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Editorial

Early psychosis reform: too fast or too slow?

''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 (1)]

Research and clinical practice reform in early psychosis has burgeoned in the past 5 years (2, 3). Could this be a passing fad, a false dawn or a quantum change in the pattern and quality of care for people with potentially severe illnesses who have been neglected by developed and developing countries alike? Kundera illustrates the sociological factors at work in any process of change, especially the power of ideas and their contagious capacity to become politically correct. The strangely invulnerable Kraepelinian concept, flawed in a fundamental way (4), is a classic example, but any heuristic idea can become entrenched and resistant to evidence. Fortunately, we have evidence-based medicine these days to help us stay on track. Or do we? Evidence is only a guide and an imperfect one at that. It is slow and sometimes very difficult to assemble. It can easily be biased or wilfully distorted. Some reforms proceed in line with or well in advance of the evidence. Others never occur despite overwhelming evidence for their effectiveness, or are greatly delayed. Clearly, sociological and marketing forces influence reform (5). How do we try to manage and influence these processes in a logical and constructive manner to bring about large-scale improvements in mental health care? If we look at the worldwide scene for the treatment of schizophrenia and related psychoses, it remains in a sorry state (6). In developing countries, there is much untreated prevalence and poor quality care, in developed countries serious neglect and a major efficacy–effectiveness gap. Patients are typically detected late, poorly engaged and generally need to demonstrate chronicity before being provided with minimalist and heavily stigmatized treatment. Too little, too late. There is an obvious need for structural reform and increased investment in all societies.

The early psychosis focus provides a potentially cost-effective vehicle for this to occur. Two papers in this issue touch on central elements of the early psychosis paradigm, firstly treatment delay and, secondly, the quality of treatment. A third element, the notion of intervening during the prepsychotic phase, still very much a focus for further research, is not addressed. Malla and Norman (2) provide an excellent recent review of this rapidly expanding field.

Treatment delay and the issue of duration of untreated psychosis (DUP) have attracted great research interest. Norman and Malla (7) review the evidence carefully. The clear majority of studies find a moderate correlation in the short term at least and perhaps even in the long term with symptomatic and functional outcome. The point has been validly made that the relationship may be partially confounded by factors intrinsic to the patient (8). This may be true; however, it is clear from data (9) and clinical experience that patient factors are only partly responsible for the timing of treatment onset. Significant contributions come from the surrounding social environment of the patient, the behaviour of the referring agency and the accessibility and acceptability to the patients of the system of care. The study of Kalla et al. (10) illustrates this. Even the apparent intrinsic qualities of the patient, e.g. gender, premorbid function, rather than being confounding variables, may influence the outcome via DUP by delaying treatment. DUP is one of the few potentially malleable influences on outcome we know of, and it *can* be shortened, with Larsen et al. (11) also showing it cannot be reduced to something merely intrinsic to the patient. It remains to be seen whether this translates into better outcome. In advance of such conclusive evidence, the UK has decided to systematically invest in systems and strategies to reduce DUP and improve care. Why? Because there is simply no argument in favour of delaying treatment (12). It is unlikely that any other branch of medicine dealing with a serious disorder for which effective

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treatments exist would be as ambivalent as academic psychiatry has been on this issue. Examples include stroke, chest pain and a range of cancers, where strenuous efforts are made to identify and treat at the earliest stage.

Turning to the second issue of quality and style of care, even more outcome variance could be related to this variable. Cullberg et al.'s (13) model springs from a desire to protect the patients from the adverse effects of standard care designed for 'prevalent' chronic cases. Our group had similar initial motivations, and on this foundation, phase-specific and sustained care systems can be built which produce at least better short-term outcome (14–16). It is unfortunate that the concurrent control group for Cullberg et al.'s study was not standard care as it typically occurs, where first-episode patients present late, are over-medicated and receive sparse psychosocial intervention. In fact, this control group apparently received very good care. This is a relatively common problem in health services research in psychiatry where no significant qualitative difference is created between the experimental and control groups (17). The presence of a historical control group in the Cullberg et al. study partially addresses this issue, and the project is a large 'real world' endeavour, and contributing useful data to guide reform.

I agree with the conclusions of Malla and Norman (2) in their careful review that the prime focus for the moment should be on the recognition and phase-specific management of patients from the point they cross the boundary to a frank psychotic illness. The first episode of psychosis is the fulcrum from which early detection efforts can spread in one direction, while in the other, determined engagement and sustained aftercare can be provided, probably for at least several years in the majority and for a minority for even longer. For this to occur, services and clinicians will have to look, feel and behave very differently. There has been a widespread yet piecemeal experimentation with reform in early psychosis around the world, more extensive in some places such as Canada, UK, and Scandinavia, than in others. A next step is the more systematic implementation of a streamed system of care for young people with early psychosis. At present, this is arguably even more important than decreasing DUP or establishing prodrome clinics as the priority for systematic reform. Services need to be acceptable as well as accessible to young people. They need to be more like magnets than forbidding fortresses. This is an argument for considering an even more ambitious reform – a youth model, in which a range of general, mental health and substance use services are provided within a single precinct along with more positive programmes congruent with youth culture. For this to occur, a nexus needs to be established between adolescent and young adult services, and streaming for say 12–25 or 15–25 year olds needs to be put in place. This will mean loosening the physical nexus in service provision between child psychiatry and adolescent psychiatry, though not necessarily the professional nexus.

Mental health in most developed and all developing countries is neglected and under-resourced. Early intervention is a potential vehicle for increasing morale, demonstrating the effectiveness and cost-effectiveness of treatment. It should be heavily invested in such a way as to generate the evidence to guide its evolution. So far the research and the reform are both healthy processes, as is the debate, which surrounds them. Evidence is the guide or the map, not the fuel or the vehicle. The passengers are our patients and ourselves. After a long delay, we are now heading in the right direction. We need sustained reform to continue the journey and accurate evidence to stay on track. Whether we are travelling too fast or too slow is largely a matter of opinion. I believe we should proceed at the maximum safe velocity.

Deinstitutionalization was a wonderful reform idea which in many places resulted in perverse outcomes because it was not properly evaluated or resourced. Early intervention should not make the same mistake.

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Patrick D. McGorry
Invited Guest Editor

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