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Mental Health Stepped Care Model & Clinical Staging

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phn EASTERN MELBOURNE
An Australian Government Initiative

We acknowledge the Wurundjeri people and other peoples of the Kulin nation as the traditional owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

Introduction

1. EMPHN's Mental Health Stepped Care Model Update

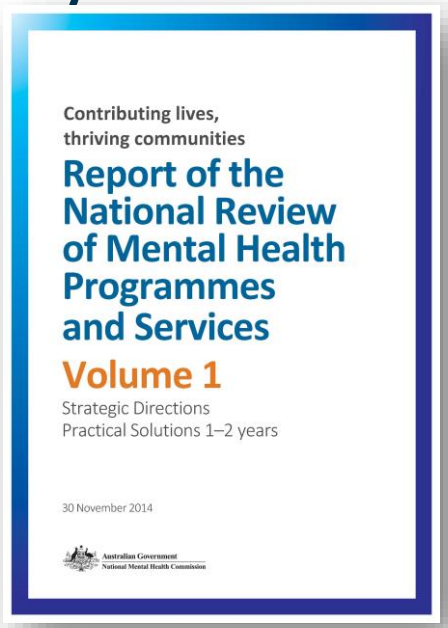
2. Mental Health Stepped Care and Clinical Staging

EMPHN's Mental Health Stepped Care Model

…..facilitating a person to live a 'meaningful and contributing life', considering 'whole-person care'

Policy Context: Commission

"instead of a 'mental health system' which implies a planned, unitary whole – we have a collection of ten uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice".



Government Response

Commission has provided a strong case to ‘redesign, redirect, rebalance and repackage’ the approach to mental health, and highlighted the risks of maintaining the status quo or further ‘tinkering around the edges’.

Mental Health Stepped Care Model

Aims to:

- Reduce programmatic silos
- Reduce service overlaps
- Facilitate better use of the health dollar
- Support clinicians to work at the **top of the scope of their practice**
- Encourage a **multi-disciplinary team approach**, including new workforces, such as peer workers, and new and innovative platforms such as eHealth and apps

Mental Health Stepped Care Model

A **continuum of primary mental health services**

- utilising a **person-centred stepped care approach**
- **evidence informed**
- **recovery-orientated**
- delivering a **range of service types** of varying intensity to match the complexity and level of need for any given consumer
- making the **best use of the available workforce and technology within the local region**
- **better match** with individual and local population need

Suite of Mental Health Stepped Care Interventions

- Utilisation of evidence based e-based technology (self-directed applications and clinician moderated)
- Low intensity evidence based counselling services/psychological interventions (face-to-face or telehealth technologies) - may include registered counsellors or an appropriate peer worker
- Evidence based psychological services/interventions delivered in a group format
- Evidence based one-on-one psychological services/interventions delivered by credentialed mental health clinicians, including focused suicide prevention services (face-to-face or use telehealth technologies)
- Dual diagnosis services delivered by appropriately trained workers
- Clinical care coordination services delivered by credentialed mental health clinicians
- Care coordination / support facilitation with no clinical or other support role

EMPHN's Mental Health Stepped Care Model

- **Whole of model** approach
- Available for people of **all ages**
- A consumer must reside or work within the EMPHN catchment and not be able to afford and/or access a similar service

Key features of EMPHN's model

- Comprehensive assessment with services matched to needs utilising a **clinical staging approach**
- **Mix of treatment modalities** defined through assessment – monitored and reviewed
- **Multi-disciplinary team** – including credentialed mental health clinicians
- The model provides **clear pathways** between care types as individuals' needs change
- **Integrated care** – ensuring consumers are linked to primary health care, including their GP, and other relevant services
- **Collaborative care plans -** service providers come together with the consumer and carer to develop a Collaborative Care Plan (CCP)

EMPHN's Mental Health Stepped Care Model Implementation Update

- **STAGE 1: North east – service delivery commenced 15 January 2018**
  - Cities of Whittlesea and Banyule, Shire of Nillumbik, and parts of Shires of Murrindindi and Mitchell
  - Banyule Community Health Service with partners HealthAbility, Nexus Primary Health & Cyber Clinic

- **STAGE 2: Outer east – service delivery due to commence 2 Jul 2018**
  - Cities of Knox and Maroondah, and Shire of Yarra Ranges
  - Request of tender underway with successful tenderer to be announced in May 2018

- **STAGE 3: Inner east – service delivery due to commence 14 Jan 2019**
  - Cities of Manningham, Boroondara, Whitehorse and Monash
  - Request of tender to be released late July 2018 (indicative)

Mental Health Stepped Care & Clinical Staging

Dr Shane Cross

Clinical Staging: Assessment

Presented by

Dr. Shane Cross

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Brain and Mind Centre

THE UNIVERSITY OF SYDNEY

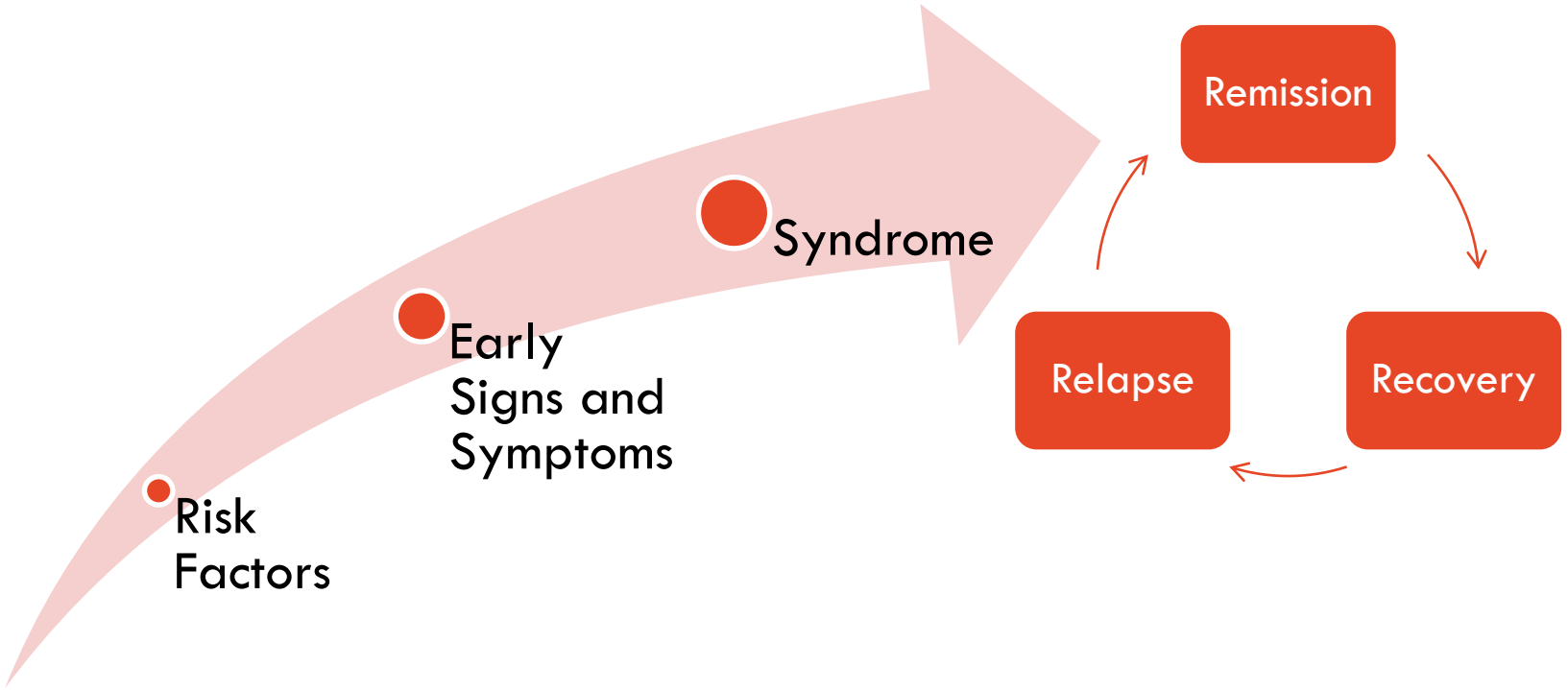
Outline

- Introductions
- Mental health and clinical staging
- Initial Assessment of Clinical Stage
- Re-Assessment

Developmental trajectories of mental disorders

- Mental disorders are a group of chronic, changing conditions.
- The symptoms often begin to appear in childhood and adolescence and ebb and flow over the course of an individual's life.
- The symptoms of many medical disorders (e.g., Parkinson's, Alzheimer's, coronary artery disease) represent a late stage of a process that began years earlier.
- As with many other medical illnesses, mental disorders tend to track along a trajectory of stages of risk: from early symptoms, to full symptoms or syndromes, to remission, relapse, and recovery.

Trajectories of Mental Disorder



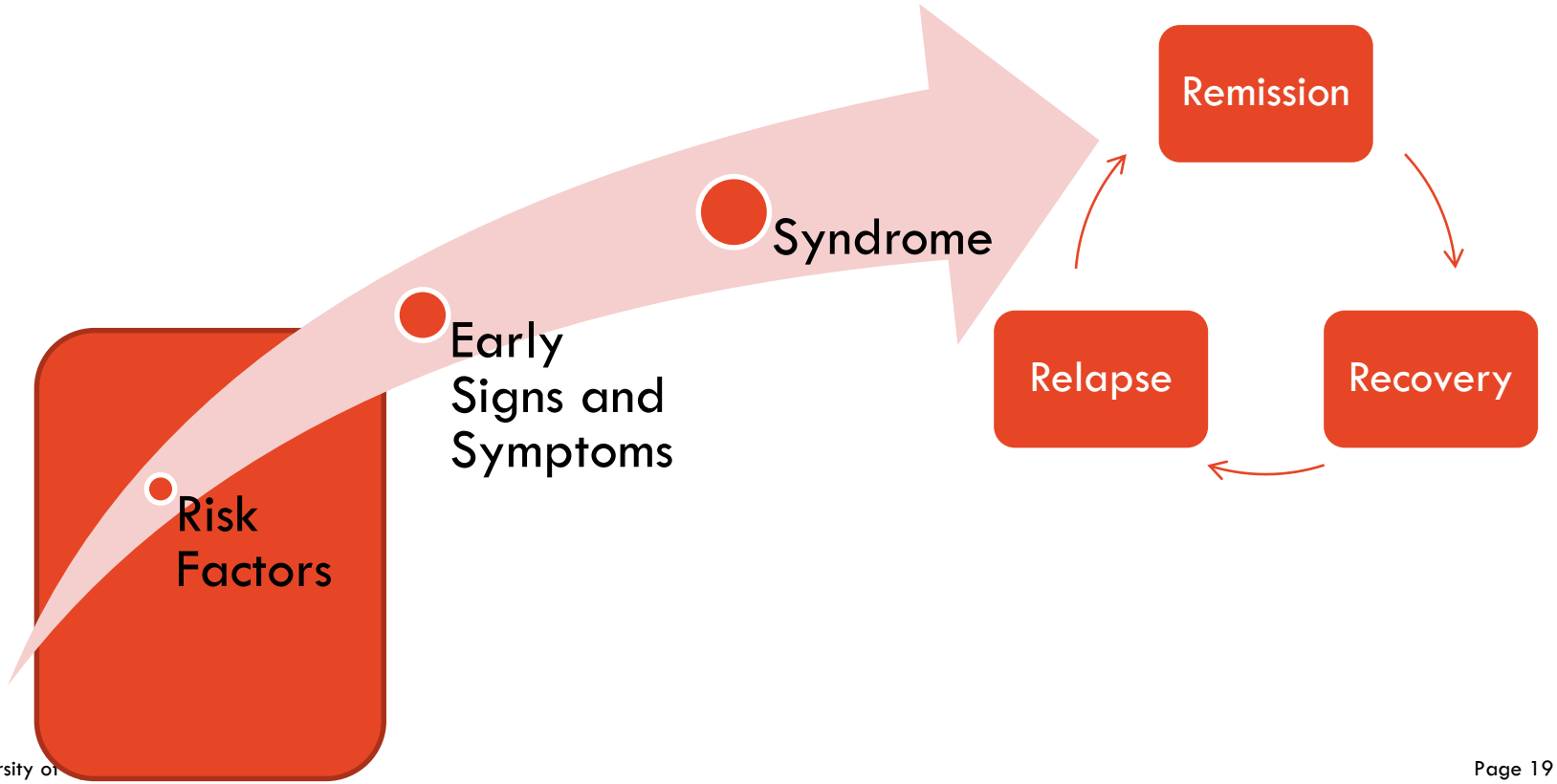
Complexity of mental disorders

- Good evidence for a *multifactoral* cause for mental disorders

- Although the final pathway to mental illness might involve a neural basis, the precise nature of this neural basis remains unclear

- Genetic and biological factors interact with shared (such as family environment) and non-shared (such as school) environmental factors, to modify the risk of mental disorders.

