Letter to the Editor

Consensus on Early Intervention in Schizophrenia

To the Editor:

The Research Strategies in Prodromal Schizophrenia meeting held in New York City on April 4–6, 2002, and organized by Barbara Cornblatt and her colleagues at Hillside Hospital, provided an opportunity to discuss our different perspectives on early intervention in psychosis and in conditions that resemble its prodrome. In light of the recent *Schizophrenia Bulletin* (October 2001) article by Warner (“The Prevention of Schizophrenia: What Interventions Are Safe and Effective?”) and our subsequent exchange of views in letters to the editor (Schizophrenia Bulletin, 28(1), January 2002), we feel it could be valuable to outline our areas of agreement.

Although we continue to differ in our interpretation of the duration of untreated psychosis (DUP) research, and whether it shows that longer DUP leads to increased morbidity and a worse course of illness, we concur that there are many other reasons to intervene early in psychotic disorders: decreased social disruption for the patient and the family; maintenance of family ties, friendships, job, studies, accommodations, and self-respect; and reduced risk of criminal behavior, substance use, and suicide. We agree that it is unnecessary to invoke the notion of biological toxicity due to prolonged untreated psychosis, because failure to treat a sustained psychotic disorder is likely to lead to psychosocial toxicity.

We concur that optimal treatment interventions should begin as early as fully declared psychosis as possible. These interventions should include ensuring security; low-dose antipsychotic drug treatment in most cases; individual and family education and support; comprehensive case management and psychosocial rehabilitative efforts to ensure adequate housing, income, and job opportunities for the patient; and a positive, recovery-oriented approach to the illness. Comprehensive, or even adequate, treatment services for first episode patients are not universally available, and early intervention focuses attention on optimal treatment and increases the prospects for improving treatment services more broadly. The positivistic approach of early intervention encourages optimism about the treatment of schizophrenia, increases community awareness, assists in stigma reduction, and boosts the involvement of consumer advocates. It is congruent with programs to promote knowledge about and understanding of mental illness and primary prevention efforts, such as improving obstetric care for women with schizophrenia.

We recognize that post-illness early intervention efforts are categorically different from subthreshold intervention approaches and that the latter may have negative consequences for false-positive cases—those who are treated as if they are likely to develop the illness, but, in fact, will not. We note, however, that treatment of symptoms that resemble the positive symptoms of the schizophrenia prodrome with antipsychotic medication can be beneficial (Cannon et al. 2002; McGorry et al. 2002) and that similar results have been obtained for people meeting the criteria for schizotypia, in which negative and cognitive symptoms are prominent (Tsuang 2000). These studies are small and preliminary, however, and require replication.

Because all those being treated in the Personal Assistance and Crisis Evaluation (PACE) program in Melbourne are symptomatic and already manifesting signs of significant disorder, the treatment of such cases is not very different from the usual care for young treatment-seeking patients in any high-quality psychiatric clinic (McGorry et al. 2002). This observation suggests that outcome assessment should include all the positive and negative consequences for subjects, including the reduction of prodromal symptoms and the occurrence of adverse treatment effects, in addition to data on the rate of transition to psychosis. We agree with Kane (personal communication, April 5, 2002) that the assessment of early intervention strategies should focus on decline in functioning as the ultimate concern, rather than on preventing the emergence of frank psychosis.

We do not believe, given the current stage of knowledge, that it is appropriate to apply early intervention strategies to asymptomatic subjects or to subthreshold cases who are not seeking help. There are potential negative consequences to the use of standard and atypical
antipsychotic medications, some of which may not yet be evident, and their use should be restricted to those individuals who might clearly be expected to benefit.

We recognize that a potential hazard of early intervention, both pre- and postinception of illness, is that those whose psychotic illness would have been brief and benign are treated unnecessarily or for longer periods than they otherwise might have been. It is not clear for what proportion of subjects this is a hazard, but it is important, nevertheless, to convey the idea that early intervention with antipsychotic medication does not imply that long-term drug treatment will be necessary.

The PACE approach to selecting subjects for pre-illness intervention will miss many people who will eventually develop psychosis but do not meet the rigorous criteria for inclusion in the PACE treatment group. Consequently, we do not see the PACE strategy as illness “prevention” in the public health sense of the term. We concur that the PACE approach should be characterized as very early clinical intervention with a symptomatic group and that reframing it in this way may eliminate much of the controversy that has been generated.

References


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