

Benefits of Enriched Intervention Compared With Standard Care for Patients With Recent-Onset Psychosis: A Metaanalytic Approach

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Objective: To assess the effectiveness of enriched intervention (EI) on symptomatic and functional outcomes, compared with standard care (SC).

Method: Studies were retrieved from search engines and, using a metaanalytic approach, we compared EI trials with SC trials. Eleven EI sample trials (1053 patients) and 6 SC sample trials (500 patients), totalling data from 1553 patients (69% male), were examined. We calculated the effect sizes (ESs) of both symptomatic and functional improvement over a follow-up period of about 1 year.

Results: Significant differences between EI and SC were observed at follow-up for the improvement of both positive and negative symptoms, respectively: positive, EI = -1.54 (95%CI, -1.63 to -1.45) and SC = -1.07 (95%CI, -1.19 to -0.94) ($Q_{\text{between}} = 40.3$, df 1, $P < 0.001$); negative, EI = -0.44 (95%CI, -0.53 to -0.35) and SC = -0.18 (95%CI, -0.31 to -0.05) ($Q_{\text{between}} = 10.6$, df 1, $P < 0.01$). We also observed a significant difference between the EI and the SC groups for functional improvement over the follow-up period with mean EI = 1.11 (95%CI, 0.99 to 1.23) and SC = 0.63 (95%CI, 0.49 to 0.77) ($Q_{\text{between}} = 24.5$, df 1, $P < 0.001$).

Conclusions: There is now quantitative evidence across multiple studies and sites to indicate that EIs for patients with recent-onset psychosis are significantly more effective than SC for symptomatic and functional improvement over a period of about 1 year.

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Clinical Implications

- There is now quantitative evidence across multiple studies and sites that EIs for patients with a recent-onset psychosis are significantly more effective, compared with SC, for symptomatic and functional improvement over a period of about 1 year.

Limitations

- The “global functioning” subgroups were formed by a limited number of independent trials.
- Measuring functional outcome accurately is likely to require a more detailed and specific instrument than the GAF provides.
- Our EI subgroups comprised multiple types of intervention that may vary in efficacy.

Key Words: *recent onset, psychosis, schizophrenia, specialized early intervention programs, psychosocial treatments, metaanalysis*

Results on the efficacy of specialized early intervention programs for recent-onset psychosis are regularly published, and recent reviews have concluded that such specialized or enriched interventions have a beneficial impact on symptomatic and functional recovery in the early course of psychosis.¹⁻³ However, these qualitative reviews do not provide any quantitative measure of the benefits of this intervention, compared with routine or standard care. Considering the intensive resources required for the provision of EIs, more tangible and quantitative evidence is needed concerning their impact on symptoms and functioning. We performed a metaanalysis based on published studies with the main objective of assessing the magnitude of the effectiveness of EI compared with SC.

Method

Literature Search

PubMed and PsycINFO databases were used to retrieve studies published between January 1995 and January 2006 that reported outcome on measures of symptoms and (or) functioning from trials using either an enriched program or a specific psychological treatment for early psychosis. The key words used for the search in all combinations were as follows: psychological/psychosocial treatment/intervention/therapy; early schizophrenia/psychosis; recent-onset psychosis/schizophrenia; cognitive-behavioural therapy. Reference lists provided by articles were examined for more trials. Review articles were verified as well.

Inclusion Criteria

Papers were checked for methodological rigour, validity, and relevance by a psychiatrist and 2 psychologists. Three major criteria guided the selection of the articles. First, the studies had to be based on samples of people with a recent onset of psychosis and (or) schizophrenia. Most of the selected samples consisted of patients with a first or second episode of psychosis. One selected study had recruited patients with a

history of a first treatment for psychosis of no longer than 5 years.⁴

As a second criterion, we included studies that presented a clearly defined specialized or EI (either a comprehensive program or a well-identified psychosocial treatment relevant to this phase of illness). One could argue that comprehensive programs and psychosocial treatments introduced as add-ons in standard treatment represent 2 different approaches to intervention in early psychosis. Conceptually, the combination of comprehensive programs and specific psychosocial treatments into an EI group could blur the boundaries between various aspects of early intervention. However, given the small number of studies available on early and specialized intervention for recent-onset psychosis, the use of a more encompassing EI group is likely the first step toward a quantitative index of effectiveness of early interventions that offered more than the standard treatment. Given the problem in the literature concerning the definition of EI and SC, an explicit operational definition was formulated. For a sample of patients to be classed within the EI+ group, the sample had to be part of a comprehensive program for a duration of at least 6 months or had to have received multiple sessions of psychosocial treatment for at least 3 months (including booster sessions), in addition to SC. Individual and (or) group sessions were accepted, as well as family interventions, social skills training, cognitively oriented therapies, and supportive psychotherapies. The comprehensive programs selected for this metaanalysis included more specialized and personalized services with a higher caregiver-to-patient ratio and a rational pharmacotherapy, in addition to the psychosocial treatment. The SC samples had to include high-quality services delivered (such as antipsychotic therapy, usually of the second generation, and some form of case management), with no specific psychological or family treatment offered.