Trajectories of Mental Disorder



Risk and protective factors

- To establish a construct as a risk factor for a negative outcome, it is necessary to show that the risk factor was present prior to the negative outcome
- The risk factor implies greater potential, and because it is probabilistic, not all individuals with the risk factor will develop the negative outcome
- Risk factors often co-occur and when they do they have an exponential rather than an additive impact on increasing the potential for negative outcomes (Rutter, 1990)
- Protective factors counterbalance the impact of risk processes
- Not only can biological factors influence psychological processes, but also social and psychological experiences exert actions on the brain by feeding back on it to modify gene expression and brain structure, function and organisation (eg. epigentics).

Complex and inter-twined risk factors for mental health problems

Biological
Exposure to toxins in pregnancy
Family history mental health
Head trauma
Birth complications
Malnutrition
Substance Abuse

Psychological
Learning disorders
Maladaptive personality traits
Abuse and neglect
“Difficult” temperament

Social
Family
Inconsistent care giving
Poor family discipline
Family conflict
Death of family member

School
Academic failure
Lack of support for attendance
Inadequate education
Bullying

Community
Community disorganisation
Discrimination
Exposure to violence

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet, 369*(9569), 1302-1313.

Protective factors against mental health problems

Biological

- Age appropriate physical development
- Good physical health
- Good intellectual functioning

Psychological

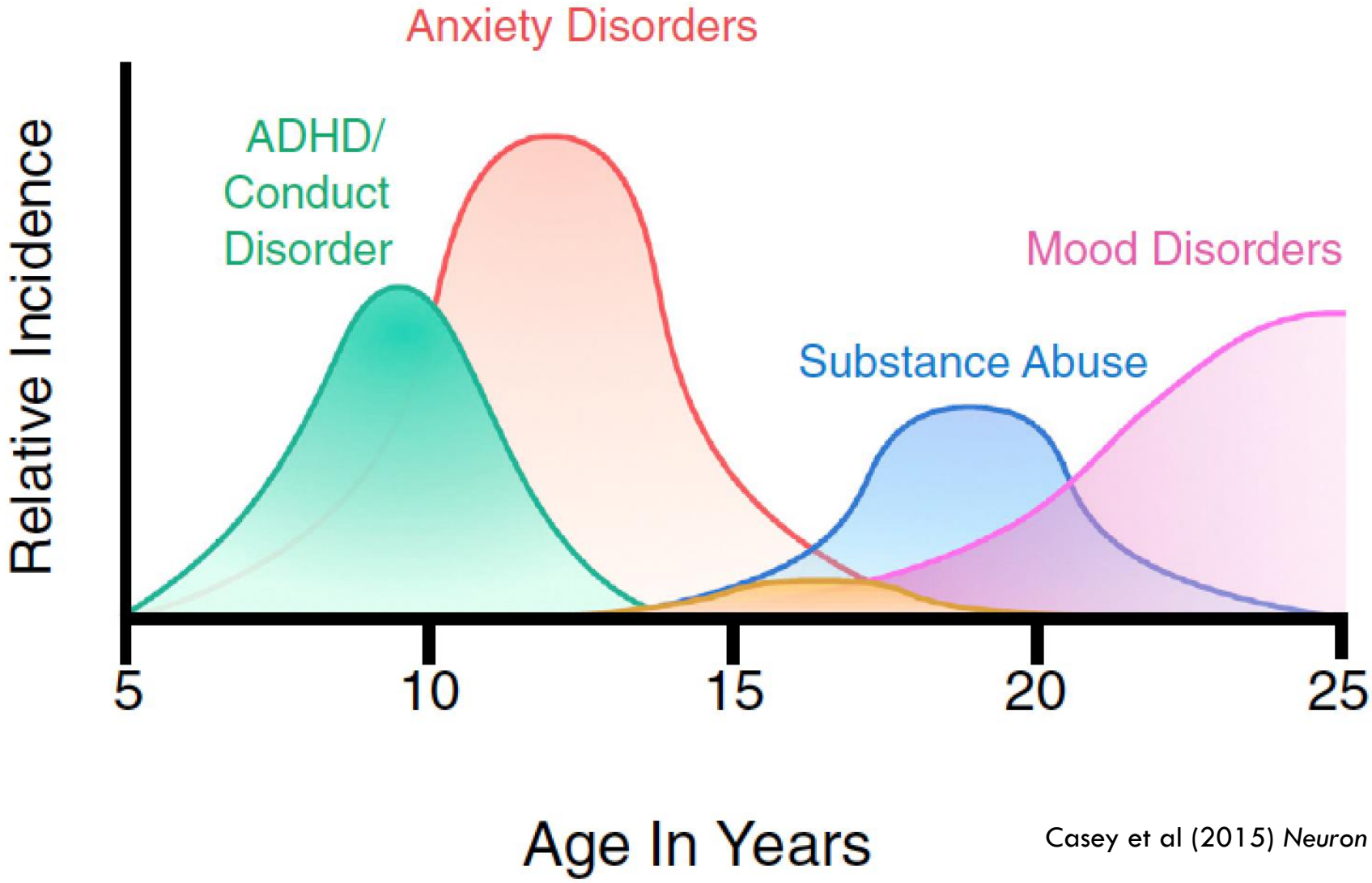
- Ability to learn from past experiences
- Good self-esteem
- Problem-solving ability
- Social Skills

Social

- Family
  - Family attachment
  - Positive involvement in family
  - Rewards for involvement
- School
  - Opportunities for involvement
  - Academic achievements reinforced
  - Identity with school
- Community
  - Connectedness
  - Opportunities for leisure
  - Positive role models

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet, 369*(9569), 1302-1313.

Developmental Emergence of Mental Disorders



Casey et al (2015) *Neuron*

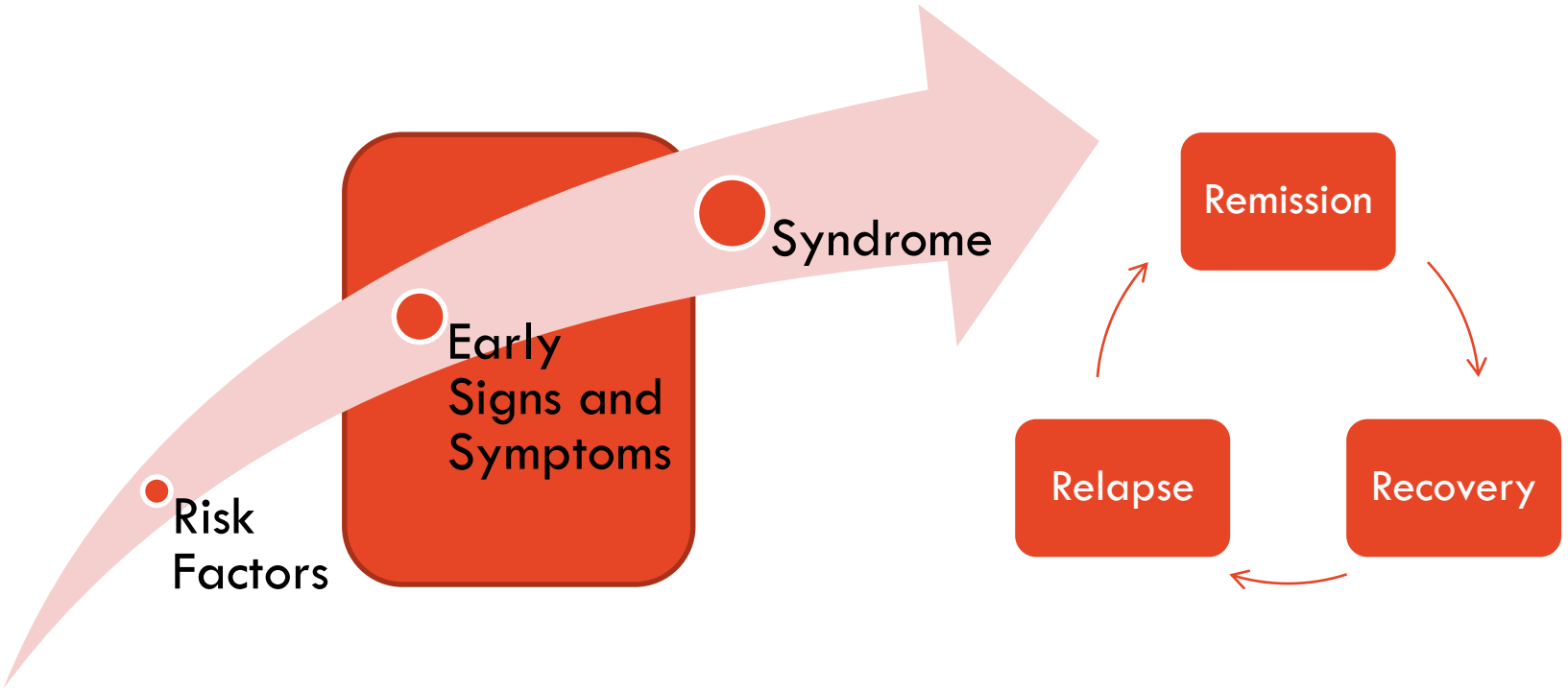
Disorder trajectories

- The presence of a disorder in childhood and early adolescence is a strong risk factor for the later development of psychiatric problems in adulthood (Copeland, 2009)
- A substantial number of children with various forms of psychopathology exhibit continuity of psychopathology into adulthood
- These continuities can either be:
  - homotypic (disorder class or type in childhood leading to the same disorder class in adulthood), or
  - heterotypic (disorder class in childhood leading to a different adult disorder class).
- More recent longitudinal studies using prospective rather than retrospective methodology and greater examination of the wide range of disorder outcomes have provided support the **heterotypic** pattern of disorder progression between childhood, adolescence and adulthood.

Child Disorders and Risk Factors for Adult Disorders

- Pathways to adult disorders; things don't stay the same:
- ADHD to substance use/ bipolar disorder
- ASD/Schizotypal to psychotic disorders
- ODD to GAD
- Anxiety to severe depression and vice versa

Trajectories of Mental Disorder



For the major anxiety, mood or psychotic disorders, the illness process typically has its onset in late childhood or early puberty and then recurs or continues progressively into adult life

**Hafner H, an der Heiden W, Maurer K. Evidence for separate diseases? Stages of one disease or different combinations of symptom dimensions? Eur Arch Psychiatry Clin Neurosci. 2008;258 Suppl 2:85-96.

**Paus T, Giedd JN, Keshavan M. Why do many psychiatric disorders emerge during adolescence? Nat Rev Neurosci. 2008;9(12):947-57.

**Merikangas KR, He J-p, Burstein M, Swanson SA, Avenevoli S, Cui L, et al. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication adolescent supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010;49(10):980-9.

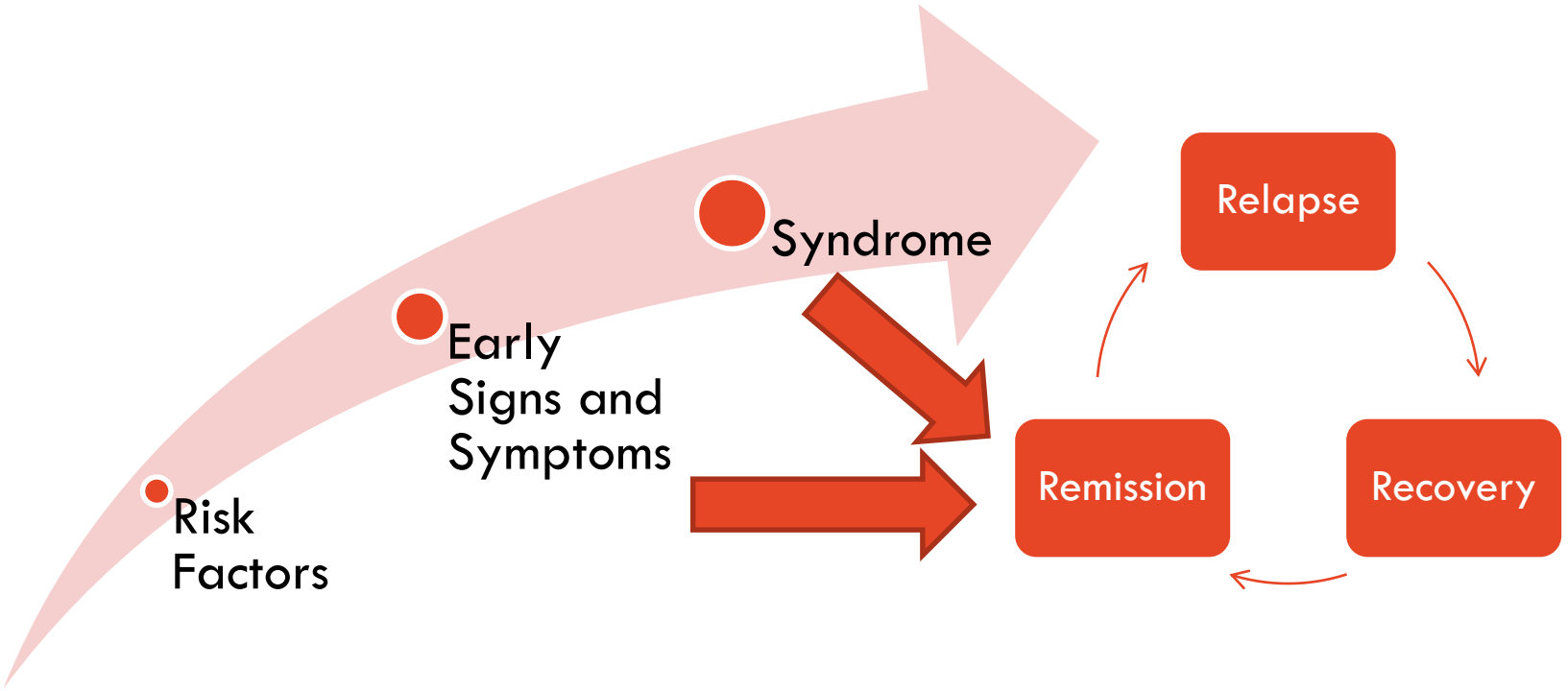
Despite some knowledge of the age of onset for FT disorders, the core critical trajectories from minor dysfunctions to SUB and FS mental disorders are not yet well understood, nor do we understand why some clinical syndromes take a malignant course while others remit

Beesdo-Baum K, Knappe S, Asselmann E, Zimmermann P, Brückl T, Höfler M, et al. The 'Early Developmental Stages of Psychopathology (EDSP) study': a 20-year review of methods and findings. Soc Psychiatr Psychiatric Epidemiol. 2015;50(6):851-66.

