Correspondence

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Value of early intervention in psychosis

The energy invested in debates about the benefits of early intervention sometimes generates more heat than light, especially when the issue is seen as related to the allocation of resources. The practice of medicine in Canada, while unique, has some parallels to the UK system and so the recent debate (Pelosi/Birchwood, 2003) is of considerable interest to us. Although we find ourselves in agreement with Dr Pelosi's concerns about intervention in putative prodromal phases of psychotic illness, the potential value of prompt intervention once psychotic illness has been established seems quite defensible on the grounds of both reducing ongoing suffering and possibly improving long-term outcome. Although the evidence for prompt treatment improving the long-term outcome for psychosis is not irrefutable, there is substantial evidence that such a relation may well exist (Norman & Malla, 2001; Malla *et al*, 2002).

Dr Pelosi implies that first-episode psychosis programmes are elitist and excluded from mainstream psychiatry. Enthusiasm for the early intervention approach need not be to the detriment of other aspects of the mental health system. Our experience is that such programmes increase the public recognition of the need for, and influence the political will to provide, a higher standard of care for people with psychotic disorders. However, we must continue to evaluate whether early intervention with phase-specific pharmacological and psychosocial interventions reduces the overall burden of chronicity or residual symptoms in these patients.

We have become concerned that the focus on prompt intervention will deflect attention from the need for delivering appropriate interventions – timing is certainly not everything! Early intervention programmes should, in time, also be able to provide information to better identify those likely to have a 'prolonged recovery' (Edwards *et al*, 1998) or be treatment refractory. This is not the time to turn back, but to move forward and support controlled trials to assess the efficacy of early intervention.

Hopefully, the development of early intervention programmes will result in better linkages between child and adult psychiatry services and also with those involved in long-term care to ensure treatment of psychosis throughout the life cycle and not just for the first 2–3 years. Early intervention programmes are the first steps towards achieving these goals.

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Pelosi, A./Birchwood, M. (2003) In debate: Is early intervention for psychosis a waste of valuable resources? *British Journal of Psychiatry*, **182**, 196–198.

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Author's reply: I find myself in agreement with many of the observations of Manchanda and colleagues. There are many examples in medicine (for example surgery) where the need to advance clinical care, to keep up with new approaches and to develop research, has led to greater specialisation within a discipline. Dr Pelosi's charge of elitism seems to me a professional one; in early psychosis, in line with the predictions of Manchanda and colleagues, I think this focus in the UK is directly responsible for the increase in public recognition of the underinvestment in these services (Rethink, 2002) and for the development of the political will for reform. The longitudinal studies have shown clearly that long-term disability and course trajectories are in place within 3 years, yet all resources are downstream (assertive community treatment, rehabilitation); thus, this new investment has been warmly welcomed by consumer groups (Rethink, 2002).

This service structure now provides an unparalleled opportunity for further research and service innovation. Important research questions now come into focus. What kind of intervention will bring the early cycle of relapse under control, and will young people find it acceptable? What strategies are effective in encouraging help-seeking to reduce duration of untreated psychosis, and what is its impact? I think it is important to emphasise that early intervention services can only provide vehicles for intervention and are not an intervention in themselves; the litmus test of a service is its ability to engage (a major problem in early psychosis) and to fix existing service problems. For example, as Dr Manchanda illustrates, the early intervention focus enables us to think creatively about how to improve continuity of care between child and adolescent mental health services and adult services and to infuse the concepts so familiar to child and adolescent services into the adult arena and vice versa (Birchwood, 2003). I agree with Dr Manchanda that continuity can work forward in time, too; however, there is a risk that early intervention, like existing services, could trap people unnecessarily in long-term services. Preparing for exit and developing community support strategies and identifying cases of 'prolonged recovery' are also important.

Dr Manchanda comments about Dr Pelosi's concerns about the ethics of 'prodromal intervention'. I too share these, but this continues to be a research issue and does not form part of the vision for early intervention services. However, the cases thrown up by the 'ultra high risk' or prodromal research involve people suffering from distressing psychotic experience that has not reached the ICD threshold; these people are all seeking help and the majority are already receiving care from

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secondary services. All clinicians will be familiar with such individuals, who present a therapeutic challenge where equipoise is acknowledged. One benefit of this research, therefore, is its potential to inform a non-pharmacological protocol of treatment, capitalising on the efficacy of cognitive–behavioural therapy in psychosis and emotional disorders.

