

Introduction to ‘Early psychosis: a bridge to the future’

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Summary Early intervention in psychiatry has taken a long time to emerge as a key strategy to reduce morbidity and mortality. In other fields of medicine it has received consistent support and great efforts are expended to educate the public about the value of early diagnosis and the benefits of timely intervention. There is finally substantial momentum behind similar endeavours in psychotic disorders, which, now they have reached ‘proof of concept’ stage, could begin to be extended across the spectrum of serious mental disorders. There is also ambivalence and resistance to this evidence-based reform which warrants careful analysis. The Third International Early Psychosis Conference proved to be a watershed and was the largest and most vibrant meeting to that point. This preface aims to set the scene for a selection of contributions, derived from the array of new evidence reported in Copenhagen, and recently fully updated.

Declaration of interest None.

This supplement presents some of the key papers from the Third International Early Psychosis Conference, held in Copenhagen in September 2002. The conference lived up to its name in capturing the rapid and diverse growth in knowledge in early psychosis and creating a route to a more positive future for people with psychotic disorders, one that is being accessed by many already.

Background

The International Early Psychosis Association (IEPA) was established in June 1996 in Melbourne, Australia, and formally constituted in 1997 in Stratford, UK to

promote a preventive and early intervention approach to early psychosis. This was to be done by developing an international forum and network of clinicians and researchers. The first two conferences were in Melbourne (1996) and New York (2000), but the Copenhagen conference was the largest so far with 1100 participants and nearly 500 scientific contributions of the highest quality. In addition to superb research, there was a substantial participation from clinicians, consumers and relatives and health planners. The early psychosis paradigm has developed exponentially in many directions – basic research, clinical research, clinical care, health services research. The field is impressively comprehensive and is necessarily wide-ranging. So far, it has been seen as a growth point within the schizophrenia field, however, it has a wider relevance for the full range of psychotic disorders, and perhaps for all mental disorders. Within schizophrenia it is probably not an exaggeration to state that it is a crucial prism for research activity and reform as judged from its ‘market share’ at international meetings and the fact that the IEPA conferences are beginning to rival in size and significance some of the traditional international schizophrenia meetings. Early intervention in psychosis has captured people’s imagination – a concept whose time has come – and we are at last able to grasp what is realistically possible for more and more people with psychotic disorders. Credibility and sustainability, however, will depend on an unwavering commitment to an evidence-based approach.

This watershed has been long overdue – indeed, pent up delay has added to the momentum. Until recently, the schizophrenia field has been a ghetto of pessimism walled off from mainstream preventive medicine. We have been trapped in a different time zone. Why has this been so? One reason may be that the concept of schizophrenia itself is fatally flawed, a

putative disorder whose fundamental and false validating principle was that people could not recover, and if they did, the diagnosis then had to be questioned. People with schizophrenia were deemed ‘losers’! This loser criterion was introduced because of Kraepelin’s early failure to find a neuropathological process correlated with the clinical picture as had been possible with Alzheimer’s disease (and earlier with neurosyphilis). We now know that there are neuropathological correlates of schizophrenia, but they are not necessarily signs of neuropathological deterioration. The false assumption that Alzheimer’s dementia was the right neurobiological model or disease analogue for the syndromes of schizophrenia has been exposed not only on neuropathological grounds, but also on the basis of course of illness, since although schizophrenia is undeniably serious, a deteriorating course is more the exception than the rule. The power of the dementia model has been toxic to notions of early intervention for nearly 100 years and correspondingly harmful to the mostly young people in the early phases of illness. The shelf-life of the core dementia praecox concept is nothing short of extraordinary. It has stifled the field for a century. Whereas early psychosis advocates have sometimes been accused of creating unjustified optimism, considerably more iatrogenic harm has flowed from this ‘loser principle’. It ruled out the possibility of a viable recovery, withdrew hope from patients and families, disempowered clinicians and manifestly increased the risks of demoralisation and suicide. This concept represents the generalisation of a disorder from the poorest outcome (minority) subtype. For example, stage 4 childhood leukaemia to stage 1 – notwithstanding the different treatment responsiveness and prognoses of these phases and samples. In one sense, childhood leukaemia is a good therapeutic model to aim for in that steady refinement of the use of modern treatments as much as a breakthrough ‘cure’ has brought about much improved outcomes. Other secondary but powerful reinforcers of this pessimism have been the effects on the patient of institutionalisation, and the related perceptual bias of the clinician’s illusion, where the patients with the most severe forms of illness determine the clinician’s stereotype of the illness, and the consequences of crude and iatrogenic use of typical antipsychotic medications, which reinforced the stereotype of the ‘deficit’ state. Can this

disastrous scenario be turned around? Are we finally giving history the slip?