‘Sub-Syndromes’

- Presentations that meet some but not all criteria for a full syndrome
- Those with sub-syndromal (SS) 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)

Trajectories of Mental Disorder



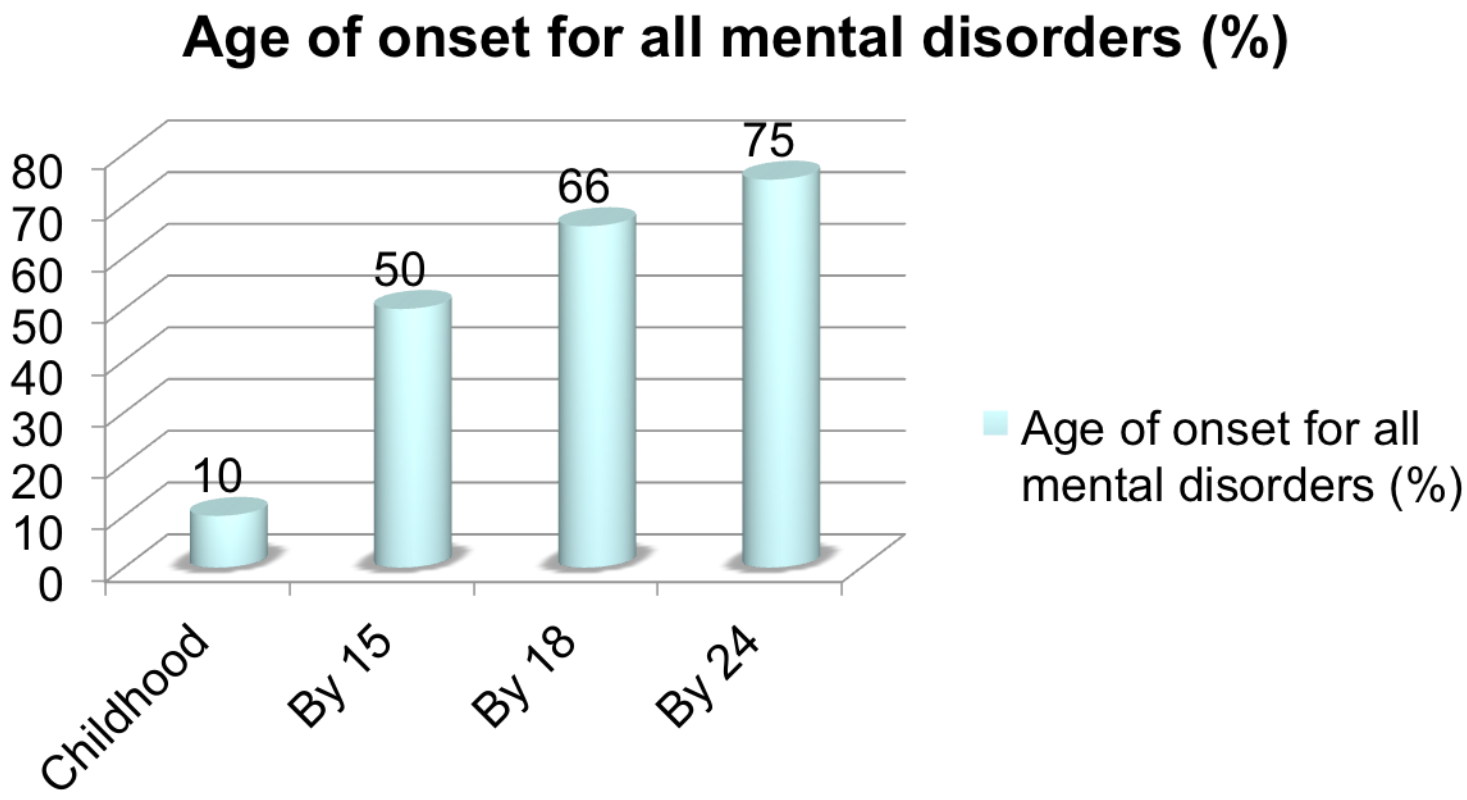
Why some clinical syndromes take a malignant course while others remit?

- The prediction of which individuals will follow a successful (recovery) path versus those who will encounter and endure significant problems is critical for preventing psychopathology and illness and promoting recovery

- Understanding **risk** factors and processes of risk is central to the identification of those most in need of timely intervention, whereas clarification of **protective** factors and processes of resilience can inform interventions to strengthen those at greatest risk.

Beesdo-Baum K, Knappe S, Asselmann E, Zimmermann P, Brückl T, Höfler M, et al. The 'Early Developmental Stages of Psychopathology (EDSP) study': a 20-year review of methods and findings. Soc Psychiatr Psychiatric Epidemiol. 2015;50(6):851-66.

Age of onset: Kessler et al 2005



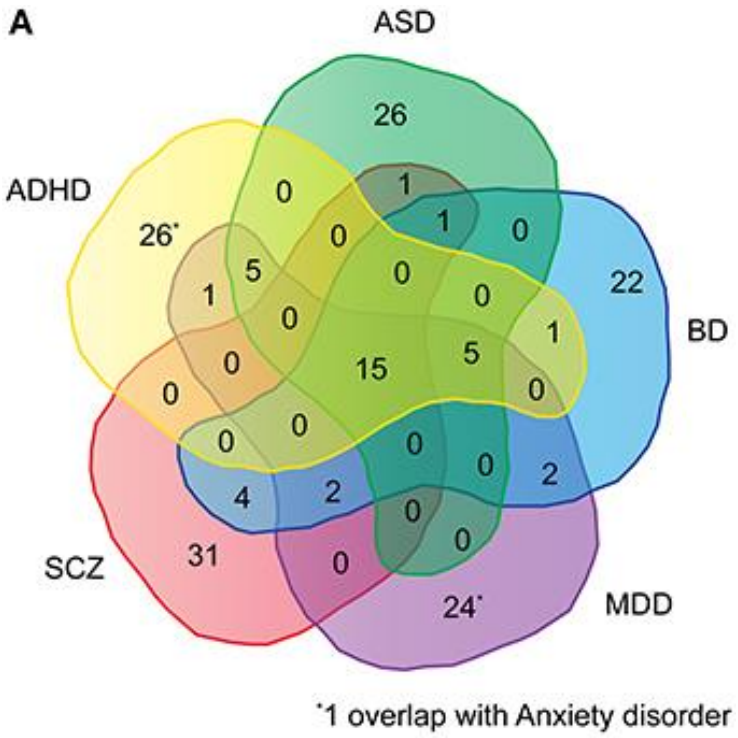
Ranges of onset age for common psychiatric disorders

Paus T, Keshavan M, Giedd JN. Why do many psychiatric disorders emerge during adolescence? *Nat Rev Neurosci.* 2008 Dec;9(12):947-57. Epub 2008 Nov 12.

Limitations of the current categorical diagnostic system

- Population level impairment from SUB disorders is much greater than for FS disorders
- DSM appears to favour inter-rater reliability over validity
- Shared genetic and neural pathways of many disorders provide evidence of the inherent structural problems of the current classification system
- Comorbidity has been described as the 'rule rather than the exception': no substantial evidence to support the position that clear discontinuities in symptom profile exist between disorders
- Lack of evidence to support the concept of natural boundaries between mental disorder and mental health: many symptoms evident in normal population
- Fails to adequately capture the complexities of clinical presentation or effectively guide treatment decisions

