Is early intervention in the major psychiatric disorders justified?

Psychiatric disease can take many years to emerge fully. **Patrick McGorry** argues that early specialist treatment is essential, but **Anthony Pelosi** is unconvinced that current evidence of benefit is enough to balance the potential harm

Patrick D McGorry professor of youth mental health, ORYGEN Research Centre, University of Melbourne, Locked Bag 10, Parkville, Victoria, 3052, Australia **pmcgorry@unimelb.edu.au**

YES Early diagnosis and treatment is intuitively appealing and widely accepted in medicine. Over the past 15 years, early intervention has become established in psychotic disorders and must now be extended to other mental disorders. Early intervention covers both early detection and the phase specific treatment of the earlier stages of illness with psychosocial and drug interventions. It should be as central in psychiatry as it is in cancer, diabetes, and cardiovascular disease.

Mental illnesses have been called the chronic diseases of the young.[1] The incidences of mood, anxiety, psychotic, personality, eating, and substance use disorders are highest in adolescence and early adult life.[2] Serious mental disorders increase mortality and may produce decades of disability and unfulfilled lives. Thus, the potential benefits and cost effectiveness of early intervention in mental disorders arguably exceed those for medical diseases, which typically emerge later in life.

Early clinical features can be difficult to distinguish from benign conditions and normal experience, leading to concerns about premature labelling. However, we now have operational criteria that not only indicate a need for immediate clinical care but strongly predict imminent transition to psychotic disorder. The criteria include subthreshold psychotic features, emerging functional impairment, and family history as risk factors (box).[3 4] Although the false positive rate may exceed 50-60%, all those identified are by definition help seeking and need some form of care. They rarely receive it from generic primary care and mental health services.

In reality, people with emerging mental disorders face the opposite problem to inappropriate labelling. Even in developed countries, people with fully fledged and sustained initial psychotic episodes have difficulty accessing appropriate care,[5] resulting in widespread unmet need, poor access, treatment delay, and undertreatment.[6] Delayed and inconsistent care may lead to suicide, offending, vocational failure, family stress, and substance misuse.[7] The real danger of lack of care overshadows the theoretical one of premature labelling and overtreatment.

Treatment delay is independently linked to poor outcome in psychosis.[8] A prospective cohort study of 281 patients in Scandinavia showed that intensive community education and mobile specialist assessment[9] substantially reduced treatment delay compared with usual treatment.

The real danger of lack of care overshadows the theoretical one of premature labelling and overtreatment

GETTY IMAGES

Anthony Pelosi honorary professor, Department of Psychiatry, Hairmyres Hospital, East Kilbride G75 8RG a.pelosi@clinmed.gla.ac.uk

NO General practitioners and psychiatrists must ensure that prompt diagnostic assessment and appropriate care are available for young people who seek help (or whose families seek help) because of worrying changes in emotions, thinking, and behaviour. In a small minority of such patients it will emerge over time that the initial symptoms were, in fact, the start of a severe—and sometimes devastating—psychotic illness.

Health professionals and families will inevitably ask themselves whether more could have been done in the earliest stages. But without the benefit of hindsight, when does it become justified to prescribe antipsychotic drugs that have serious side effects? When should patients be offered at least as powerful and potentially dangerous psychotherapy addressing the causes and consequences of psychosis? Important programmes of research are under way that will inform these difficult clinical judgments.[1] So far, evidence from randomised trials does not support the use of psychological therapies or drugs as preventive interventions. At best, they have led to only modest delays in the development of full blown psychosis in some of the participants with potentially prodromal symptoms.[2]

Unfortunately, researchers have somehow managed to convince themselves that general practitioners and ordinary psychiatric teams are not interested in these difficulties, leading to care that is "often delayed or inadequate, and sometimes crude or harmful."[3] They have established an international movement that advocates highly specialised services for the specific identification and treatment of young people who may be developing psychotic illness.

Richard Warner and others have pointed out the clinical and epidemiological flaws in their approach.[4 5] In particular, Warner has patiently explained how the positive predictive value of any test is dependent on the prevalence of the condition to which it is applied.[4] Schizophrenia and related illnesses are rare, but symptoms that point to their imminent onset are quite common.[6] Therefore most patients who enter these specialist programmes will unnecessarily receive potentially dangerous treatments. Data are emerging from the clinics of early intervention enthusiasts that

WHERE DO YOU STAND ON THE ISSUE?
Tell us on bmj.com

This in turn improved clinical outcomes, such as suicidal risk, social recovery, and negative symptoms.[10] However, the course of positive psychotic symptoms was unchanged.

