Catching them before they fall…
early intervention in mental health

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Why youth mental health?

Age of onset for all mental disorders (%)
Kessler et al 2005

Why early intervention?

- Duration of untreated illness associated with more adverse life outcomes
- Major biological, psychological and social changes in adolescence result in increased risk factors
- Intervening early can modify risk factors thereby reducing illness progression and the secondary collateral impacts of social and vocational functioning (McGorry et al 2007)
- High rates of DHS. Suicide is a leading cause of death in this age group (Patel et al 2007)
- Maximum negative impact of illness in terms of social and economic outcomes (for both the individual and wider society is 22) (Murray & Lopez 1996)

Clinical Challenges for EI

- Most YP with mental health problems do not seek/receive face-face professional care
- Wide range of presenting issues; relationship breakups through to psychosis.
- Limitations of current diagnostic systems as they apply to early forms of disorder
- Many with evolving, unclear or mixed sub-syndromal presentations receive no or at best poor care
- Those with early forms of disorder just as impaired in terms of symptoms and functioning
- What's the most effective and safest intervention for this person at this time?
- Managing the developmental needs of young persons and their support systems (parents, friends, schools, etc)

‘Sub-Syndromes’

- Those with sub-syndromal depression, bipolar disorder and psychosis at much higher risk of developing ‘full-blown disorders’
- 27.4% SS Depression -> Severe Depression in 1-2 years (Fergusson et al 2005)
- 45% with SS Bipolar to either BPI/BPII within a year (Axelson et al 2011)
- ~20% SS Psychosis to schizophrenia (McGorry et al 2012)

Scott et al 2009 MJA

Table 3: Diagnostic characteristics of patients attending youth mental health programs at the BMRI Youth Mental Health Clinic and headspace Campbelltown

<table>
<thead>
<tr>
<th>Primary diagnosis* (%)</th>
<th>BMRI Youth Mental Health Clinic</th>
<th>headspace Campbelltown</th>
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<tbody>
<tr>
<td>Affective disorder</td>
<td>18%</td>
<td>22%</td>
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<tr>
<td>Anxiety disorder</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>Ultra high risk</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Substance use</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Autism spectrum</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>No clear diagnosis</td>
<td>75%</td>
<td>52%</td>
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*Not determined by assessing clinician at point of service entry. Ultra high risk of severe affective or psychotic disorder according to the clinical staging model developed by McGorry et al.

Scott et al 2009 MJA
Clinical Staging

- Model used in general medicine and applied to diseases that are chronic and have an illness course (such as cancer)
- Aims to match interventions to stage of illness to ensure safer and effective interventions are offered.
- Ultimate aim is to reduce illness progression
- Early forms of illness as modifiable risk factors for later and more serious illness
- Helps clinicians be more aware of the possible course of illness
- Has been applied mostly to psychotic disorders (McGorry et al 2006), with emerging application to other serious disorder pathways

Staging at a glance

- Stage 4: Severe, persisting and unremitting illness
- Stage 3: Recurrent or persistent disorder
- Stage 2: First episode of 'serious' disorder
- Stage 1b: Attenuated syndromes
- Stage 1a: Help-seeking with mild symptoms
- Stage 0: Non-help seeking with risk factors

Mental health service tiers

- Long Stay Facilities (Tertiary)
- Specialist Community Mental Health Services (State-based-Secondary)
- headspace (Specialist/ Enhanced Primary Care)
- Primary Care (GPs, School Counselling, Generalist Community Services)

Severity/Complexity/Chronicity Staging: 1a          1b          2            3+

Stage by Type

- Developmental
- Anxiety
- Circadian

Hickie et al. (2013) BMC Medicine

Staging Percentages

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<tbody>
<tr>
<td>1a</td>
<td>33.3%</td>
<td>40.5%</td>
<td>10%</td>
</tr>
<tr>
<td>1b</td>
<td>38.2%</td>
<td>40.3%</td>
<td>54%</td>
</tr>
<tr>
<td>2</td>
<td>14.3%</td>
<td>11.1%</td>
<td>25%</td>
</tr>
<tr>
<td>3+</td>
<td>7.3%</td>
<td>8.0%</td>
<td>11%</td>
</tr>
</tbody>
</table>

* Data combined with in-city service who typically see older clients with greater illness chronicity
Stage progression

- **Stage 1a**
  - 40% of all clients
  - 10% transition rate

- **Stage 1b**
  - 5% of clients
  - 50% transition rate

- **Stage 2**
  - 5% of clients
  - 50% transition rate

- **Stage 3**
  - 5% of clients

Hickie et al 2013
*Early Int Psychiatry*

Current Research

- Service level research applying clinical staging to service delivery:
  - more thorough assessment, including psychometrics, medical (metabolic), neuropsych
  - monitoring progress more assertively/regularly
  - reducing premature treatment drop out
  - determining the mix of interventions that result in reduced progression

Cross et al in press *Psychiatric Services*

Neuropsych Differences

Hermens et al. (2013) *BMC Psychology*

Thanks

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