Harold & DeGarmo also question whether there was indeed a difference in the standard control condition (usual care) for participants in the US and UK studies. There are certainly likely to be differences in the nature and uses of group care between the two countries, given the differences in their child-welfare and juvenile-justice systems. However, the point we were making is that, in the USA, the MTFC programme for adolescents has been principally found to be successful when targeted at young offenders, in studies that have used a variety of measures of recorded reoffending to assess its effectiveness.[1–3] This emphasis on the effectiveness of MTFC-A with young offenders is also clear from the programme developers' own website (www.mtfc.com). By contrast, the participants in our study were young people with complex emotional and behavioural difficulties, 93% of whom were in care because of abuse or neglect and less than a third of whom had a recent criminal conviction. The differences between the populations served by MTFC-A are clearly evident in an article comparing outcomes for high-risk adolescent girls written by the programme developers in the USA and their English colleagues[4] and may perhaps partly explain why the results of the English evaluation were less positive than those in the USA.

1 Chamberlain P. Comparative evaluation of foster care for seriously delinquent youth: a first step. *Community Altern* 1990; **2**: 21–36.

2 Chamberlain P, Reid JB. Comparison of two community alternatives to incarceration for chronic juvenile offenders. *J Consult Clin Psychol* 1998; **66**: 624–33.

3 Leve L, Chamberlain P, Reid JB. Intervention outcomes for girls referred from juvenile justice: effects on delinquency. *J Consult Clin Psychol* 2005; **75**: 1181–4.

4 Rhoades K, Chamberlain P, Roberts R, Leve L. MTFC for high risk adolescent girls: a comparison of outcomes in England and the United States. *J Child Adolesc Subst Abuse* 2013; **22**: 435–49.

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Are we reinforcing the anti-medical model?

The results of Penttilä *et al*'s meta-analysis emphasised the importance of the duration of untreated psychosis (DUP) in long-term recovery from schizophreniform illness.[1] Timely initiation of effective treatment has been demonstrated to improve outcome, but the modality of treatment is currently under much debate. Robust evidence exists for the efficacy of antipsychotic medication[2] but recent studies have proposed psychological interventions, specifically cognitive–behavioural therapy (CBT), as an alternative first-line treatment.

In a recent randomised controlled trial, CBT was used as a single intervention, instead of conventional antipsychotic treatment.[3] To our complete surprise, one of the exclusion criteria was treatment with antipsychotic drugs. We wonder how ethical approval was granted, despite Tiihonen *et al*'s robust demonstration of reduced mortality over a considerable follow-up period for patients receiving antipsychotic medication.[4] We feel that this will set a dangerous precedent of offering psychological treatment as an alternative to evidence-based treatment. In a clinical setting, adherence to drug treatment is already a significant issue and there is potential to reinforce the idea that antipsychotic medication is harmful and unnecessary. We feel that this would further disadvantage an already vulnerable group of patients.

This issue has recently received a fair degree of coverage in the media, with articles such as Freeman & Freeman's piece in *The Guardian* fuelling long-held popular beliefs that antipsychotics are ineffective and in fact damaging to health.[5] Given the well-documented drawbacks of antipsychotic drugs, it is understandable that patients and professionals will invest hope in non-drug alternatives. However, a large meta-analysis with over 3000 participants shows at best a small effect size for CBT.[6] In reference to Penttilä *et al*'s paper, we would be interested to read subgroup analyses of specific first-line treatments and wonder if outcomes would differ between modalities.

While we would endorse any treatment, drug or non-drug based, that is proven to reduce DUP, it is vital that we do not lose sight of the fact that antipsychotics are the only evidence-based first-line therapy in psychotic illness.

1 Penttilä M, Jääskeläinen E, Hirvonen N, Isohanni M, Miettunen J. Duration of untreated psychosis as predictor of long-term outcome in schizophrenia: systematic review and meta-analysis. *Br J Psychiatry* 2014; **205**: 88–94.

2 Leucht S, Arbter D, Engel RR, Kissling W, Davis JM. How effective are second-generation antipsychotic drugs? A metaanalysis of placebo-controlled trials. *Mol Psychiatry* 2009; **14**: 429–47.

3 Morrison AP, Hutton P, Wardle M, Spencer H, Barratt S, Brabban A, et al. Cognitive therapy for people with a schizophrenia spectrum diagnosis not taking antipsychotic medication: an exploratory trial. *Psychol Med* 2012; **42**: 1049–56.

4 Tiihonen J, Lannqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, et al. 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study). *Lancet* 2009; **374**: 620–7.

5 Freeman D, Freeman J. At last, a promising alternative to antipsychotics for schizophrenia. *The Guardian*, 7 March 2014.

6 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.

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Author's reply: Dr Bindman and Dr Kripalani have suggested an analysis of the association between DUP and outcomes in subgroups by specific first-line treatment modalities. Unfortunately, it was not possible to analyse this in our meta-analysis, since none of the original studies had used only one treatment modality, but a combination of them in the early phases of treatment. As Bindman & Kripalani point out, and based on current knowledge of the efficacy of treatments in the early phase of schizophrenia, it would not be ethical to study treatment without antipsychotic medication in a first-episode clinical sample.[1] Also, DUP is usually defined as ending at the initiation of antipsychotic medication, which in clinical practice usually occurs about the same time as other treatment modalities begin; therefore, the included studies give only a little information on the effects of different treatments. However, it is interesting to note that de Haan *et al*[2] investigated the effect of delay in intensive psychosocial treatment by comparing this effect with delay in treatment with antipsychotic medication; and found that delay in psychosocial treatment may be a more important predictor of negative symptoms than delay in antipsychotic treatment.

The discussion about the possible effects of antipsychotics has been rather intense recently. However, the current guidelines for treatment of psychosis and schizophrenia clearly indicate that