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The International Early Psychosis Association would like to contribute to the debate on early intervention (Pelosi/Birchwood, 2003).

First, the international network promoting reform in early psychosis is led by clinicians and academics who have a record of commitment to evidence-based medicine and leadership in scientific research. The attempt to discredit this network as mere evangelism does not bear scrutiny. However, successful reform in health care is always a blend of logic, evidence and advocacy. The latter is not only a legitimate but an essential element.

> 'We should be active and loud advocates of the mentally ill and be in the forefront of their battle to realise their rights. This might require that we relinquish some of our professional role and add some political activism to our daily chores – a sometimes difficult but now ever more necessary reorientation for doctors in general and psychiatrists in particular' (Sartorius, 1998).

Second, Dr Pelosi seriously underestimates the weakness of existing generic models of care for early psychosis patients and their families (Garety & Rigg, 2001). Access to and quality of initial care for first-episode psychosis is poor in the UK setting, as it is in most affluent, developed countries. This indicates a structural as well as a funding problem. Services targeting 'serious and enduring mental illness' inevitably focus on the needs of 'prevalent' rather than 'incident' cases. The early intervention paradigm asserts that there is a need to subspecialise in relation to the needs of young early psychosis patients, both in terms of structure of the service and the content of interventions, according to a 'staging' model. This assertion has tapped into resistance to subspecialisation in general within psychiatry, which Dr Pelosi passionately expresses. However, excessive reliance on purely generic service models is not defensible and is bound to limit the quality of response in many areas of psychiatry. A balance should be sought.

Third, implementing overdue reforms inevitably creates secondary problems and 'perverse effects', which seem to lie at the heart of Dr Pelosi's concerns. Workforce supply, quality and morale are crucial issues. Without careful planning, there could indeed be adverse effects on pre-existing elements of the system. These second-order issues need to be tackled but do not seriously challenge the logic and urgent need for reform in early psychosis, and should not be allowed to delay or derail it. In the longer term, greater specialisation within an umbrella of integrated services is a pathway to better morale and quality. The successful emergence of other sub-specialty areas (e.g. old age psychiatry) illustrates this point. Looking further ahead, early intervention could ultimately represent a way station en route to a sub-specialty of youth psychiatry (McGorry & Yung, 2003).

Fourth, the emerging early intervention services are targeted from first-episode psychosis onwards and do not specifically include the prodromal phase, which remains a research issue. There are genuine issues involved in sub-threshold detection of a low-incidence disorder and these remain to be solved. However, the caution required in extending intervention to potentially prodromal patients cannot be used as an argument for delaying intervention to people with clearly diagnosable first-episode psychosis.

Far from being wishful thinking, this reform process is already leading to improved short-term outcomes for young people with psychotic illness in many centres around the world (Edwards & McGorry, 2002). The reform is delicately poised in the UK and there may well be secondary effects on mainstream systems, but these should not be seen as fatal flaws, rather as problems to be solved. In the UK setting, it is to be hoped that psychiatrists will play a leadership role in this vital endeavour, which should ultimately lead to a strengthening of the specialist mental health system. In other parts of the world we are looking to you to make a success of this important task and hope your pioneering reforms will help to guide our own efforts.

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Author's reply: The advocacy and political activism of the International Early Psychosis Association has clearly been successful in the UK since teams for their narrow sub-specialty have been introduced despite widespread shortages of trained mental health professionals. General psychiatrists also consider themselves to be advocates for people with mental illness. They may not have the public relations skills of the early intervention movement but they believe that clinical experience and knowledge of epidemiology and health economics should be more important in determining health policy.

The most ambitious aim of the early intervention specialists has been to identify and treat people during a pre-psychotic phase of illness. There now seems to be unanimous agreement that any such attempts to prevent the onset of, for example, schizophrenia could only lead to more harm than good. The International Early Psychosis Association should return to users, carers, policy makers and members of the public whom they have influenced (Goode, 1999) and explain the epidemiological and clinical errors behind their previous dreams of primary prevention.

There should also be unanimous agreement with your earlier correspondent that provision of care to young people who have recently developed a psychotic illness is not 'rocket science' (Owen, 2003). I have read and re-read accounts of the clinical methods

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