Social and occupational outcomes for young people who attend early intervention mental health services

In reply: We thank Rickwood and colleagues[1] for their comments about the generalisability of our findings to other headspace cohorts, which is a challenging question given the likely variability across services nationally. Based on data available, our sample is comparable to other published headspace cohorts on demographic and clinical characteristics including age (18.1 ± 3.3 in our study *v* 17.1 ± 3.4), sex (61.6% *v* 61.3% female), disengagement from employment, education and training (15.8% *v* 18.5%), and functional impairment (Social and Occupational Functioning Assessment Scale [SOFAS] score, 62.3 ± 9.03 *v* ~ 62.7–64.7).[2-4] Our online Supporting Information highlights that the 1391 young people we excluded tended to be male, older, have higher rates of disengagement, previous hospitalisation and more severe disorders (ie, psychosis), a group that may be less closely matched with other headspace cohorts.

The letter asserts that the changes in function in our cohort are inconsistent with other headspace cohorts, despite similar proportions of subjects having poor functional outcomes. For example, 65% of our study participants had significantly impaired functional outcomes, which is compared with 63% from the other published headspace data.[3] Compared with that previous cohort (that was followed for 90 days), to our knowledge, our study is the first to report on longer term outcomes (median, 490 days). These new data demonstrate clearly that the needs of many young people are more complex and enduring than the current headspace service model anticipates.

headspace is one of the most important mental health innovations in Australia. Our work acknowledges that the current service model may meet the needs of up to one-third of those who present for care. However, the current model lacks clear pathways to more intensive, ongoing, multidisciplinary or specialised services for up to two-thirds of patients who have more complex needs. The goal should be to provide "right care, first time", supported by highly personalised assessment and measurement-based longitudinal care.[5]

We also thank Lenehan[6] for his comments about the limitations of SOFAS as a measure, and we acknowledge there is no ideal measure of social and occupational function in young people. One cited review suggests that an alternative measure, the Personal and Social Performance (PSP) scale, could supersede the SOFAS.[7] While we acknowledged potential limitations of the SOFAS, we do not consider the PSP scale to be a major advance, as it includes other symptom-based domains (eg, disturbing and aggressive behaviours) and uses the same basic scaling system (0–100, with the same major cut points at 30 and 70). SOFAS remains a standard outcome measure in youth mental health with established psychometric properties. Results are also easily compared with data from other major youth-focused longitudinal and intervention studies, and most notably in young people with early mood disorders.[8]

The key issues raised by our study are not the relative benefits of different forms of measurement or the absolute rate of functional change over time. All measures have limitations and all estimates of change have uncertainty. The reality, which may be an unpalatable message for some, is that we have an urgent need to build a more comprehensive and responsive youth mental health system that puts less emphasis on access and much more emphasis on delivering better long term outcomes.

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