Diagnostic overlap

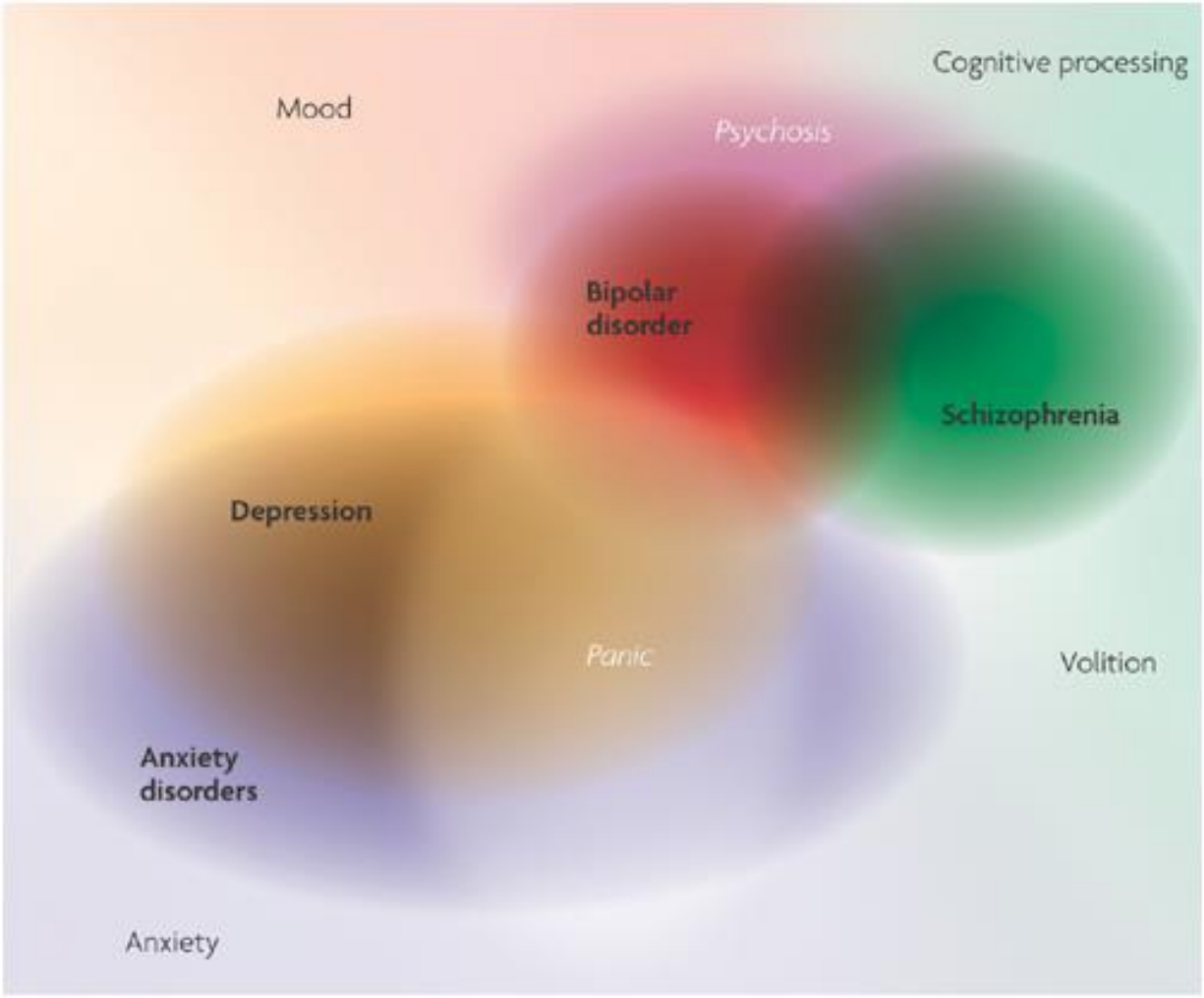


B

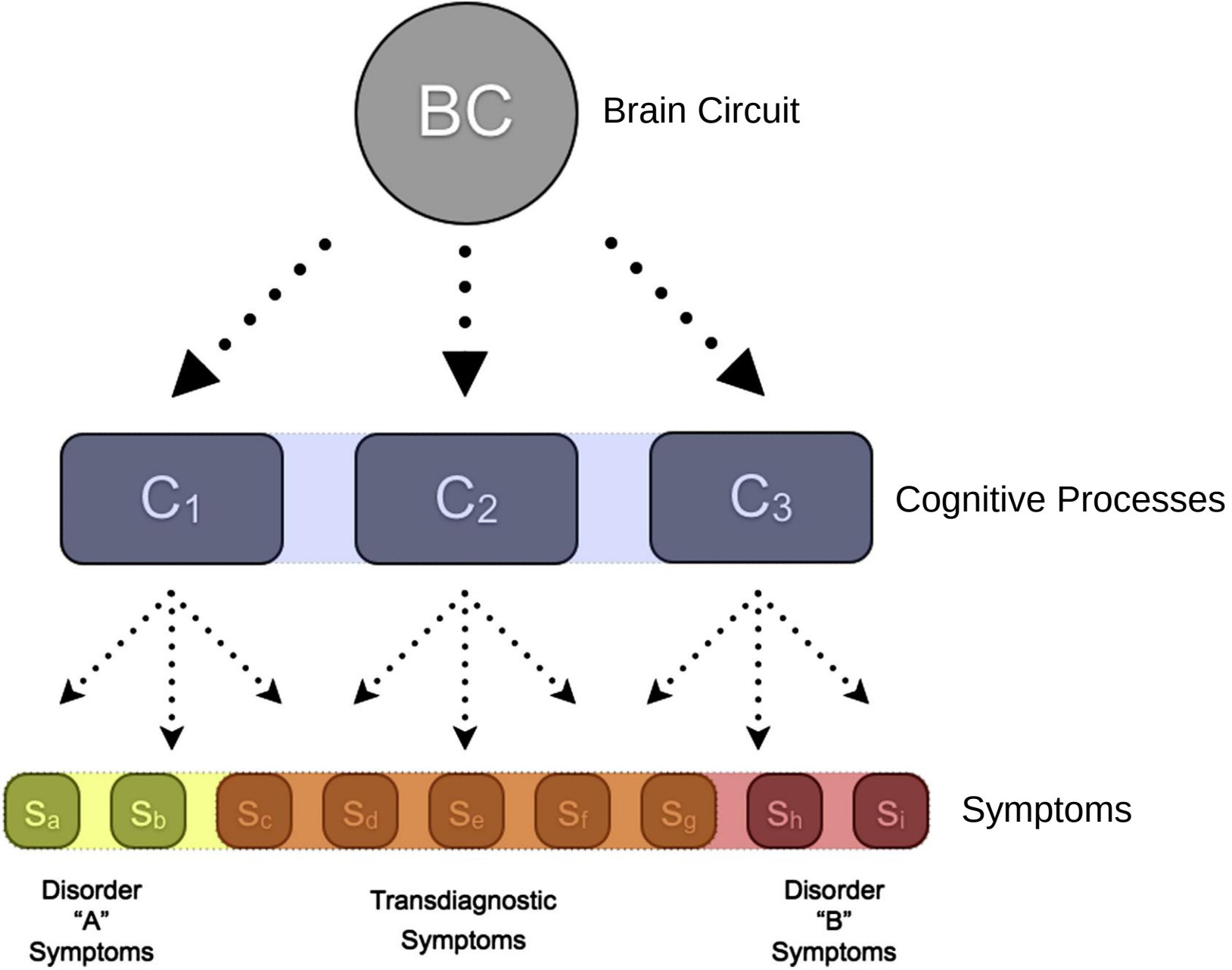
Genes shared among	N genes
6 disorders	0
5 disorders	15
At least 4 disorders	20
At least 3 disorders	28
At least 2 disorders	39

Lotan A, Fenckova M, Bralten J, Alttoa A, Dixson L, Williams RW and van der Voet M (2014)
Neuroinformatic analyses of common and distinct genetic components associated with major neuropsychiatric disorders.
Front. Neurosci. **8**:331. doi: 10.3389/fnins.2014.00331

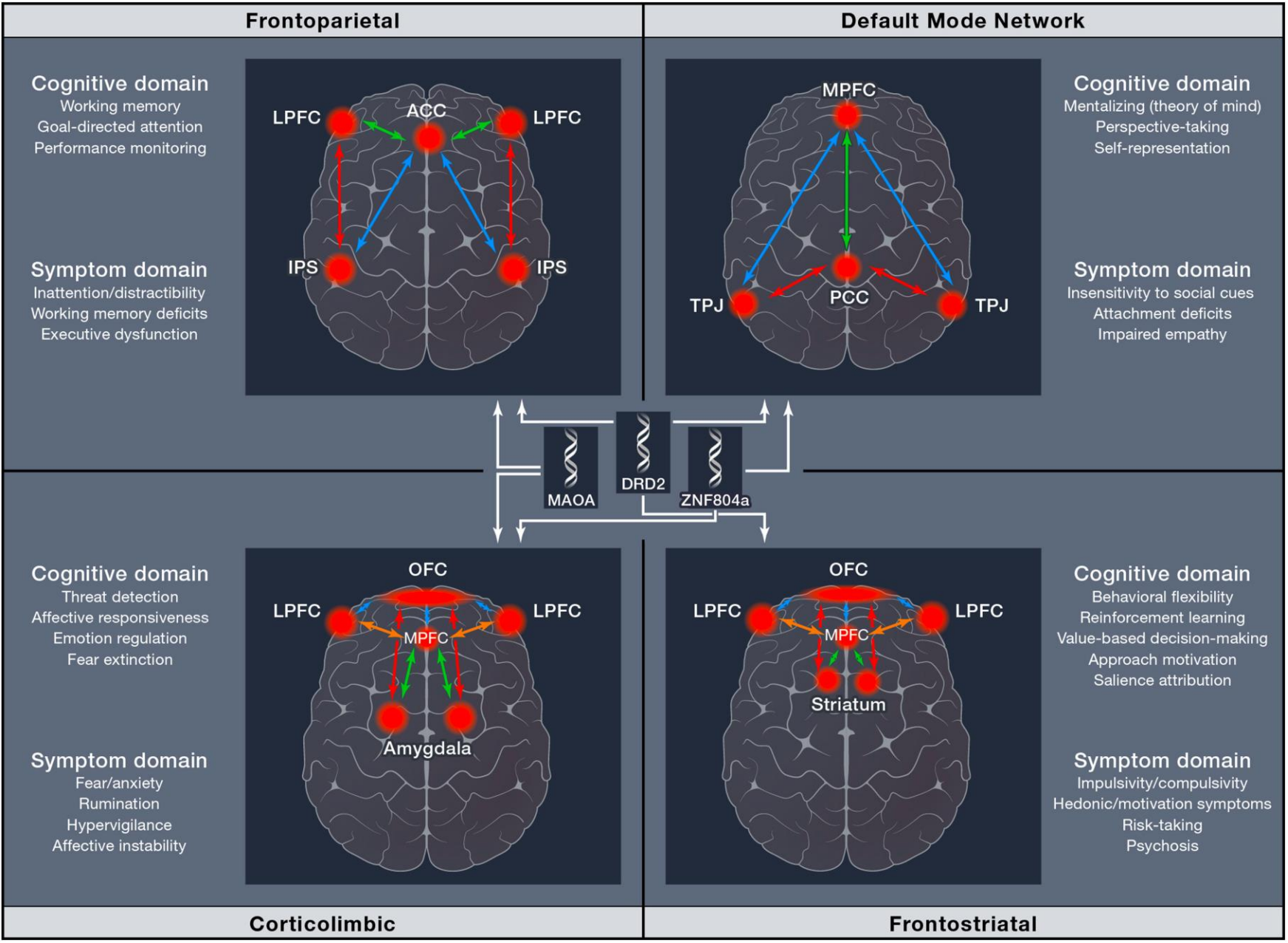
Overlapping Phenotypes



Burmeister et al (2008). Psychiatric genetics: progress amid controversy. Nature Reviews | Genetics



Buckholtz, J. W., & Meyer-Lindenberg, A. (2012). Psychopathology and the human connectome: toward a transdiagnostic model of risk for mental illness. *Neuron, 74*(6), 990-1004. doi:10.1016/j.neuron.2012.06.002



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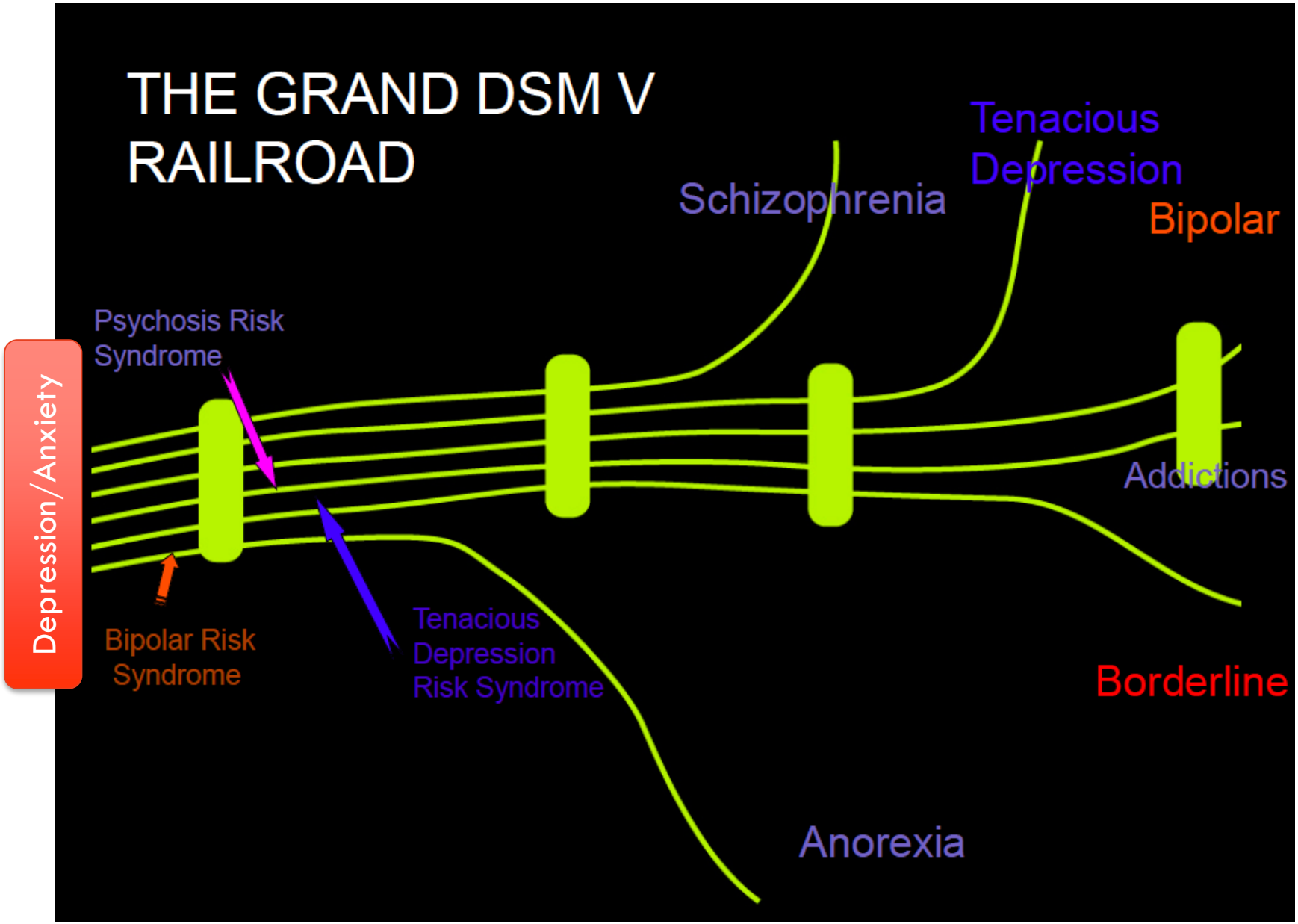
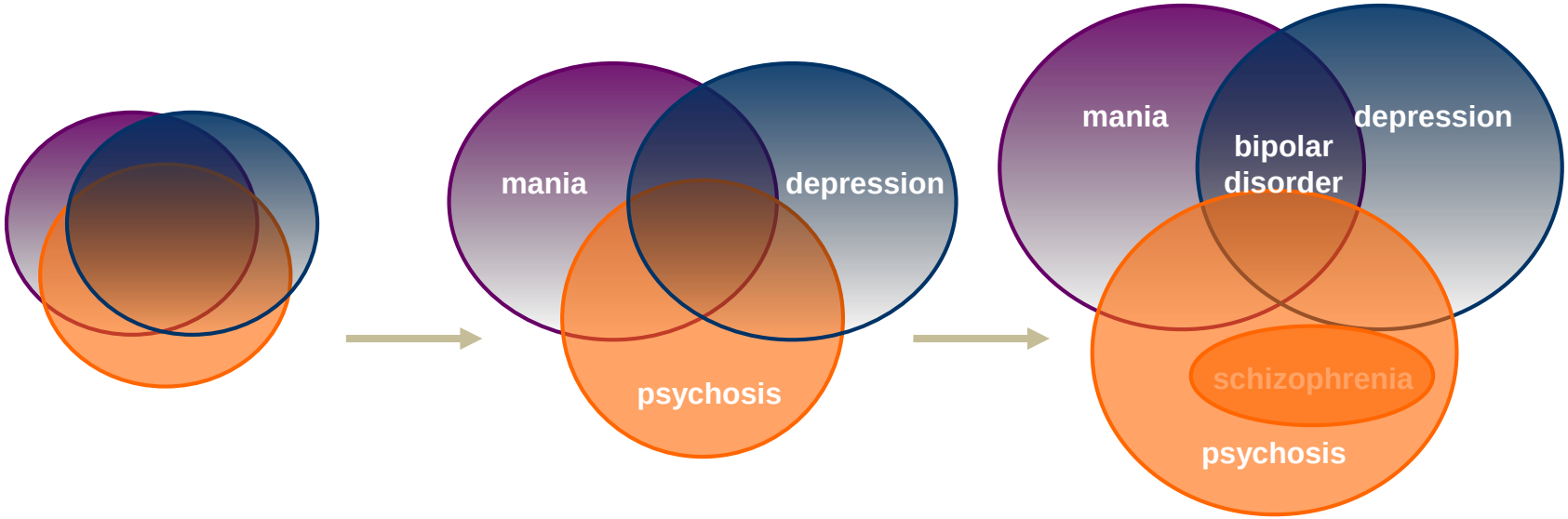
Staging

