Psychiatric Bulletin (1990), **14**, 267–269

The Early Intervention Service: the first 18 months of an Inner London demonstration project

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Rigorous studies of community alternatives to hospitalisation show that they are feasible and effective but have spawned considerable debate about their methodology, replicability, and appropriateness for normal clinical practice. In Britain, many demonstration projects have been centrally funded and evaluated initially by the Personal Social Services Research Unit at the University of Kent and latterly by Good Practices in Mental Health (Renshaw *et al*, 1988). Such community-based projects have attempted to avoid the problems of community mental health centres in the United States which have, with some important exceptions, failed to offer a comprehensive service that would allow closure or a significant drop in bed numbers at state hospitals (Dowell & Ciarlo, 1983). In practice, the design of community services is very dependent on local circumstances, including the demography of the population, existing service provision and attitudes. For this reason, planners and practitioners need to be aware of many practical options for service delivery.

This paper reports on the first 18 months work of the Early Intervention Service (EIS), originally a demonstration project funded by the Department of Health and now incorporated into the mental health services of Parkside Health Authority. The EIS was primarily designed as a service rather than as a research project and contains no intrinsic evaluation of its effectiveness (although a separate study is examining this). This paper describes the operation of the service and data concerning the patients seen and outlines some unusual, possibly distinguishing, features.

The EIS is a community mental health team which works in the Paddington and North Kensington area of inner London (the Southern half of Parkside District Health Authority). This is a densely populated area of approximately four square miles with an ethnically and socially diverse population estimated as 116,500 in 1988. The team comprises three community mental health nurses, two social workers, an occupational therapist, a consultant psychiatrist (senior lecturer), an administrator and a psychologist, and has been in clinical operation since January 1988. The target group for referring agencies consists of people aged between 16 and 65 with "severe mental health problems" without further refinement in diagnostic terms, except that patients with known primary addictions were excluded. Such referrals include people with major mental disorder and others in crisis, who in many cases might be admitted to hospital but not compulsorily. Distinctive features of the service include joint assessment and therapy with workers from other agencies (including GPs), the assumption of a high level of clinical responsibility by team members irrespective of their primary discipline through a case manager system, and a problem-orientated approach to casework. A fuller account of the philosophy behind team practice is given by Onyett & Green (1989).

The study

Information on all patients was entered on a database immediately after collection on standard record forms. The data included full demographic particulars and social variables, referral details, previous psychiatric history and mental state assessment. When all relevant clinical information had been obtained, a formal mental state and personality diagnosis was reached by PT together with two independent colleagues (SL & SM), using the 1988 draft version of the 10th revision of the *International Classification of Diseases*.

All who referred patients to the EIS in its first year of operation were sent a feedback form. The form contained 14 hypothetical statements about the EIS with which the referrer was asked to indicate agreement on a five point-scale (from 'strongly agree'

https://doi.org/10.1192/pb.14.5.267 Published online by Cambridge University Press

to 'strongly disagree'). Half the questions were construed in favour of the EIS and half against. Referrers were offered the opportunity of returning their forms anonymously in order to achieve more honest feedback.

The findings

Over the 18 month period 387 patients (mean age 36 years; 41% males) were seen: 100 (26%) were non-Caucasian, with Afro-Caribbeans (57 [15%]) making up the largest ethnic minority; 259 (67%) were born in the United Kingdom, with the Republic of Ireland (25), West Indies (22) and sub-Saharan Africa (19) comprising the largest proportion of the remainder; 208 (52%) were single; 98 (25%) were homeless patients (living rough, in bed and breakfast hotels, or hostels), and only 92 (24%) were in paid employment.

Full information on past medical and psychiatric history was obtained for 337 patients and sufficient details to reach a formal ICD-10 diagnosis in 294. Of the patients, 161 (52%) had a psychiatric history, with a mean of 3.2 admissions (range 1 to 34) and a mean interval since first psychiatric contact of 10.0 years.

The ICD-10 diagnoses of the 294 patients fully assessed covered the spectrum of psychiatric disorder; 107 (36.4%) had neurotic and related disorders, 69 (23.5%) had schizophrenia and associated conditions and 71 (24.1%) had mood disorders, with only 47 having either an organic diagnosis (5), physiological dysfunction disorder (6) or substance abuse disorder (including alcohol) (36). The two most common single diagnoses were adjustment disorder (56) and paranoid schizophrenia (31). Difficulties in reaching ICD-10 diagnoses were reduced by referring to the diagnostic guidelines introduced in the 10th revision. Where patients had more than one diagnosis, only the primary one was recorded. Personality status was assessed independently of mental state and information from informants used in reaching a diagnosis; 298 patients had sufficient information on personality status to enable diagnosis and of these 138 (46%) had a personality disorder, with the emotionally unstable group (comprising both impulsive and borderline categories) forming the largest group (31), followed by paranoid (19), histrionic (17), dependent (16), anxious (15), schizoid (14), dyssocial (11), anankastic (7) and others (8).

Of the 387 referrals, 95 were still in treatment after 18 months. There were 21 referral groups, of which GPs were the largest (35%), followed by psychiatrists (11%), psychiatric and generic social workers (9% each), self-referrals (6%) and housing agencies (4%). There was an even distribution across four categories of urgency expressed by referrer: 'urgent' (24%), 'this week' (19%), 'next week' (28%) and unspecified (28%). The modal waiting times for assessment were same day for 'urgent' referrals, two days for 'this week' referrals, seven days for 'next week' referrals, and 13 days for 'not specified' referrals. The referrer was involved in 34% of assessments, social workers in 11.3% and primary care workers in 8.8%. Two EIS members were used in 41.1% of assessments.

