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Research report

Disability is already pronounced in young people with early stages of affective disorders: Data from an early intervention service

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ABSTRACT

Background: Although there is growing recognition that disability emerges early in the course of psychotic disorders, it is unclear whether young people with early stages of anxiety or affective disorders are similarly affected. This study examined patient self-reported disability in young people attending a designated early intervention service.
Methods: Cross-sectional study comparing new *headspace* patients on self-reported measures of disability and distress (Kessler-10, Work and Social Adjustment Scale, and Brief Disability Questionnaire) with clinician-rated diagnosis and clinical stage.
Results: Data from 330 participants with an average age of 16.8 years (50.0% male) was analysed and demonstrated high levels of psychological distress and disability in the overall group. Higher levels of self-reported psychological distress and disability were associated with affective disorder diagnosis and increased with advancing clinical stage. Female gender and younger age also predicted affective disorder diagnosis.
Limitations: Clinician-rated participant disability was obtained via a single global measure (SOFAS) and not a systematic assessment. Additionally, data collected was cross-sectional and collected at intake only. Longitudinal assessment of clinical features and disability is required to map changes in disability over time.
Conclusions: Surprisingly high levels of psychological distress and disability are apparent in young people presenting to early intervention services. Data suggests that distress and disability in those with anxiety is less than for affective disorder. Results also suggest that clinical staging approaches capture the increasing disability associated with illness progression. The obtained results highlight the need for interventions that specifically target disability, rather than just symptoms of mental health problems.

1. Introduction

Research in young people 'at risk' for psychotic disorders, via sub-threshold symptoms or genetic loading, has indicated that disability is already well established in the prodromal period (Yung et al., 2004a). Indeed, disability and impaired psychosocial functioning in these 'at risk' groups are likely consequences of sub-syndromal illness (Yung et al., 2004a; McGorry et al., 2007a; Yung et al., 2004b, 1995). Of concern to the early intervention services seeking to reduce illness burden (Hetrick et al., 2008b; McGorry et al., 2007a) is that not only does disability peak before symptom frequency and intensity have reached the threshold for clinical diagnosis, but also persists despite symptom resolution (McGorry et al., 2002; Yung et al., 2002, 2004a).

In Australia, there now exists an innovative opportunity to examine the emergence of disability in those 'at risk' of non-psychotic mental disorders. This opportunity is in association with *headspace*, a novel services framework targeting youth

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mental health (McGorry et al., 2007c). With an overarching mandate of reducing illness burden amongst young people aged 12–25 years, *headspace* sites offer young people a breadth of multi-disciplinary mental health services. Young people accessing this service are considered to be 'at risk', by virtue of the presence of sub-threshold symptoms, either with or without a decline in social, occupational or vocational functioning.

In clinical psychiatry, a promising paradigm for guiding targeted interventions has emerged in the form of the clinical staging model (McGorry, 2007; McGorry et al., 2006; Insel, 2009). This model offers a framework for tracking course of illness based on symptom progression, neurobiological changes and social and occupational impairment. An important test of the utility of the clinical staging model is the degree to which disability is progressive and correlated with clinical stage. An additional consideration, particularly when early clinical stage is linked potentially with treatments, is the degree of impairment at first presentation for care.

Early intervention research and treatment using this clinical staging approach has typically focused on those 'at risk' of psychosis (McGorry et al., 2006; McGorry et al., 2007a). No known studies to date have examined disability in young people 'at risk' of affective disorder. Moreover, although clinical staging paradigms have been proposed to be applicable to affective disorders (Hetrick et al., 2008b), none have examined whether disability progresses with stage or diagnostic group. This lack of attention to early disability in affective disorders has occurred despite the fact that affective disorders are a leading cause of disability worldwide (Scott et al., 2009; Hickie, 2002; Hetrick et al., 2008a; Lepine, 2001; Naismith et al., 2007; Hickie et al., 2009; Berk et al., 2007; Kessler, 2007). Additionally, like the psychotic disorders, depression is associated with underlying neurobiological changes that are linked to cognitive impairment (Hickie et al., 2005; Naismith et al., 2002, 2006) which, in turn are associated with disability (Naismith et al., 2007; Ormel et al., 2004; Rytsala et al., 2006). Thus, early intervention strategies targeting sub-threshold depressive symptoms (symptoms which are too few, infrequent, or lacking in intensity for threshold diagnosis) may result in improved patient outcomes (Hickie et al., 2009), altered neurobiology, and consequent reductions in associated disability.