McGorry et al 2007; Hickie et al 2013

- Used in chronic conditions and have a course (such as cancer, diabetes)
- Used as an adjunct alongside traditional diagnosis to provide context
- Early stages of illness and other risks (unemployment, etc) are seen as modifiable risk factors for later stage illness
- Aim is to stop stage progression and promote recovery
- Matches treatment intensity to the stage (severity)
- Severe disorders have common features at earlier stages, mostly anxiety and depression symptoms
- Emerging evidence demonstrating validity of concept in mental health


THE GRAND DSM V RAILROAD
Tenacious Depression
Schizophrenia
Bipolar
Psychosis Risk Syndrome
Depression/Anxiety
Addictions
Bipolar Risk Syndrome
Tenacious Depression Risk Syndrome
Borderline
Anorexia

Clinical Staging



Stage by Type

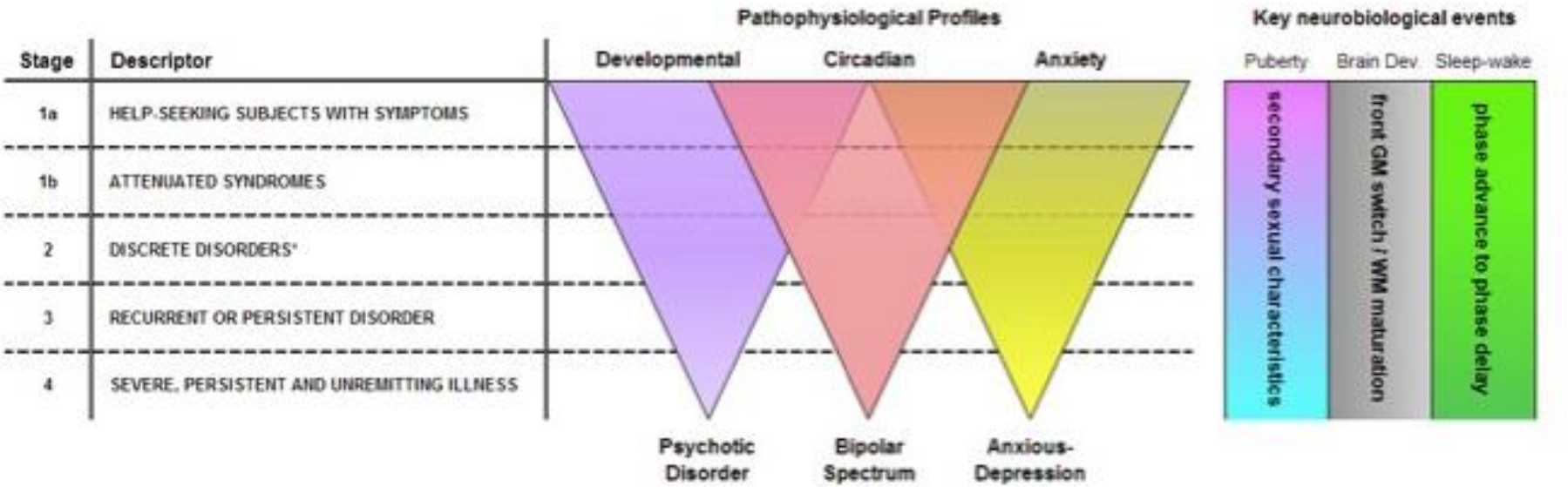
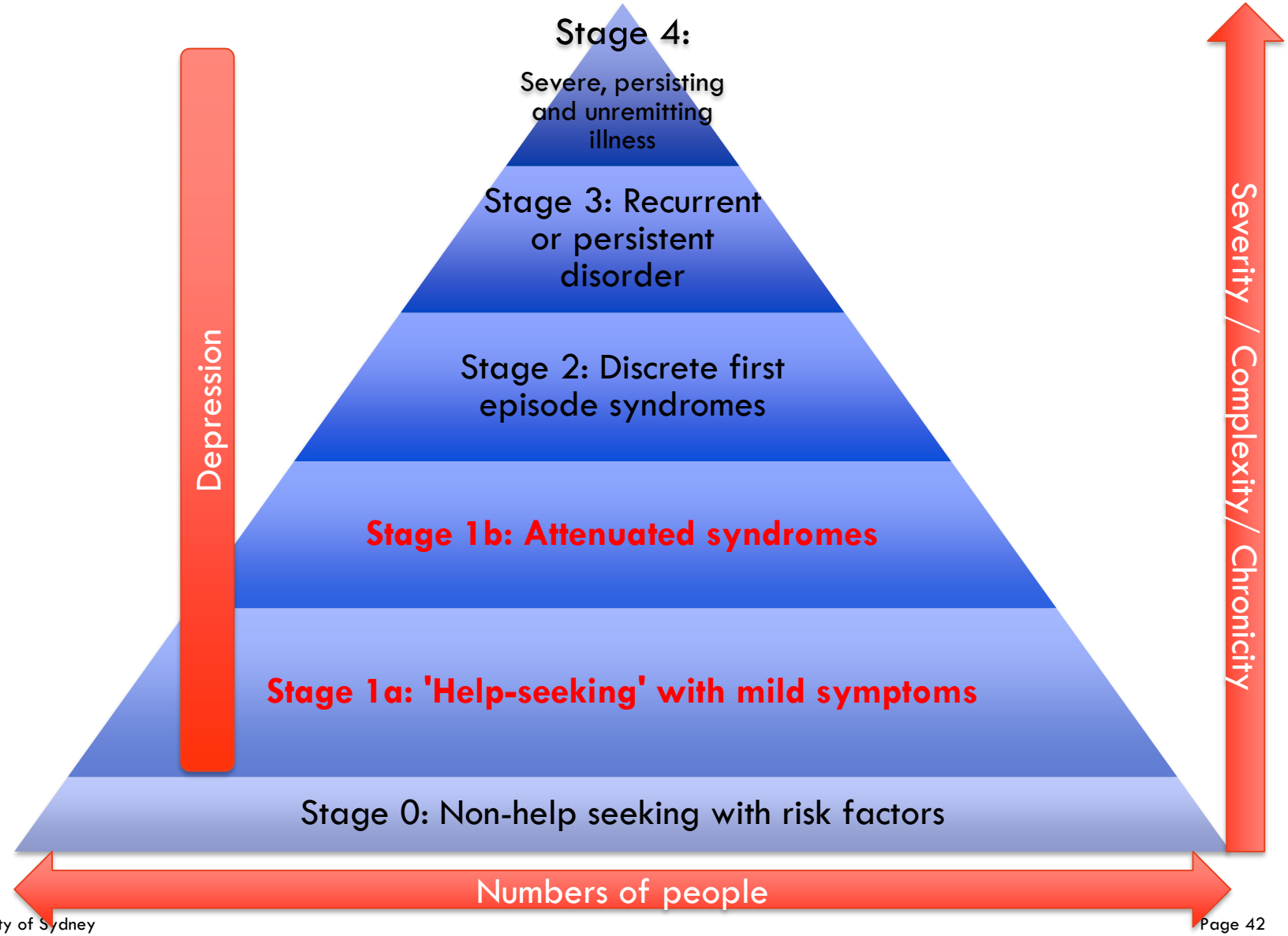


Figure 1: A clinical staging model for post-pubertal onset and course of major mental disorders: putative developmental, circadian or anxiety pathophysiological pathways typically progress from non-specific to discrete syndromes. While the prevalence of early non-specific forms is high in early adolescence only a minority are expected to progress to discrete adult syndromes.

