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Letter to the Editor

Early intervention in psychosis: a response to McGorry *et al.* (2010)

The Commentary of McGorry *et al.* (2010) on our Editorial in the March 2010 edition of the Journal

(Bosanac *et al.* 2010), used the opportunity to promote the early intervention agenda. Unfortunately it did not adequately address the challenges we raised. It is instead an example of how the early intervention agenda has been so successful in influencing policy – a simple solution to a complex problem, argued with passion.

The fact remains that there is no evidence that we can ameliorate the longer term course of psychosis with existing early intervention programmes. The Lambeth Early onset Group in the UK (Gafoor *et al.* 2010), the Danish OPUS study (Bertelsen *et al.* 2008) and an early intervention study from The Netherlands (Linszen *et al.* 1998) all show no overall beneficial effects of early intervention programmes in the medium term (5 years). We also know that most patients continue to have symptoms well beyond the early phases, despite the very best early care. For example, in the EPPIC 7-year follow-up study, only 14.9% of the schizophrenia/schizophreniform patients achieved social/vocational and symptomatic remission (Henry *et al.* 2010). It may be, as McGorry and colleagues suggest, that the interventions have been too short and hence early gains have not been maintained. But this surely undermines the rationale for a primary emphasis on early intervention in enhancing the longer term trajectory of illness. Rather it points to a need for better integration of early intervention programmes into the mainstream of psychiatric care so that the beneficial elements of the intervention can be continued. To focus exclusively or even predominantly on early intervention rather than promote continuity of quality care across the lifespan of psychotic illness seems unjustifiable given this evidence on the loss of early gains.

McGorry *et al.* (2010) suggested that we wish to maintain the *status quo* regarding the management of schizophrenia; that we ‘deserve censure’ and ‘cause real harm by delaying care’ and are ‘manufacturing a hopelessness that is by no means justified by the facts’. We do not believe that this is so. Rather than labelling generic services as ‘pessimistic’ (McGorry *et al.* 2010, p. 402) we should be engaging generic services in the provision of a coherent and comprehensive response to people with schizophrenia whatever their stage of illness. Stand-alone early intervention services have their own problems, including silo effects, the potential de-skilling of the generalized workforce in the area of early psychosis and the difficulty of transitions between services for patients, their families and clinicians. Transition between services is associated with loss and other adjustment problems (Friis, 2010). And it is not true that generic services cannot deliver good care: they can meet all the fidelity guidelines for early psychosis within generic structures as long as they are resourced and structured to do so.

We have yet much to learn about the care and treatment of people with psychotic illnesses such as schizophrenia. The main lesson to date from the early intervention field, namely that timely and comprehensive care is beneficial to patients whilst it is being delivered, is important. Further research into whether it may be possible fundamentally to change illness trajectories through intervention early in its course, remains important. Without such evidence, however, a predominant focus on early intervention seems a step too far.

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