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Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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Treatment is necessary!

I read the editorial by Shiers *et al*[1] with some interest largely due to my previous attempts at highlighting this issue both in mental health trusts and to the readership by previous responses and articles.

However, I have been left mildly disappointed again with the tenor of the article, which did not mention the increased risks of mortality without treatment: something an editorial in the *BJPsych* should be mentioning! We have several past and recent longitudinal studies[2] which clearly highlight the risks of increased mortality without antipsychotic treatment. I have followed this trend of certain health professionals not advising patients to go on to antipsychotic medication because of risks to physical health. The trend took a further (dangerous) turn when a study was granted ethical approval which allowed patients with psychotic symptoms not to be treated with antipsychotic medication,[3] and some regarding it as a proof of concept that cognitive therapy is an alternative to antipsychotics.

An article in the *BPsych*[4] clearly discredited cognitive–behavioural therapy as a viable alternative, but was not given the same media coverage as the pilot study by Morrison *et al*.[3] My day-to-day work involves being based in an early intervention team and despite being aware of what needs to be done to monitor physical health, poor investment and increased demand (with the upper age limit now correctly abandoned, see www.nice.org.uk/guidance/cg178/chapter/1-recommendations#first-episode-psychosis-2), we struggle to monitor all our patients to the standard we would like to achieve.

Despite the above factors, there are other issues to consider, including the stigma of the diagnosis and taking medication, lack of family support and working memory deficits[5] to name a few, but readily ignored. I wish the editorial could take a more unbiased role rather than continue to bash on about one factor, i.e. antipsychotic medication and its side-effects. Untreated patients also have higher morbidity risks, which I feel the editorial did not highlight.

Looking at it from a systems theory point of view would have led to a more balanced reading. However, I laud the attempt of this editorial and the attempt to reduce the inequalities and mortality gap.[6]

Declaration of interest

M.K works in an early intervention in psychosis service.

1 Shiers D, Bradshaw T, Campion J. Health inequalities and psychosis: time for action. *Br J Psychiatry* 2015; **207**: 471–3.

2 Tiihonen J, Mittendorfer-Rutz E, Torniainen M, Alexanderson K, Tanskanen A. Mortality and cumulative exposure to antipsychotics, antidepressants, and benzodiazepines in patients with schizophrenia: an observational follow-up study. *Am J Psychiatry* 7 Dec 2015 (doi: 10.1176/appi.ajp.2015.15050618).

3 Morrison AP, Turkington D, Pyle M, Spencer H, Brabban A, Dunn G, et al. Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial. *Lancet* 2014; **383**: 1395–403.

4 Jauhar S, McKenna PJ, Radua J, Fung E, Salvador R, Laws KR. Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br J Psychiatry* 2014; **204**: 20–9.

5 Lui SSY, Liu ACY, Chui WWH, Li Z, Geng F, Wang Y, et al. The nature of anhedonia and avolition in patients with first-episode schizophrenia. *Psychol Med* 2016; **46**: 437–47.

6 Crump C, Winkleby M A, Sundquist K, Sundquist J. Comorbidities and mortality in persons with schizophrenia: a Swedish national cohort study. *Am J Psychiatry* 2013; **170**: 324–33.

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Authors' reply: We thank Dr Kripalani for his interest in our editorial and we share his aspiration to improve the physical health of people who use mental health services. We would like to respond to some of the issues he has raised and note the following.

We believe our editorial demonstrated that this continuing health inequality represents a systems failure of primary care, secondary care and public health to coordinate to prevent premature mortality through implementation of evidence-based interventions. Our proposed systems solution was reflected in a recent editorial by Mitchell & De Hert '. . . there is much more we can do to help promote physical health in our patients with schizophrenia. We should be doing this early, at first contact by proactively attempting to minimise the accrual of cardiometabolic risk factors. In the long-term, this will prove a more effective strategy than responding only once the complication is established'.[1]

Our editorial highlighted the importance of evidence-based interventions that include antipsychotics. Our call for careful antipsychotic prescribing, well-balanced with psychological interventions and promotion of physical health, resonates with views of others, including major guidelines, particularly in the critical early treatment phase of psychosis:

- National Institute for Health and Care Excellence (NICE) guidelines (www.nice.org.uk/guidance/cg178) explicitly recommend that people experiencing first-episode psychosis (FEP) should access an early intervention service and be offered a range of evidence-based interventions that include pharmacological, psychological and physical health-promoting approaches.

- NICE recently endorsed the Lester UK Adaptation of the Positive Cardiometabolic Health Resource supporting systematic monitoring of those receiving antipsychotics (www.rcpsych.ac.uk/quality/NAS/resources).

- The British Association of Psychopharmacologists recommend specific prescribing considerations for treatment-naive individuals with FEP; for example antipsychotic choice based on relative side-effect liability, patient preference, low-dose initiation and titration within *British National Formulary* range, systematic side-effects monitoring following initiation, etc.[2]

- Dixon & Stroup recently highlighted, 'Because medication experiences for individuals at the beginning of treatment may have a lasting impact on their attitudes toward medication and course of illness, this is a critical time to optimise prescribing.'[3]