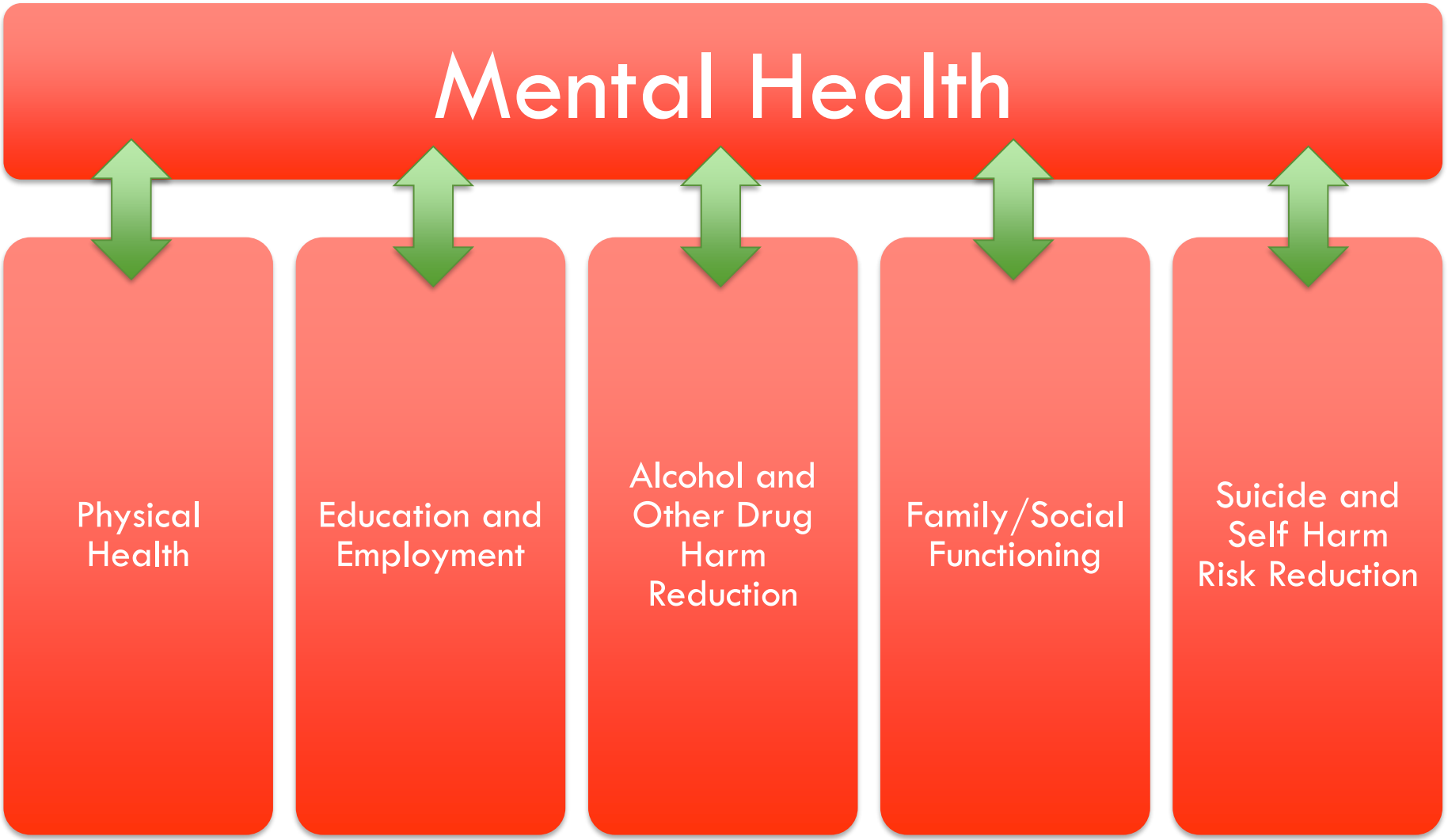
Hickie et al. (2013) *BMC Medicine*

Transdiagnostic staging in mental health



Hickie et al (2013) *Early Intervention in Psychiatry*

Interacting factors require concurrent attention



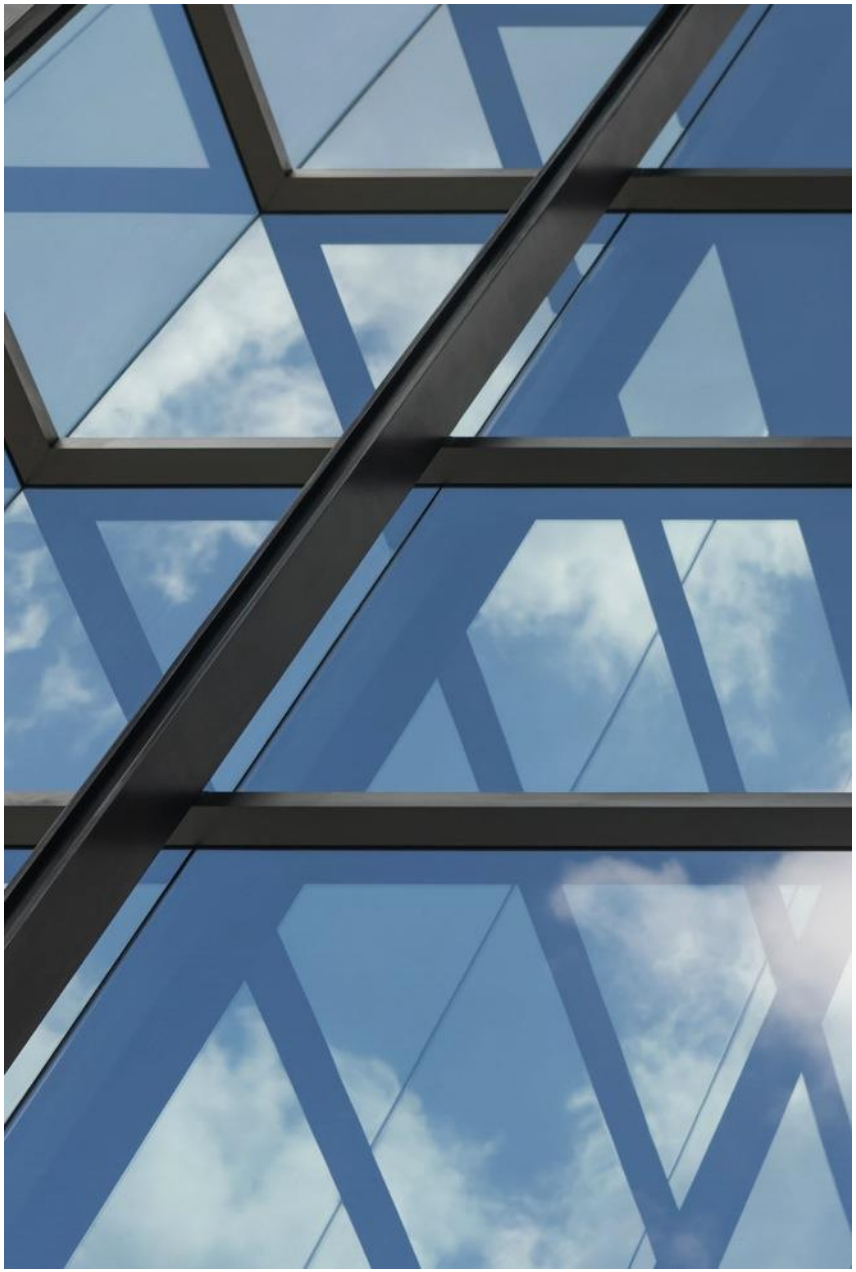
Group Exercise

In your experience, what problems in mental health service delivery exist because of our conventional views/approaches to diagnosis?

Answer from the perspective of the client, a clinician and a coordinated mental health system

How can the adjunct use of a staging model improve this?

Assessing Clinical Stage



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Principles in Assessing and Assigning Clinical Stage

- Although symptom type is noted, clinical stage is not expected to coincide with the silo-based diagnostic concepts
- It seeks to capture the clinical "gestalt" - drawn from the nature and severity of the individual's illness course.
- It is highly likely that individuals in the early phases of illness will have mixed symptoms, that is a symptom complex that ranges across the various diagnostic categories.

Principles in Assessing and Assigning Clinical Stage

- Consequently, individuals with the same formal diagnosis (e.g. major depressive episode) may be rated as being at different clinical stages (e.g. '1b *vs* 2') based on factors such as:
  - symptom profile (e.g. psychomotor change, neuropsychological impairment),
  - symptom severity,
  - level of disability,
  - risk of harm and
  - need for hospital admission or
  - comorbid symptoms (e.g. psychotic symptoms, anxiety, substance misuse, phobic avoidance).

Principles in Assessing and Assigning Clinical Stage

- As illness course is followed longitudinally, subjects may transition to later stages, due largely to a categorical shift in their symptom set or functioning.
- If they do not progress, then they may continue to be symptomatic and/or impaired within the same stage.
- If, by contrast they remit spontaneously or respond to treatment then this is noted.

Principles in Assessing and Assigning Clinical Stage

- Within the model, subjects are assigned the highest stage that they have ever achieved in their lifetime.

- Assigning a clinical stage at first assessment may be difficult if the person has been extensively treated previously, particularly when that person has responded well to treatment and is no longer displaying the symptoms or degree of impairment that is characteristic of that stage.

Principles

- Cardinal features driving stage: **symptoms & functional impact** (i.e. duration & life impact)
- Stage 2+ = clear evidence of an episode (**severity x impact;** e.g. hospitalisation)
- Family history and childhood disorders are a risk factor
- Current treatment (e.g. psychotropic medication) is **not a factor** in the staging decision
- Key rule: "when in doubt rate down"
- Stage by consensus
- Do not confuse current distress with staging

Assumptions with the Staging Model

- Early in the clinical course the major disorders share a common symptomatic 'trunk'.
- Only somewhat later in the course do more distinctive clinical syndromes or 'branches' (e.g. bipolar I disorder, severe major depression, schizophrenia) become apparent.
- While each individual, if left untreated, may have the potential to develop their own unique illness ('the leaf') our goal is to determine whether exposure to relevant interventions at earlier stages of illness can prevent a broader range of outcomes

Assessment Domains

- Current Major Symptoms
  - (severity, frequency, type),
- Current and premorbid functioning (SOFAS)
- MSE
- Age of onset of illness
- Clinical course of illness and 'worst ever' symptoms
- Significant Risk Factors, Recent Stressors,
- Maintaining Factors
  - include any other factors maintaining illness
- Family History of Mental Illness

Assessment Domains

- Current & Previous Treatment/s and Treatment Outcomes:
  - list all treatments provided and whether they were effective, include no. of prev. hospitalisations.
- Risk Assessment and Management:
  - outline any risks (past and present) and how they are being managed.
- Clinical Measures (and sig. changes since last review)

Example Measures

Symptom Type, Functioning and Severity

- K10 and SOFAS
- Brief Psychiatric Rating Scale (BPRS)
- Quick Inventory of Depressive Symptomatology (QIDS)
- Prodromal Questionnaire (PQ16)
- WHO Disability Assessment Schedule (WHODAS)

- *and:*
  - Waist circumference, weight, height (BMI)
  - Physical activity, smoking status
  - Bloods and blood pressure
  - Neuropsychology

Stage 0

0: 'ASYMPTOMATIC SUBJECTS'; RISK FACTORS

- ☐ first-degree teenage relatives of probands
- ☐family history of mental illness
- ☐preterm delivery or low birthweight
- ☐childhood physical or sexual abuse
- ☐presence of a major developmental disorder
- ☐childhood-onset anxiety or affective disorders

Stage 1a

'HELP-SEEKING' SUBJECTS WITH SYMPTOMS

- ☐ Non-specific symptoms of anxiety or depression
- ☐ Mild to moderate severity of symptoms
- ☐ Mild neuropsychological deficits.
- ☐ Recent or mild impacts of illness on social, educational or occupational function
- ☐ SOFAS 70-100

Stage 1a

‘HELP-SEEKING’ SUBJECTS WITH SYMPTOMS

- Typically help-seeking individuals with non-specific anxiety or depressive symptoms.
- Symptoms are of mild to moderate severity:
  - For anxiety – mild to moderate levels of arousal without significant or persistent avoidant behaviours
  - For depression – mild to moderate levels of depressive ideation without specific features indicative of a more disabling disorder
- May include those with earlier childhood-onset symptoms who have re-presented or worsened during the adolescent period
- May include those with earlier onset neurodevelopmental or attentional disorders who now present with anxiety or depressive symptoms in the adolescent years
- Typically adolescent or early adult populations assessed in primary care or educational settings or identified by screening within relevant primary care, employment or educational settings of relevant populations
- May be referred to specialist settings for further assessment

Stage 1b

'ATTENUATED SYNDROMES'

- ☐ Specific symptoms of severe anxiety, moderate depression, brief hypomania or brief psychotic phenomena
- ☐ May include subjective or objective evidence of at least moderate neuropsychological change
- ☐ Moderate to severe impact of illness on social, education or employment functioning
- ☐ SOFAS 60-70

Stage 1b

'ATTENUATED SYNDROMES'

- Development of more specific anxiety, depressive or mixed syndromes of at least moderate severity:
  - anxiety syndromes characterized by more severe symptoms and development of specific avoidant behaviours
  - depressive syndromes associated with persistently depressed mood, anhedonia, suicidal ideation or thoughts of self-harm and/or some neurovegetative features
  - hypomanic symptoms of less than 4 days' duration during any specific episode
  - psychotic symptoms are of brief duration only
- Syndromes at this stage should be persisting and clearly having a significant impact on major aspects of psychosocial function.
- Consequently, this stage may include subjects who meet diagnostic criteria for specific anxiety disorders, major depressive disorder or bipolar II disorder, as long as the disorder does not have the characteristics of those assigned to Stage 2.

Stage 1b

1b 'ATTENUATED SYNDROMES'

- May have somewhat mixed syndromes in terms of their symptomatology or have features of a number of different diagnostic groups (e.g. anxiety plus depressive disorders, OCD plus depression, anxiety or depression plus substance use). Typically, such co-morbid disorders will be more severe and have greater impact on functioning.
- 'Comorbidity' of anxiety, depressive and substance misuse disorders is common at this stage.
- The presence of regular, deliberate self-harm without overt suicidal intent may occur in this stage. This includes impulsive low lethality overdose occurring in context of psychosocial stressor and in the absence of severe depression.
- The presence of significant circadian disturbance (e.g. prolonged fatigue or sleep disturbance) with co-morbid anxious or depressive syndromes is common.
- Treatment may have already commenced and/or the person may have been referred for further specialized assessment.
- Some degree of treatment with an antidepressant, antipsychotic or mood-stabilizing agent is common for subjects in this stage, particularly where there has been limited access to specialized psychological therapies.

Stage 2

'DISCRETE DISORDERS'

- ☐ Clear episodes of psychotic, manic or severe depressive disorders
- ☐ Full threshold disorder with moderate-severe symptoms and persistence over time
- ☐ Typically associated with significant neuropsychological deficits
- ☐ Illness is clearly having a major impact on social, educational or occupational functioning
- ☐ SOFAS 40-60

Stage 2

'DISCRETE DISORDERS'

Discrete depressive, manic, psychotic or mixed syndromes.

- Although these syndromes are 'discrete' in presentation, many remain mixed in phenomenological terms – that is, they do not necessarily match a single or discrete DSM-style disorder or correspond to a specific cut-off point on a specific rating scale for anxiety, depressive, manic or psychotic symptoms.
- The syndromes are characterized by key symptoms that are no longer transient.
- The syndromes themselves persist and are typically associated with more severe symptoms.
- The syndromes must have evidence of major impacts on social, educational or occupational functioning.

Stage 2

'DISCRETE DISORDERS'

- For depression:
  - The disorder needs to have features indicative of more severe disorders including psychomotor retardation, agitation, impaired cognitive function, severe circadian dysfunction, psychotic features, brief hypomanic periods, severe neurovegetative changes, pathological guilt or severe suicidality.
- For anxiety disorders:
  - These need to be complicated by at least moderately severe and concurrent depressive disorders, typically associated with marked agitation, fixed irrational beliefs, overvalued ideas or attenuated psychotic symptoms, or substantial and persistent substance misuse.