Forty-nine per cent of patients were assessed at home, and 14% each in GPs' surgeries and bed and breakfast hotels. Other sites included hostels (7%), hospital (7%), and day centres (3%). Of the 387 patients seen, 13 (3%) were admitted to hospital immediately without further contact, 67 (17%) were returned to the referrer with advice only and 313 (81%) were allocated to a case manager, who continued to see the patient and reviewed them regularly at team meetings. Sixty-six patients (17%) could not be engaged satisfactorily.

Therapy

Therapy involved almost the full range of procedures, including initiation and monitoring of drugs, behaviour and cognitive therapy, marital and brief dynamic psychotherapy, counselling, or training in activities of daily living.

The mean length of first contact was 2.6 months. For those allocated to case managers only, the mean was 3.0 months, with a maximum of 9.9 months. The mean number of clinical contacts at first closure was 5.7 (6.6 for those allocated to case managers only).

One admission was required by 24 patients and one had two admissions, while in contact with the EIS. The mean duration of stay was 23.3 days. In many cases involvement was handed back to the referrer with agreement for re-referral at the earliest signs of impending relapse. Of the 111 cases also referred elsewhere, 14.4% were referred to area social work teams, 17.1% to local in-patient units and 15.3% to voluntary agencies. Referrals were also made to homeless person's units (8.1%), work projects (7.2%), local housing departments (6.3%), physicians (5.4%), hostels (4.5%) and day centes (2.7%). Fifty-nine cases were referred to other agencies including forensic units, specialist services for alcohol dependency, community psychiatric nurses, health visitors, DSS officers, family therapists, and general medical, psychiatric, and psychotherapeutic services outside the district.

Feedback from referrers

One hundred and two forms were sent out and 62 returned. The respondents comprised 15 social workers, 9 general practitioners, 6 psychiatrists and residential agencies (4), probation officers (3), psychotherapists (2) and voluntary organisations (2), with one each from 11 other sources. Ten anonymous

https://doi.org/10.1192/pb.14.5.267 Published online by Cambridge University Press

feedbacks were received. Differences between deviations from the mid point for each statement (i.e. neutral verdict) were tested using two-tailed Wilcoxon signed rank tests. All significant findings demonstrated approval of the EIS with approval of joint working ($z=-6.7$, $P<0.0001$), need for permanent status ($z=-6.6$, $P<0.0001$), value of working away from hospitals ($z=-6.5$, $P<0.0001$) and ease of referral ($z=-6.2$, $P<0.0001$) the most positive statements, with over 90% of responses favouring the EIS.

Comment

Although the patients referred were diverse and had no unifying characteristics, two main groups could be distinguished: people with a psychiatric history who were suffering from symptoms of major mental disorder but were out of touch with services; and those in crisis brought about by personal catastrophe, such as abuse, bereavement, homelessness, physical trauma or severe social problems, many of which fell into the diagnostic criteria for adjustment disorders.

The crisis intervention service in Lewisham, London is perhaps the only similar service that has data of sufficient detail to allow comparison (Bouras *et al*, 1986); that in the London Borough of Barnet (Scott, 1960) has been in existence for much longer but does not have equivalent data. The Lewisham team had a similar mode of working but referred more cases for assessment and treatment elsewhere. However, there are similarities with the EIS data with regard to diagnosis, with 26.5% of the Lewisham patients having schizophrenia, 12.1% affective psychosis and 18.3% adjustment reactions using ICD-9 terminology. Furthermore, 60.6% had past in-patient or out-patient treatment and West Indians made up 11.3% of the sample. Neither service offers 24 hour cover, and when this is provided (e.g. Lim, 1983) a more disturbed population is seen.

The views of referrers to the EIS suggested that the team was perceived as suitable for people with severe problems and that, despite the vagueness of this term, an appropriate population was being referred and treated, sometimes using a crisis intervention model but at others offering more conventional treatment to those who could not, or would not, visit hospital-based services. Even though the EIS had only one medical member it was able to treat a full range of psychopathology, much of it severe, through a case manager system with frequent reviews. The effectiveness of this system can only be determined by proper evaluation but our findings show that it is at least feasible and acceptable to referrers.

Referrers valued highly the joint working of the EIS and although only a third of assessments were performed with non-EIS workers, this figure is still relatively large, given that most referrals came from busy GPs and duty social workers. The ready accessibility and liaison with agencies concerned with homeless people may have accounted for the homeless forming a quarter of all referrals. Many of these have significant psychiatric disorders (Lodge-Patch, 1971; Priest, 1976) and recent studies suggest that the numbers are increasing (Bartlett, 1989; Timms & Fry, 1989). These issues are highlighted in inner cities and there is likely to be an increasing need for community-based psychiatric teams to detect and treat those patients who otherwise are in danger of falling outside the welfare provision available to the rest of the population.

Acknowledgements

We thank John Green for constructive criticism, Duncan Sellers and Barbara Ward for their help in data collection, and the World Health Organisation for permission to quote the diagnostic categories from the 1988 draft of the 10th revision of Chapter V of the *International Classification of Diseases*, produced by the Division of Mental Health, Geneva.

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https://doi.org/10.1192/pb.14.5.267 Published online by Cambridge University Press