A large Danish randomised controlled trial has provided the best evidence so far that improved engagement, reduced relapse rates, and better social relationships and vocational recovery, can be achieved with a more specialised early psychosis programme that provides assertive community care, including phase specific drug and psychosocial interventions.[11] This trial has further shown that for these widespread initial benefits to be maintained, a longer period of specialist care is needed because benefits erode with transfer to standard models of primary and psychiatric care.[12] Most patients who develop psychosis manifest an often prolonged period of morbidity, retrospectively characterised as the prodrome. Several randomised controlled trials have shown that it is possible to delay the onset of fully fledged psychotic illness in young people at very high risk of early transition with either low dose antipsychotic drugs or cognitive behavioural therapy.[13]

A recent Cochrane review of seven randomised controlled trials,[14] which mainly cover the prodromal stage, was unwilling to draw definitive conclusions because of insufficient data from randomised trials. However, in keeping with the conservative approach of Cochrane reviews, data from the extensive service reforms underway in hundreds of locations worldwide were not included. Randomised trials measuring long term outcomes are notoriously difficult in health services research. Yet early intervention is now better supported by data from such trials than comparable recent reforms in mental health. The best way to obtain further data is to extend the reform process, since evidence for new models typically emerges hand in hand with sequential yet flexible reform, as we have seen in both home based treatment and early intervention for psychosis.[15] This is consistent with evidence informed rather than evidence based investment, which has been recognised as too restrictive. Early intervention is likely to be of similar value in other potentially severe psychiatric disorders, notably mood, personality, and substance use disorders, where emerging data and public policy are increasingly supportive.[16]

The risk to benefit ratio certainly shifts as treatments are offered earlier in the course of any illness. Yet, as for most other medical conditions, evidence indicates that a critical point exists in the natural course of mental disorders, after which therapy is less effective.[17] Professionals genuinely wish to avoid mistakes with change. Yet many resist altering their clinical practice and oppose and devalue the kind of subspecialisation essential for early intervention because of a misplaced faith in generic models of care.[15 18]

The first step in establishing successful early intervention is to ensure that the potential seriousness of unrecognised and poorly treated mental illness is understood. Secondly, it should be acknowledged that, with the best will in the world, hard pressed generic services cannot deliver the results that the community deserves. Developing youth friendly services for enhanced access to quality multidisciplinary care[19] is probably the single most cost effective measure in mental health care reform.16 Thirdly, clinical staging should be strongly embraced20 as treatment needs differ according to stage of illness. Staging minimises stigma, creates exit strategies for people who have been wrongly diagnosed or whose disorder or problem resolves with simple intervention, and promotes the study of novel interventions, consumer choice, and sequential specialisation of care. Finally, a broad based social movement is crucial to sustainable evidence based reform, and we need to listen to the wider community, which is demanding genuine progress in mental health care.

I thank Rosemary Purcell for editorial help in preparing this manuscript.

Competing interests: PDMcG has received unrestricted research grant support from Janssen- Cilag, Eli Lilly, Bristol Myer Squibb, Astra-Zeneca, Pfizer, and Novartis. He has acted as a paid consultant for, and has received speaker's fees and travel reimbursement from, all or most of these companies. He has also received extensive research support from the Australian government's National Health and Medical Research Council and independent research foundations.

Cite this as: *BMJ* 2008;337:a695

The box and all references are in the version on bmj.com

illustrate nicely what they have been warned about for years.[7] When psychiatrists referred selected patients to a schizophrenia prodrome clinic, about half went on to develop a psychosis. After teachers, college counsellors, and families were encouraged to refer young people with possibly prodromal symptoms directly to the same clinic for the same care plans, the proportion developing psychosis steadily declined, until almost 90% were receiving unnecessary "preventive" interventions.[7]

When the leaders of the early intervention movement are pinned down, they accept these criticisms and concede that preventive work should be confined to research projects.[8 9] However, this has not stopped their skilful lobbying of politicians, journalists, patients, and carers with upbeat messages about the prevention and attenuation of schizophrenia.[10-12] Service commissioners are being fed information that "a local at risk service demonstrated a lower rate of transition to psychosis (7%) when compared with local (22-30%) and international (36-50%) data in the absence of targeted preventative interventions."[12] Who can blame policy makers for diverting resources to such services when nobody explains to them that such differences in outcome can only be due to patterns of referral?

Evidence from randomised trials does not support using psychological therapies or drugs as preventive interventions

As well as exaggerating the current scope for prevention, practitioners of early intervention claim special expertise in the initial treatment of young adults who have developed a psychotic illness. However, their care plans consist of standard interventions that should be provided by every multidisciplinary psychiatric team.[13] The subspecialists may obtain better short term outcomes, but they do so mainly by turning down difficult referrals. Lists of exclusion criteria vary but can contain the following: any previous treatment with neuroleptic drugs, affective psychoses, brain injury, drug or alcohol induced psychosis, and personality disorder.[14] Early intervention centres provide care for only three years because they have decided this is the critical period in major psychiatric disorders. If the workload becomes too much for them, the teams simply reduce their input to two years or even 18 months.[14 15]

These services disrupt continuity of care. Patients are often transferred back to the psychiatrist who originally diagnosed the psychosis, and up to 40% are being discharged to their general practitioner.[1] Many of these patients will relapse, although we cannot accurately predict which ones. Hard pressed family doctors and inpatient and community mental health teams will, of course, have to pick up the pieces while the previous key workers will remain unaware and unable to learn from their wrong decisions.

I am sorry to be critical of well intentioned colleagues. However, their self imposed lack of clinical experience combined with relentless political lobbying have led to unacceptable distortions of healthcare priorities. It is time to divert resources to ordinary clinicians who are prepared to tackle the genuine challenges of treating and trying to prevent severe mental illnesses. Unfortunately, this requires a lot more than carefully regulated work for some arbitrary critical period of a few years.

Competing interests: None declared.

Cite this as: *BMJ* 2008;337:a710

All references are in the version on bmj.com