The aim of this study was to examine patient self-reported disability in young people experiencing mental health problems, with particular focus on those 'at risk' of affective disorders. The specific aims were to examine disability with respect to: i) clinician-rated diagnosis; ii) levels of psychological distress; and iii) clinical stage.

2. Method

2.1. Sample

Participants were recruited from the *headspace* Macarthur, Campbelltown, and Southern Highlands (MCSH) Clinic located in Campbelltown, NSW, Australia. *Headspace* MCSH is a novel mental health service for young people with mental health problems aged 12–25 years. Patients are referred by general practitioners, paediatricians, schools, welfare agencies, family, friends, or are self-referred. Each referral is screened by an intake worker as part of an interview-based intake process. All *headspace* patients must be assessed as having a mental health problem by their own general practitioner and formally referred to *headspace* prior to assessment, in order to access Medicare funding. The *headspace* MCSH clinic comprises a range of clinicians (psychiatrists, clinical psychologists, neuropsychologists, mental health nurses, occupational therapists, vocational and educational specialists, and general practitioners) and all services are free to patients and are bulk-billed under Medicare. *Headspace* is a multi-disciplinary treatment clinic where patients are seen by multiple clinicians dependent on the presenting problem. *Headspace* MCSH is managed by a consortium of partners led by the Brain and Mind Research Institute, University of Sydney. The Human Research Ethics Committee approved this study, and all patients gave prospective written informed consent for their clinical data to be used for research purposes. Parental consent was obtained for patients under 16-years of age. Patients who did not consent for clinical data were not required to explain withholding consent.

2.2. Measures

Patient clinical information included demographic data, clinician assessment, and patient self-report questionnaires.

2.2.1. Clinical assessment

Assessment at intake was undertaken by: clinical psychiatrists, clinical psychologists, mental health nurses or general practitioners with training in the mental health field (Scott et al., 2009). Data was collected from the clinician who first assessed the patient at intake. In addition to standard assessment clinicians completed a structured assessment, which probed for the following: reason for patient referral; who the patient attended with; and primary diagnosis (DSM-IV based) or diagnostic area of the presenting concern (for subsyndromal disorders). Primary diagnoses or areas of presenting concern listed were affective (all affective disorders), anxiety (all anxiety disorders), psychotic (all psychotic disorders), personality (all personality disorders), attention deficit, conduct disorder, behavioural difficulties, substance misuse, eating disorder (all eating disorders), and diagnostic area not yet specified (not meeting criteria for any disorder). Personality, attention deficit hyperactivity, conduct, behavioural difficulties, substance misuse, and eating disorder categories were collapsed into a composite diagnostic group named 'behavioural/developmental' to allow for analysis. Clinicians rated functioning using the Social and Occupational Function Assessment Scale (SOFAS: Goldman et al., 1992; Morosini et al., 2000). On this scale, functioning is rated from 0 to 100, with lower scores suggesting more severe impairment. Additionally, in accordance with the early intervention framework and clinical staging model (McGorry et al., 2006, 2007b), clinicians, who had received training in the McGorry and colleagues clinical staging paradigm, were asked to indicate the clinical stage in accordance with the published criteria (McGorry et al., 2006, 2007b). This rating, focussing on symptoms, places patients at one of seven illness stages. These include: Stage 1 for subsyndromal disorders: 1a — mild or non-specific symptoms or 1b — higher risk for development of a full syndrome; Stage 2 — an episode of a DSM-IV based syndrome; Stage 3a — incomplete remission of a DSM-IV syndrome; Stage 3b — recurrence or