Stage 2

'DISCRETE DISORDERS'

- For manic disorders:
  - Must clearly have had manic syndromes (not just symptoms) for more than 4 days during a specific illness event; hypomanic symptoms or brief hypomanic syndromes alone do not constitute a discrete disorder
- For psychotic disorders:
  - Must have had a clear psychotic syndrome for more than a week
- For mixed or 'comorbid' syndromes:
  - Must have had significant symptoms (depressive, manic or psychotic) within the context of a more severe syndrome that is persisting and having a major impact on function. At some points, the significant co-morbidity may include alcohol or substance misuse, abnormal eating behaviour or other relevant psychological disorders

Stage 2

'DISCRETE DISORDERS'

- Importantly, the primary discrete syndromes may themselves co-occur.
  - For example, severe anxiety and depression; severe depression complicated by hypomanic periods; severe bipolar depression; and severe depression complicated by a psychotic syndrome.
- The 'discrete disorder' stage generally corresponds with the clinical point at which specific medical treatments would be considered an essential part of clinical management (e.g. prescription of antipsychotic or mood-stabilising agents).
- If the patient has been hospitalized for treatment, then typically they would have met criteria for this stage.

Stage 2

'DISCRETE DISORDERS'

- If the patient required very intensive outpatient care due to suicidal or homicidal intent, plan or history of attempt, florid or persistent psychotic or very severe depressive symptoms (e.g. psychomotor change, psychotic features), he/she would have been likely to have met criteria for this stage.
- Moderately severe mood or anxiety disorders that are complicated by significant and persistent alcohol or other substance misuse may reach this stage.
- Typically, patients with discrete disorders have been referred to specialist services for further assessment or have been managed extensively by suitably qualified primary care or other interdisciplinary services

Stage 3

'RECURRENT OR PERSISTENT DISORDER'

- ☐ Incomplete remission from discrete disorder at 12 months after entry to care following reasonable course of treatment (of at least 3 months' duration)
- ☐ Recurrence of discrete disorder after period of complete recovery (having fully recovered for at least 3 months)
- ☐ Illness course is associated with objective evidence of deteriorating neuropsychological function
- ☐ Illness course is associated with deteriorating social, education or occupational function due to persistence or recurrence
- ☐ SOFAS <40

Stage 3

'RECURRENT OR PERSISTENT DISORDER'

- Discrete disorders are assessed and specifically treated for at least 3 months and are then associated with poor response or incomplete response to treatment.
- Discrete disorders may have fully recovered but then relapse to the full extent described in stage 2 (for anxiety/depression, depression, mania, psychotic or mixed states, which may also be complicated by alcohol or other substance misuse).
- Over at least a 12-month period after entry to relevant specialist or enhanced primary care services, there has been clear evidence that the illness course has resulted in marked worsening in social, education or occupational function.

Stage 4

'SEVERE, PERSISTENT AND UNREMITTING ILLNESS'

- ☐ Severe, persistent and unremitting illness assessed after at least 24 months of engagement with relevant specialized clinical services and provision of a reasonable range of medical, psychological and social interventions
- ☐ Illness course is associated with objective evidence of severe deterioration in neuropsychological function
- ☐ Illness course is associated with clear evidence of marked deterioration in social, education or occupational
- function due to persistence or recurrence
- ☐ SOFAS <30

Stage 4

'SEVERE, PERSISTENT AND UNREMITTING ILLNESS'

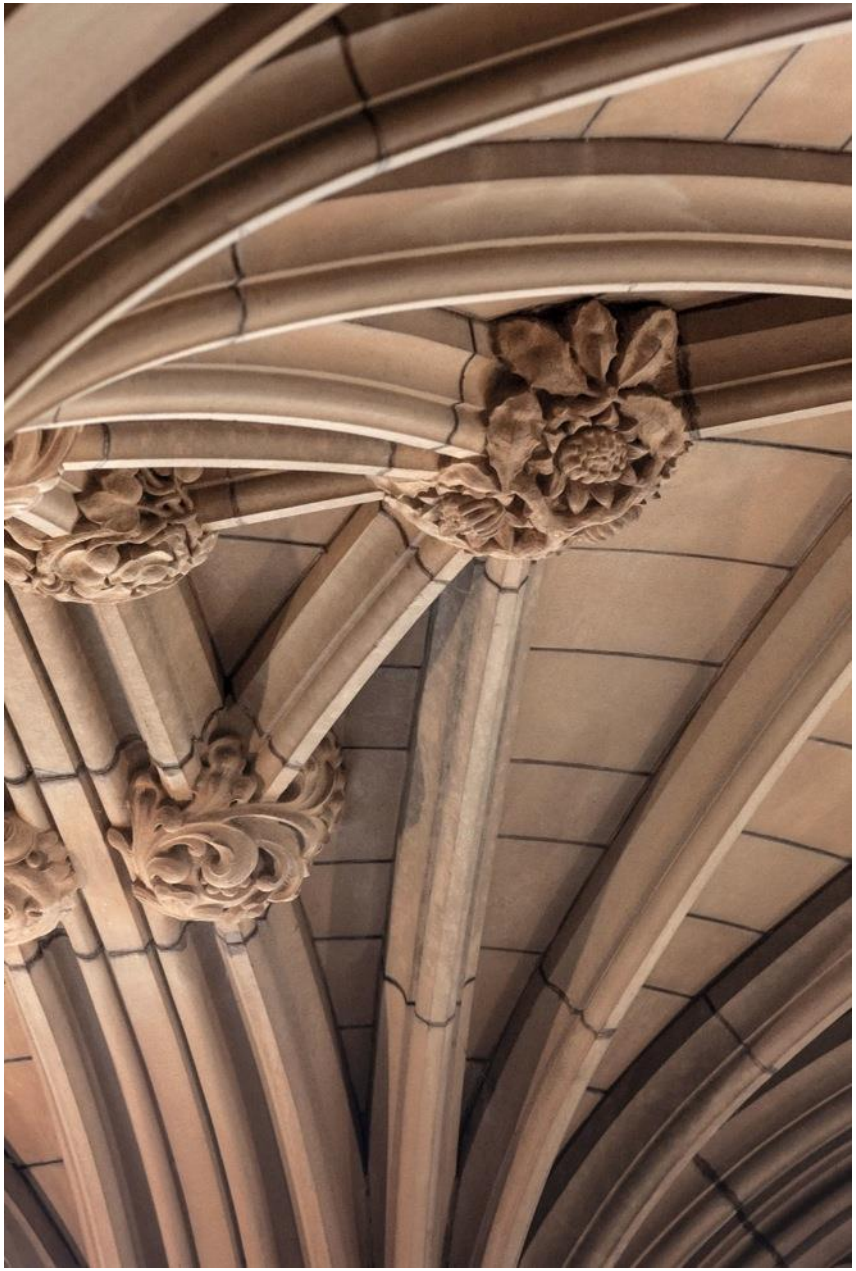
- Chronic deteriorating severe depressive, bipolar and/or psychotic illness, which may be complicated by alcohol or other substance misuse, and has persisted without remission for at least 2 years

Case Discussion

- In small groups of 3-4, briefly summarise your case and see if you can all agree on a clinical stage

- What were the decision sticking points?

Stage Re-assessment



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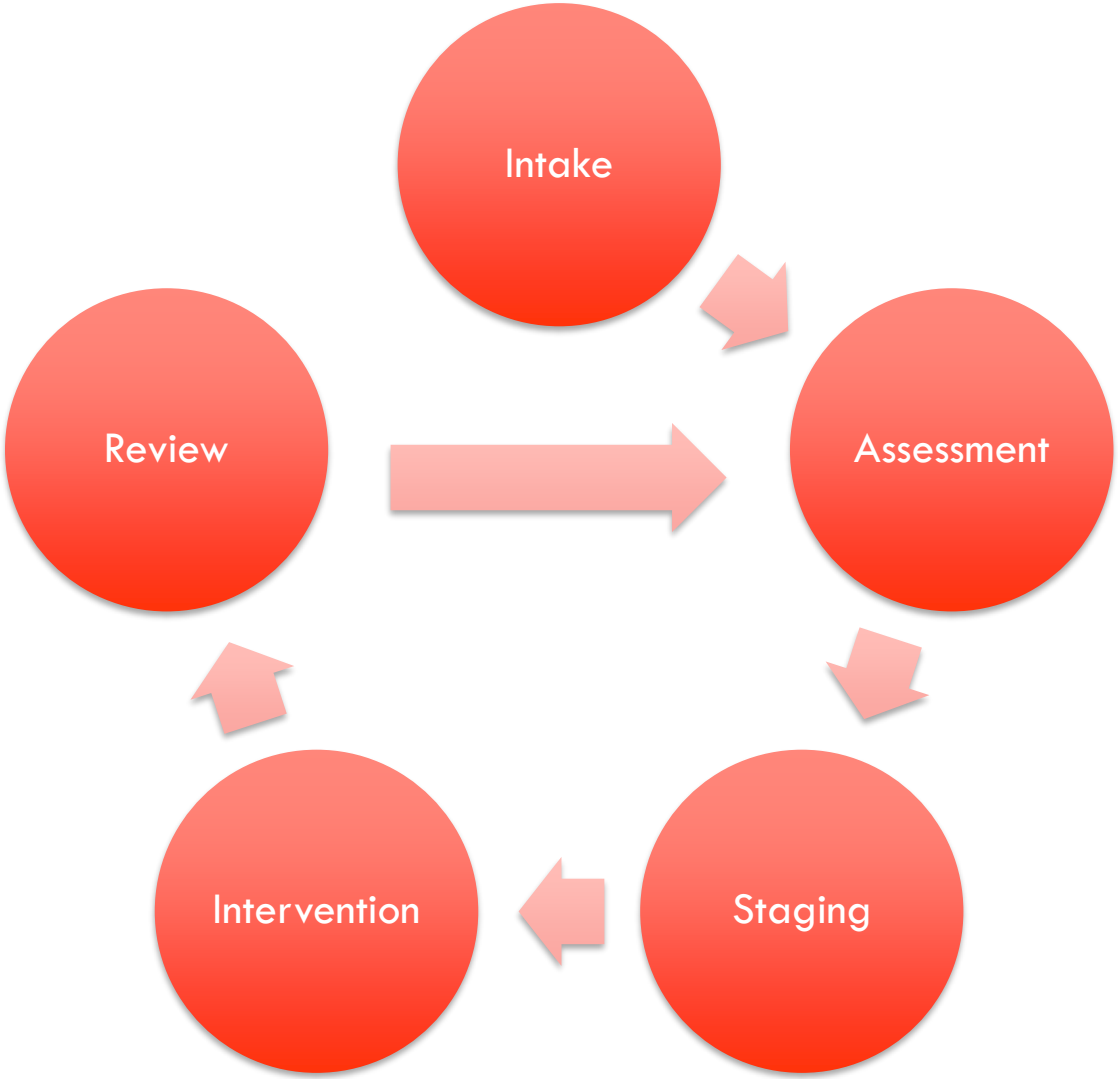
Process

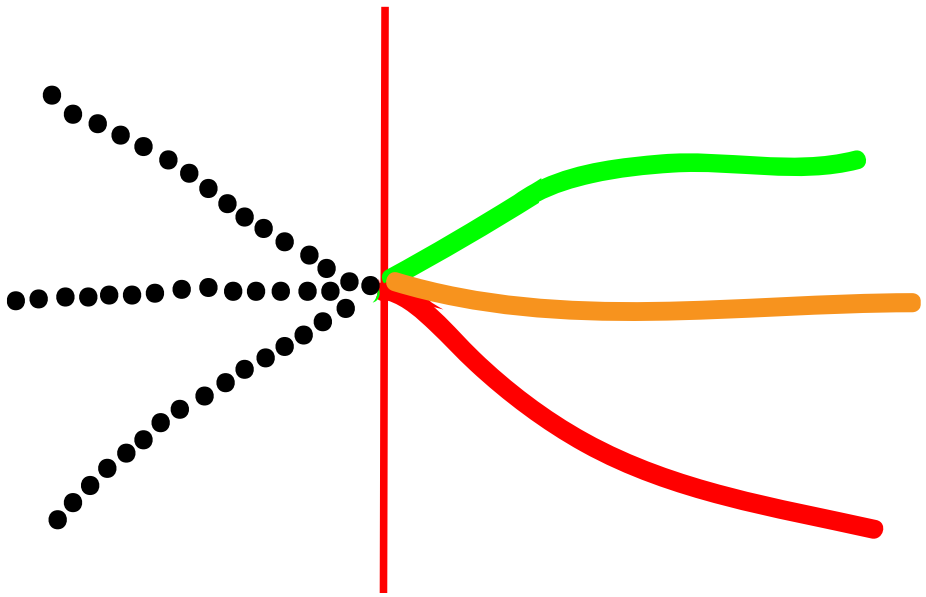


Treatment Progress and Re-Assessment of Stage

- Regular clinical review AND objective outcome measure
- objective measures are very important because:
  - Clinicians are poor at tracking outcomes on the basis of their memory or 'clinical judgement' alone
  - 80% of clinicians do not notice their clients deteriorating (Hatfield et al 2010)
  - about half of all clinicians believe that they have never had a client regress under their care (Walfish et al 2009)
  - Change scores from session 1-3 account for 40% of variance in outcome. Dx, ct & th. demo, theo. or. account for less than 1%. (Lambert, 2013).

