness' in the research literature, where definition to enable replication is essential, there is major variation and ambiguity. A systematic review of 788 studies of people with 'serious mental illness' or 'severe mental illness' found that 85% of studies did not provide an operational definition (Gonzales et al., 2022). And that, of the 15% that did define the term, there was minimal between-study agreement. In contrast to the 1992 US Federal definition which included all types of mental illness so long as they were associated with substantial functional impairment, only 4% of the overall sample of 788 research studies allowed that 'any' diagnosis could constitute serious mental illness. The samples were overwhelmingly characterised by a diagnosis of psychosis, seemingly to the exclusion of other conditions. For instance, only 1% of the 788 studies included a diagnosis of OCD. Indeed, some studies operationalised serious mental illness as a diagnosis of a psychotic disorder. The substitution of serious mental illness in lieu of the more accurate psychotic disorder can be understood as incentivised by policy settings (Kale et al., 2017). Nonetheless, the sequelant

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'semantic shift' in the meaning of serious mental illness feeds back into health services, for instance, via reports commissioned by policymakers (Kakuma et al., 2017).

Nonetheless, the practical meaning of concepts such as serious mental illness is perhaps most influenced by resource available at the coalface. For instance, triage decisions by state mental health services with finite resources mean that psychotic illnesses and acute risk will typically be dealt with first. This is one reason for the age-based banding of health services: the mental health needs of children would be de-prioritised according to these criteria.

Compounding the implications of the applied definition of serious mental illness is the impact of the reduced range of accepted diagnoses for continuing care by public mental health services on the readiness to deliver treatments such as trauma-focused cognitive behavioural therapy for PTSD or exposure and response prevention therapy for OCD. These types of therapies require specialised training and supervision in addition to sufficient clinical practice to maintain competency. This skill gap then influences the likelihood that a service will accept a referral, albeit in the context of broader resource constraints.

High-quality epidemiological studies of the prevalence of mental disorders, associated functional impact, and clinical need are critical to service planning. However, owing to the cost of this type of research, supplementary methods are also used. For instance, one indicator of clinical need to determine the prevalence and types of serious mental illness is the analysis of mental health service utilisation. This is something of a *Catch-22*. Public mental health service admission processes are influenced by their definition of serious mental illness. People with diagnoses or acute risk profiles not conventionally accepted as serious mental illness may have trouble accessing services and thereby not be represented in research studies using service utilisation as a measure of clinical need (Whiteford et al., 2017). This then reinforces their omission from the category of serious mental illness as currently applied.

The formal policy definition of serious mental illness in Australia has developed over the past decade as part of a broader process (Whiteford and Diminic, 2020). In 2009, Australia's Fourth National Mental Health Plan committed to the development of a framework to establish targets for a full range of mental health services. Between 2011 and 2013, NSW Health and Queensland Health jointly led the initial development which included comprehensive stakeholder engagement. In 2018, researchers from the University of Queensland were commissioned to continue the development of a National Mental Health Service Planning Framework. The Framework, now operational, incorporates population estimates and other data to arrive at age-banded mental illness severity categories (mild, moderate, severe-standard and severe-complex) based on the level of functional impact and type of health service response needed. The severe-complex group needing intensive multidisciplinary care and inter-agency coordination provided by specialist public mental health services and so could be considered to represent serious mental illness (Gossip et al., 2023). The categorisation system used in the Framework is predominantly transdiagnostic, albeit with accommodation for first-episode psychosis and perinatal mental illness. The Framework will continue to incorporate epidemiological and other data, the availability and quality of which will be critical.

It is worth considering OCD as one case example relative to this new Framework. The Australian Institute of Health and Welfare estimates that 3.5% of adults have OCD, a condition that typically has its onset in childhood or youth (Australian Bureau of Statistics, 2023). Community estimates indicate that one third of people with OCD have severe symptoms which are associated with severe functional impairment across multiple domains (Ruscio et al., 2010). Indeed, one cohort study shows that severe OCD is associated with the same functional impairment in independent living skills as schizophrenia and that this impairment reversed on treatment for OCD (Bystritsky et al., 2001). These data indicate that OCD, as with any mental disorder, occurs across a range of illness severity and functional impact.

The architects of the National Mental Health Service Planning Framework recognised current limitations of available data. Indeed, they highlight the opportunity to enhance health data systems to iteratively improve the performance of the Framework (Whiteford et al., 2017). Policymakers, health service providers, researchers and other stakeholders have an opportunity to re-imagine how we measure mental illness including what we mean by terms such as serious mental illness and the impact this has on access to mental health services in Australia.

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References

Australian Bureau of Statistics (2023) *National Study of Mental Health Wellbeing methodology*. Canberra, ACT, Australia: ABS. Available at: www.abs.gov.au/methodologies/national-study-mental-health-and-wellbeing-methodology/2020-21 (accessed 29 October 2023).

Bystritsky A, Liberman RP, Hwang S, et al. (2001) Social functioning and quality of life comparisons between obsessive–compulsive and schizophrenic disorders. *Depression and Anxiety* 14: 214–218.

Gonzales L, Kois LE, Chen C, et al. (2022) Reliability of the term 'serious mental illness': A systematic review. *Psychiatric Services* 73: 1255–1262.

Gossip K, Diminic S, Comben C, et al. (2023) *The National Mental Health Service Planning Framework – Care Profiles and Top-ups – Commissioned by the Australian Government Department of Health and Aged Care* (Version AUS V4.3). Brisbane, QLD, Australia: The University of Queensland.

Kakuma R, Hamilton B, Brophy L, et al. (2017) Models of Care for people with severe and enduring mental illness: An evidence check rapid review brokered by the Sax Institute for the NSW ministry of health. Available at: www.saxinstitute.org.au (accessed 30 October 2023).

Kale B, Siravuri HV, Alhoori H, et al. (2017) Predicting research that will be cited in policy documents. In: *Proceedings of the 2017 ACM on web science conference*, Troy, NY, 25–28 June, pp. 389–390. New York: ACM.

Ruscio AM, Stein DJ, Chiu WT, et al. (2010) The epidemiology of obsessive-compulsive disorder in the national comorbidity survey replication. *Molecular Psychiatry* 15: 53–63.

Whiteford H and Diminic S (2020) The National Mental Health Service Planning Framework: Where has it come from and what is its future? *Australian and New Zealand Journal of Psychiatry* 54: 1152–1153.

Whiteford H, Buckingham B, Harris M, et al. (2017) Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. *Australian and New Zealand Journal of Psychiatry* 51: 799–809.