Correspondence

EDITED BY KHALIDA ISMAIL

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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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

https://doi.org/10.1192/bjp.185.2.171 Published online by Cambridge University Press