Progress

The sad plight of people with schizophrenia and the widespread therapeutic nihilism has triggered a series of major challenges to the status quo. Secessionist movements, notably the anti-psychiatry movement, and to a lesser extent deinstitutionalisation itself, were in part dramatic reactions to this unacceptable scenario. Sporadically, advocates of early intervention would emerge, however, without safe and effective treatments, early interventions clearly lacked credibility in the face of such serious and potentially disabling psychotic disorders, and the poor morale and suffocating pessimism endemic in psychiatric services. Chronicity accumulated and seemed inevitable, predetermined. The rise of schizophrenia research in the 1970s–1980s with exponential increases in investment was a key platform for release from this closed system of thinking and care. A highly influential cohort of leaders, including the late Richard Wyatt, Tim Crow, Nancy Andreasen, John Strauss, Will Carpenter, John Kane, Robin Murray, Daniel Weinberger, Thomas McGlashan, Jeffrey Lieberman, Ian Falloon, Heinz Häfner as well as others set the stage for remarkable expectation and progress. Seminal first-episode studies – an early feature of the growth of schizophrenia research, from Northwick Park (Tim Crow and Eve Johnstone) in the UK, Hillside Hospital in New York (John Kane and Jeffrey Lieberman) and Mannheim in Germany (Heinz Häfner) – helped the field to see the research potential of the early psychosis focus. Clinical services organised around such a research focus immediately recognised the potential for much better clinical care that could have far-reaching effects on course and outcome of illness. First, a clear-cut ‘need for care’ was clearly evident in most cases long before diagnosis according to the traditional diagnostic concepts was possible or actually effected. Second, an early priority was to reduce the serious iatrogenic harm that was being visited on the young people who were presenting for treatment after long delays ‘in extremis’, usually after a dangerous crisis when treatment could no longer be deferred. Traumatic entry to treatment beginning completely on the wrong foot with coercive practices and overdosage with typical antipsychotics

was and still is all too common. Early detection and comprehensive early care was seen as a way of minimising such iatrogenesis and creating a much better foundation for improved outcomes and quality of life – not exactly rocket science! The landmark 1991 paper by Richard Wyatt on early intervention and the pioneering exploratory work of Ian Falloon in Buckingham, UK played a catalytic role in the early 1990s in promoting ‘lift-off’.

Recent developments

As with any rapidly growing paradigm, recent developments in early psychosis have provoked two responses: one has been a release of pent-up demand for a more optimistic approach to an increasingly treatable group of disorders. Clinicians in particular have been encouraged and liberated through a new permission to think more positively about their patients and their prospects without being written off as being unrealistic or as having been seduced by rescue fantasies. The recent UK clinical practice guidelines (National Collaborating Centre for Mental Health, 2003) for the treatment of schizophrenia list as the very first guideline the need for clinicians to approach their patients within an atmosphere of hope and optimism. Biological researchers too are convinced of the value in identifying the underlying mechanisms of onset and entrenchment of illness, and new knowledge, and new treatment, have moved us beyond simple neurodegenerative and neurodevelopmental hypotheses. We can now conceive of a kind of third way similar to other complex diseases with a dynamic model involving multiple risk and protective factors, and gene–environment interactions. Odd how long it has taken us to get there! A credible renaissance of psychosocial interventions led by pioneers, such as Max Birchwood and a cohort of clinical psychologists, and more radical service reforms, which have ensured that people with early psychosis remain in the mainstream of our community life and health systems, have fuelled the momentum.

To any new paradigm or reform there is always a reaction, however, and this extract illustrates the sociological nature of such processes.

