

Editorial

Can early intervention services modify pathways into care?[†]

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**Summary**

Pathways into care have not changed significantly since the introduction of early intervention services for psychosis in London. Some groups have different pathways into care and those whose pathway originates in primary care have a longer route to services. This editorial explores the nature of these challenges, for both early intervention services and referring agencies.

Declaration of interest

I work in the same institution as one of the co-authors of Ghali *et al* and am a member of the ÆSOP study team.

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Ghali *et al*'s paper in this issue of the *Journal* is an important and timely addition to the literature in three key areas.¹ First, in examining duration of untreated psychosis (DUP) in a sizable group of referrals to early intervention services (EIS) in London; second, in exploring the pathways to such services for different groups; third, in pointing towards possible facilitators and delays towards access to these services. Their paper is important as much for the questions and challenges it poses for EIS as for what it tells us.

The DUP dilemma

In his accompanying commentary, Warner argues that, essentially, the 'central tenet' upon which EIS are based (namely, that DUP is the important driver of outcome and that it should be reduced) is fundamentally flawed.² Rather, he argues, it is mode of onset (acute *v.* insidious) that is the important issue (and which in turn influences DUP). Certainly, we know that a more insidious onset of illness is associated with poorer outcome and intuitively, it makes sense that someone with a more acute, florid presentation is likely to come to the attention of services (mental health or criminal justice system) more quickly (and thus have a shorter DUP) than those with a slower, less florid initial onset. Indeed, the ÆSOP study demonstrated that a more insidious onset was associated with a longer DUP.³ However, this does not necessarily mean that attempts to reduce DUP are in vain. Some would argue that, at the very least, any attempt to reduce a period of suffering (especially one as distressing as a first episode of psychosis) can only be a good thing, regardless of whether it changes prognosis. The more difficult question is whether, in our increasingly resource-constrained services, this is the best use of limited resources and staff. The truth is that we still do not know with sufficient certainty whether length of DUP centrally affects illness outcome or whether it is a mere indicator of poor prognosis illness. We do know that certain aspects of early illness course are ameliorated by EIS⁴ compared with generic services, but equally, it is unclear whether, once people migrate to generic

services after EIS, their progress is maintained.⁵ One interpretation of this is that it may not be any particular novel intervention that makes this early difference, but rather the quality and intensity of the service and support delivered. Indeed, EIS may be merely a blueprint for what all mental health services (given sufficient funding) should strive for.

Pathways

Ghali *et al*'s findings in terms of differences in DUP and pathways to care in EIS largely mirror the findings of the original ÆSOP study (performed in parts of the same geographical location in the previous decade, prior to the advent of EIS).^{6,7} In brief, they found shorter DUP for certain Black and minority ethnic (BME) groups and also higher rates of referral via primary care for White British people and higher rates via the criminal justice system for some BME groups. On this latter point, two issues are worth noting. First, that over a 10-year period, and one which has seen the initiation of EIS, little appears to have yet changed in terms of patterns of referral. And second, higher rates of referral via the criminal justice system persist for some groups. It is worth noting that EIS are still relatively young and are developing rapidly, and that changes in practice can take some time to be reflected in changes in outcome. That notwithstanding, these findings do pose a question as to whether EIS need to further develop, or even develop in a broader direction, in order to be more effective. For example, in some countries (most notably Australia but increasingly others such as Ireland), much closer links are being forged between statutory services and voluntary agencies that cater for younger adults with a broad range of mental health distress. Further, given that adolescents and younger adults may present with non-specific 'symptoms' that do not accurately predict one specific disorder, should EIS broaden their remit beyond psychosis? Put plainly, should EIS be less diagnosis specific? Should we be thinking more in terms of duration of untreated illness or distress rather than duration of untreated psychosis?

Strikingly, Ghali *et al*'s paper shows continuing high rates of referral via the criminal justice system. About one-quarter of the overall sample was identified via this route, a proportion that was even higher for some BME groups. At first glance, this appears troubling. Indeed, many use the somewhat pejorative terms 'coercive' or 'adverse' as a synonym for the criminal justice system pathway. Ideally, everyone with early signs of illness would see

[†]See pp. 277–283 and 284–285, this issue.

their primary care physician who would then promptly refer them to their local EIS, who would then promptly assess them and treat them as appropriate. I would argue, however, that it is somewhat reassuring to see credible rates of referral via the criminal justice system (be they the police, the probation or the prison services). At least this suggests that these services appear able to detect and identify certain behaviours as indicators of illness and make the appropriate referrals. I would be more concerned if these rates were low, possibly suggesting that services were failing to detect genuinely unwell individuals.

Like AESOP, this study found that certain BME groups had higher rates of referral via the criminal justice system. According to Warner's thesis, this may be due to more acute, florid illnesses perhaps being more common in these groups leading to their being identified earlier and on the basis of behaviour that attracts the attention of the police and emergency services.² Intriguingly (and Ghali *et al* refer to this in their paper), the causes for this phenomenon may be more complex than at first glance. For example, in the AESOP study,⁷ it was found that Black Caribbean family members were more likely than other groups to call the police rather than mental health services if they noticed unusual or disturbing behaviour in another family member.

Perhaps the most intriguing finding is that referral via primary care was associated with a longer DUP than other routes, a finding particular true for the White British group. Ghali *et al* speculate as to why this may be the case. Are individuals who are White British more likely to have a more insidious, less florid illness onset that is less likely to lead to a quick referral? Are general practitioners more likely to treat and/or observe such cases for longer prior to ultimately referring them on? Or are they not yet sufficiently quick at detecting the early signs of illness? The data in this paper do not allow us to arrive at a solid conclusion, but certainly this is an area that will need to be examined further, since the EIS model would argue that the earlier a referral is made to them, the better.

Conclusion

In his commentary, Warner suggests that EIS samples are biased in terms of an overrepresentation of more brief disorders, which are more likely to remit and have a better prognosis, and also that certain BME groups may have more of this type of disorder (and hence, a more prompt referral with shorter DUP and perhaps higher rates of referral via the criminal justice system).² Again, the evidence for groups such as Black Caribbean people having a more

remitting, acute-onset form of illness (with a presumed better prognosis) is mixed. More definitive studies, such as the 10-year follow up of the original AESOP sample (originally collected prior to the advent of EIS), may be able to answer such questions more comprehensively in the near future, particularly in terms of whether DUP accurately predicts longer-term outcome and whether outcome itself is different between different groups.

Ghali *et al*'s findings of persisting differences in both DUP and pathways to care between groups are challenging both to EIS and to referring services (be they primary care, emergency services or the criminal justice system). At present it is unclear what the most effective way of overcoming these obstacles might be (and the available evidence does not clearly support any single route). It may be that increasing public education and awareness, greater training in detection (perhaps particularly at primary care level), combined with enhanced cooperation with a broader range of voluntary agencies and less stringent referral criteria is the best route forward at present.

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