- Re-stage and re-evaluate treatment plan with the treating team

Do clients enter care on varied pre-treatment trajectories?...

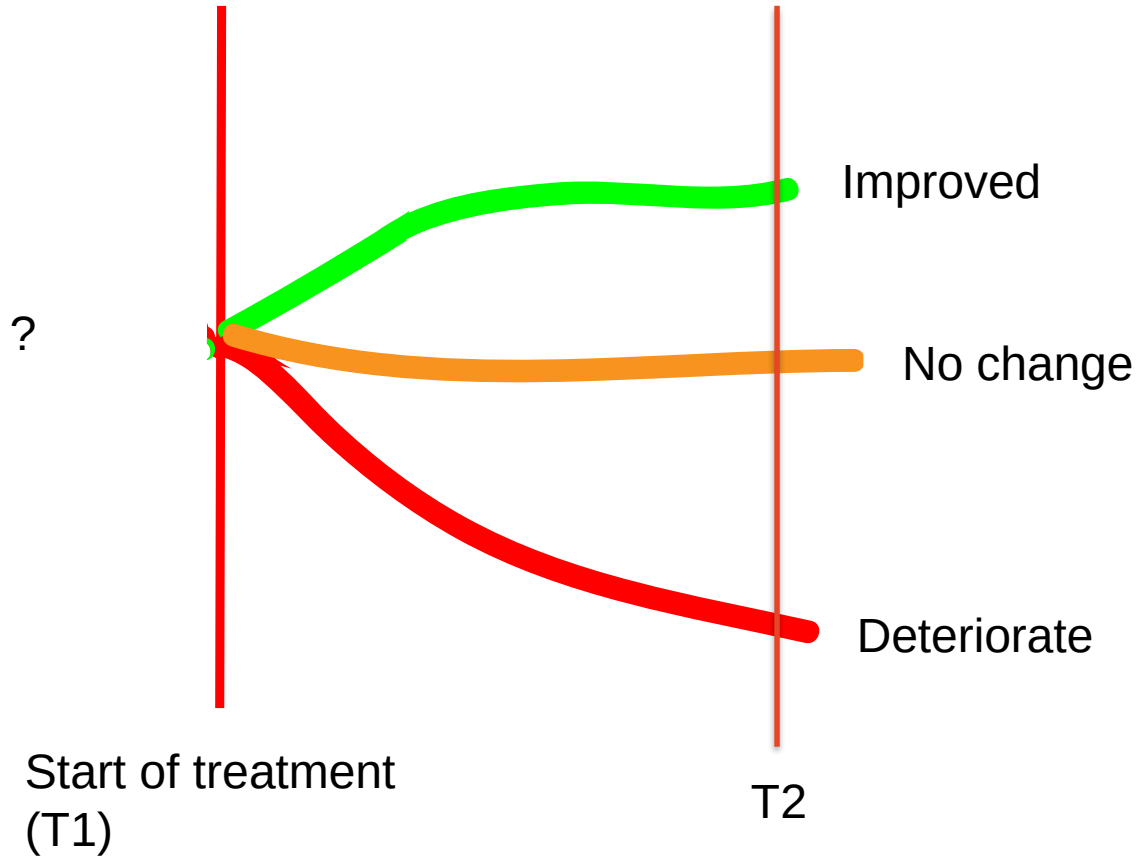


Start of treatment

Lambert (2013) *"..a portion of patients are on a negative trajectory at the time they enter treatment and the deteriorating course cannot be stopped"*

Tracking progress in care

Treatment outcome best predicted by initial progress in treatment, rather than baseline characteristics



‘Reliable-change’ group outcomes over 6 months

Measure and Time point		Reliable Deterioration*	No Reliable Change*	Reliable Improvement*
SOFAS (+/- 10 points)				
	0 – 3 months	12%	66%	22%
	0 – 6 months	**9%**	**66%**	**25%**
K10 (+/- 7 points)				
	0 – 3 months	17%	56%	28%
	0 – 6 months	**13%**	**54%**	**33%**
BPRS (+/- 11 points)				
	0 – 3 months	8%	74%	18%
	0 – 6 months	**4%**	**72%**	**23%**

Cross, Scott, Hermens, Hickie (2018) *Psychiatric Services*

Individual pathways to same outcomes (SOFAS) – fast and slow

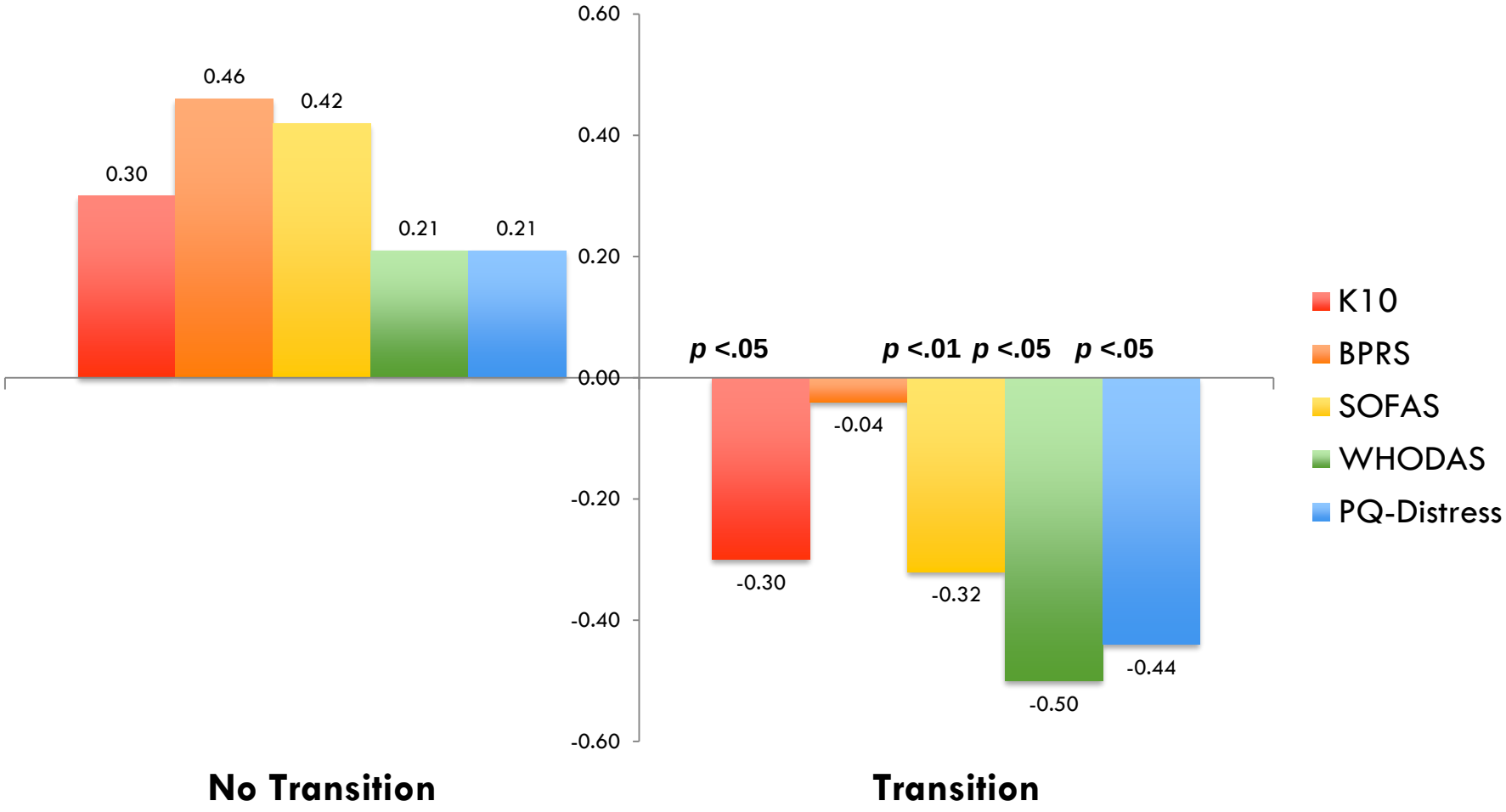
	N	0-3 months	3-6 months	N	
Deterioration at 6 months (5 pathways)	21	Deterioration	No Change	8	38%
			Improvement	1	
		No Change	Deterioration	3	
			No Change	8	38%
			Improvement	1	

	N	0-3 months	3-6 months	N	
Improvement at 6 months (7 pathways)	61	Deterioration	Improvement	1	
		No Change	Deterioration	3	
			No Change	15	25%
			Improvement	7	
		Improvement	Deterioration	3	
			No Change	28	46%
			Improvement	4	

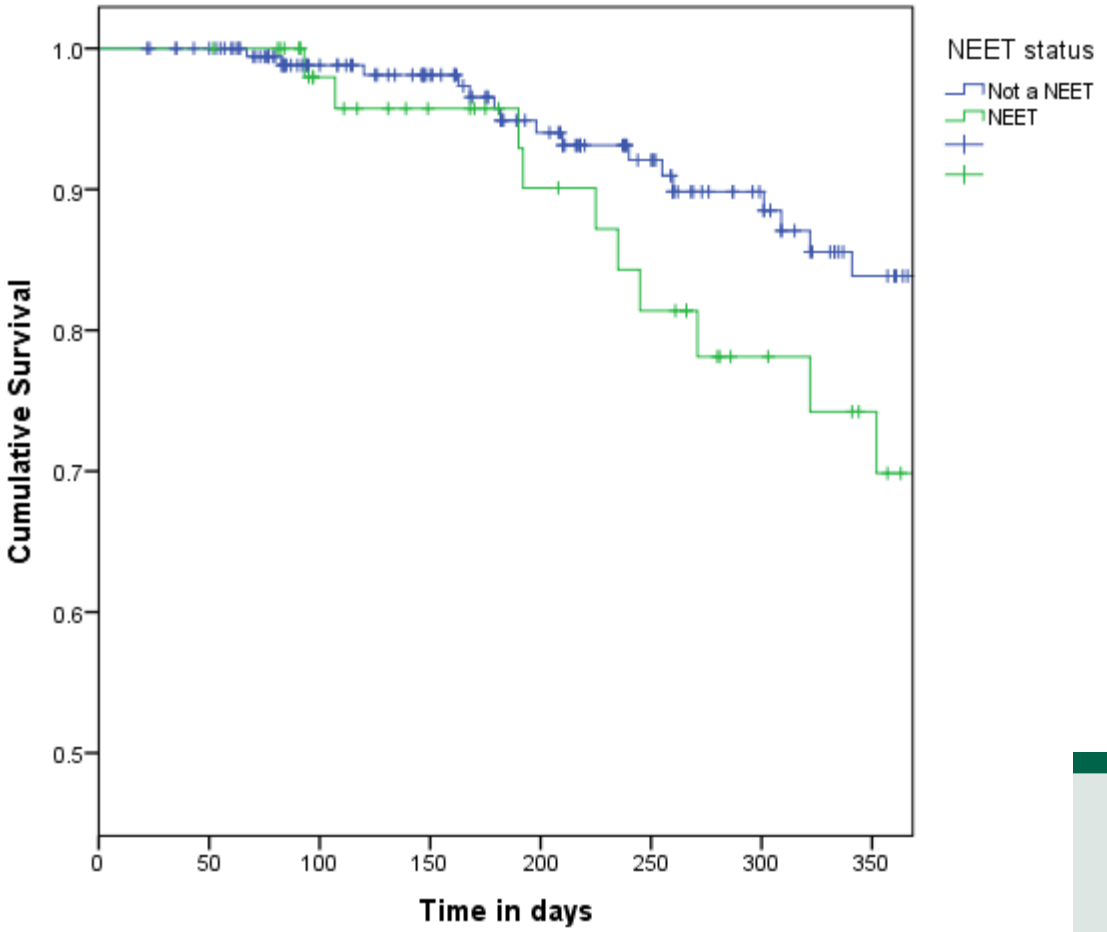
Cross, Scott, Hermens, Hickie (2018) *Psychiatric Services*

Change in Effect Size between baseline and 3 months

Transition or no transition by 6 months



‘NEET’ associated with deterioration



NEET at baseline associated with transition: **OR 5.19**

High negative symptoms at baseline associated with transition: **OR 1.45**

Predicting early transition from sub-syndromal presentations to major mental disorders

Shane P.M. Cross, Jan Scott, and Ian B. Hickie

BJPsych Open (2017)
3, 1–5. doi: 10.1192/bjpo.bp.117.004721

Group Exercise

- Break up into three groups.
- Review the follow up details from 3 of the earlier cases
- Re-assess stage with the available information

Questions