



Early intervention in psychosis: concepts, evidence and perspectives

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McGorry et al have persuasively and passionately advanced the case for early intervention in psychosis. The urgency to intervene early in life is underpinned by the fact that psychosis, like most other mental disorders, tends to have an onset in adolescence and early adulthood, which happen to be highly sensitive developmental periods in the life cycle.

Though heuristic, early intervention in psychosis is handicapped by problems of clinical staging and acceptability.

Clinical staging has a continuum, ranging from the earliest possible beginning of psychosis to first episode diagnosis of psychosis and the critical first 5 years after the diagnosis. The beginning pre-dates the “prodrome”, which term assumes certainty that the psychotic state will develop. We are talking of the very thin boundary when normal *begins* to transit to abnormal.

The concept of ultra-high risk has been coined in the attempt to pre-date the “prodrome”. Efforts to increase the predictive value of ultra-high risk criteria have the potential to produce false negatives and in the process deny people

who would otherwise benefit from early intervention the opportunity for treatment. On the other hand, less predictive ultra-high risk criteria would lead to false positives and in the process end up putting people on treatment when they do not need it, more so given the side effects and the negative impact at an early age.

Despite the evidence, there are still skeptics who argue that there is not enough evidence for the concept of early psychosis and/or that early intervention works. Nevertheless, such skeptics have a role to play in keeping the inventors of the evidence on their toes while both appealing to a wider audience and eventually influencing policy and practice. This is indeed a healthy debate.

Nearly all research on early intervention in psychosis comes from resource-rich countries, and little from developing





countries and in particular from Africa. It is true there is a gross shortage of human and financial resources in this continent (1-3). This cannot, however, be an excuse for Africa to be left out of this endeavour. This continent has a young population, with more than 50% being less than 25 years of age, and a total population which is about 12% of the global one. Thus, Africa has a claim to this endeavour. The major players in this kind of research and their respective funders should collaborate with researchers operating in Africa in designing simple community-based identification of ultra-high risk individuals and initiating interventions. This does not require highly skilled psychiatrists. The social support is still intact in most societies in Africa and affordable drugs such as haloperidol, despite their limitations, are widely available.

As happens with any new ideas, regardless of the overwhelming supportive

evidence, the progression from evidence to policy and practice will be on a continuum. On this continuum will be on the one hand the few researchers producing the evidence and, on the other, the skeptics or laggards demanding for more evidence. In between will be a continually increasing number of acceptors, initially on the basis of the evidence, then on the basis of an increasing number of opinion leaders who practice the intervention, and finally on the basis of standard practice without even questioning the evidence for or against.

The challenge to the inventors is whether or not they have the tenacity to generate both new and more evidence and navigate their inventions through this continuum while at the same time constructively engaging the skeptics. The way to achieve this is through research designs that will provide focused evidence of the earliest possible time inter-

vention can be initiated, minimizing both false positives and false negatives. This should be a collective effort that takes on board globally representative participants with diverse sociocultural and economic backgrounds. This way, it will be much easier for the results to be co-owned and therefore easily accepted and implemented. Scientific evidence alone is not always enough.

References

1. Saxena S, Sharan P, Garrido Cumbreira M et al. World Health Organization's Mental Health Atlas 2005: implications for policy development. *World Psychiatry* 2006;5:179-84.
2. Patel V, Boardman J, Prince M et al. Returning the debt: how rich countries can invest in mental health capacity in developing countries. *World Psychiatry* 2006;5:67-70.
3. Ndeti DM, Ongecha FA, Mutiso V et al. The challenges of human resources in mental health in Kenya. *South Africa Psychiatry Rev* 2007;10:33-6.