‘The best progressive ideas are those that include a strong enough dose of provocation to make its supporters feel proud of being original,

but at the same time attract so many adherents that the risk of being an isolated exception is immediately averted by the noisy approval of a triumphant crowd.’ (Milan Kundera, 1996, p. 273)

In psychiatric as well as other reform processes, logic and scientific evidence are necessary but insufficient. Rhetoric, marketing, effective networking, altruistic promotion of a vital public health issue, economic arguments and a confluence of common interests have fuelled the momentum and are vital for real reform to take root. This is public policy analysis complementing evidence-based medicine. Given the history of psychiatry where some of these factors have driven reform in the absence of evidence, this naturally makes some people nervous, but without these factors operating we will not only fail to translate the most strongly evidence-based practices (e.g. family interventions in schizophrenia into routine practice), but our systems of care will fail to evolve and will again become paralysed. Evidence-based medicine and its cousin, evidence-based healthcare, particularly the latter, are complex concepts and represent the ideal basis for service delivery. But particularly in healthcare systems, evidence is hard won (only 10% of randomised clinical trials relate to systems of care) and we should move forward based on the best *available* evidence rather than timidly stick with what we all know is not working (Cooper, 2003; Lin & Gibson, 2003). An especially constructive international leadership group within the IEPA, both official and informal, have worked together to promote and guide this growth. A mushrooming of early psychosis centres across the developed world is occurring, guided by increasing amounts of ‘best available evidence’.

Research often seems to cut the threads that bind it to ordinary thought and feeling – to clinicians and patients it may seem detached and of uncertain relevance, lacks urgency or connection. In early psychosis, these threads seem strong, bonds rather than threads, between neurobiology, humane patient care, service models and the wider community. The stakes are high but so is the energy and commitment. The threads are human feelings combined with the power of reason and technical skill – a multiple helix rather than a thread. Evidence without connection to the meaning and emotional significance will fail to achieve maximum impact and real world

reform. Compassion, the distress and anxiety and the strength too of the patients and relatives, the humanity and morale of researchers and clinicians, the courage and confidence of people to survive and achieve, especially in the shadow of great adversity – these are the essential ingredients for true progress. The new momentum then is overdetermined with deep roots and many influences. There are lessons for the rest of psychiatry here.

The future

Schizophrenia has been called ‘the sacred symbol of psychiatry’ (Szasz, 1988), one which has been approached with a great deal of complacency. This complacency remains a massive worldwide problem – leading to a huge efficacy–effectiveness gap between what is provided and what could be done for people with schizophrenia. Such comfort represents not ‘realism’ but decay and lost opportunity. This is what the early psychosis perspective has helped to expose. Notwithstanding the limitations of the modelling and conclusions of Andrews *et al* (2003), Goldberg (2003) and Warner (2003), even by applying what we already know we could reduce the global impact of psychotic disorders dramatically. Despite this complacency, or perhaps resignation is a better word, ‘comfort zone’ psychiatry flourishes everywhere, and lacks confidence, adequate funding and a recognition of its public health significance. The *Global Burden of Disease* report attests to this (Murray & Lopez, 1996). We have a number of tasks to progress to turn this around. In perhaps one of the least auspicious fields for preventive strategies, we have made progress and

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begun to show what is possible. It is hoped that this is the beginning of a great big wake-up call. The participants at the Copenhagen conference represented what are known in marketing terms as the ‘early adopters’, those with vision, energy and a sense of openness and purpose in relation to something new. Of course, it is critical to avoid the risk of this vital reform process becoming a ‘fad’ or a blind alley. It is crucial to avoid serious mistakes, while recognising that some mistakes will be made and must be detected. We do need evidence as a tool and guide and ally but not as an inhibitor or even prerequisite for exploration of reform. Evidence is the language of reform but there are other elements in communication. There is also rhetoric, prosody, persuasion and at the heart of things, a chorus of voices reflecting the human experience of illness and recovery. The latter can be a uniquely powerful force for change. We sense that a large rock has been cast into the lake of psychiatry. The ripples are spreading. In time they may spread to all shores to help to improve the survival and quality of life for all people affected by psychotic disorders. In turn, the prospects for psychiatry as a whole and all those bearing the hidden burden of mental disorders may correspondingly improve.

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