Finally, studies had to provide longitudinal data (sufficient for ES calculation) on symptomatic (positive, negative, and [or] total symptoms) and (or) global functioning improvement over a follow-up period of up to 2 years. We did not exclude single-group trials, as we calculated ESs on the basis of longitudinal improvement (from baseline to follow-up) and not on differences between an experimental group and a control group at the follow-up. Hence, calculating this longitudinal effectiveness index allowed us to include a maximum number of trials, including those involving a single-group design. Finally, the selected studies⁴⁻¹³ excluded participants with neurologic disorders and (or) diagnosis of substance dependence.

Outcome Parameters

With respect to total symptomatic improvement, ESs were calculated from the PANSS¹⁴ or, when not available, from the

Abbreviations used in this article

| | |
|-------|---|
| BPRS | Brief Psychiatric Rating Scale |
| df | degrees of freedom |
| EI | enriched intervention |
| ES | effect size |
| GAF | Global Assessment of Functioning |
| ns | not significant |
| PANSS | Positive and Negative Syndrome Scale |
| SANS | Scale for Assessment of Negative Symptoms |
| SAPS | Scale for Assessment of Positive Symptoms |
| SC | standard care |

BPRS total score.¹⁵ Specific improvement of either positive or negative symptoms was retrieved when available from the PANSS and BPRS positive and negative subscores, and also from the SAPS and SANS.^{16,17} Overall functioning improvement was determined from the scores obtained on the GAF.¹⁸ The outcome parameters for each of these scales were reported in ESs as the difference between baseline and follow-up scores.

Metaanalytic Techniques

The symptomatic and functional outcomes were combined across studies through metaanalytic techniques, which yielded an overall weighted-average relative effect.¹⁹ A fixed-effects metaanalytic approach was selected because of the relatively small number of studies available. Such an approach is appropriate, as our sample of selected studies was not considered as a random sample from a relatively larger group of studies. Analyses compared EI with SC for the improvement of total symptoms at follow-up, as well as for positive and negative symptoms and for global functioning. In this metaanalysis, all ESs were presented as standard Cohen's d ,²⁰ according to the method described by Lipsey and Wilson.²¹ Cohen's d refers to the difference between the means, that is, the difference between a scale mean score obtained at a follow-up time point minus a scale mean score obtained at a baseline time point, divided by the pooled standard deviation $[(M_1 - M_2) / \sigma_{\text{pooled}}]$. Hence, ES of the longitudinal treatment effectiveness was calculated for each outcome measure obtained from each selected sample trial. We then applied a small sample size correction to each ES $[ES \times 1 - (3 / 4N - 9)]$ to ensure that any upward bias associated with such a small sample would be removed.²¹ Since the exactness of a given ES is associated with the sample size, we also weighted each ES by using the inverse variance approach $[\text{weight} (w) = 1 / (\text{standard error})^2]$.²² Finally, on the basis of target outcomes, all sample trials were pooled in different subgroups: EI total symptoms improvement, EI positive symptoms improvement, EI negative symptoms improvement, EI global functioning improvement, SC total symptoms improvement, and so on. Mean ESs were calculated for each subgroup of trials by using standard calculation $[\text{mean ES} = \Sigma (w \times \text{ES}) / \Sigma w]$.

One of the selected studies¹³ provided longitudinal data from 3 different centres (Liverpool, Manchester–Salford, and North Nottinghamshire) for 3 types of intervention (cognitive-behavioural therapy, supportive counselling, and treatment as usual). Thus the longitudinal data of 9 independent samples of subjects are presented in this article. To simplify the presentation of the data for each of the target outcomes, we “pre-pooled” the 3 sample trials presented for each type of intervention. As a result, we obtained a mean ES for each type of intervention and for each of the target outcomes. The mean

ESs were then pooled again with the ESs calculated from the other studies.

Except for global functioning, all ESs computed had negative values because symptom ratings at follow-up were subtracted from baseline symptom ratings. To visually illustrate the magnitude of effectiveness, we transformed those negative values into positive ones (see the figure and tables). Hence, positive ES represents the magnitude of decrease in symptom ratings or improvement in functioning. We also calculated the mean follow-up period (F-U) in months for each subgroup, using the weight of each trial $[\Sigma (F-U \times w) / \Sigma w]$. Next, it seemed relevant to check whether the difference between the results obtained from trials within a subgroup were greater than what would be expected by chance alone, by using tests of heterogeneity. To this end, we used a Q statistic,²² from which a significance level of less than 0.05 was interpreted as evidence of heterogeneity. Mean ESs obtained from the EI and SC subgroups for each target outcome were also compared with the Q statistic. We compared the EI and SC subgroups for each target outcome by calculating a separate Q for each subgroup ($Q_{\text{EI}} + Q_{\text{SC}} = Q_{\text{within}}$). A Q_{total} was also calculated by pooling the trials of these 2 subgroups. Finally, the subtraction of the Q_{within} from the Q_{total} provided the Q_{between} , which represents an index of a statistical difference between the 2 subgroups. Statistical significance was determined according to the chi-square distribution.

Results

Characteristics of the Selected Trials

Eleven EI sample trials (1053 patients) and 6 SC sample trials (500 patients), totalling data from 1553 patients (69% male), were examined. Tables 1 and 2 provide a list of the different samples of patients selected from studies that evaluated the effectiveness of an EI and SC. All studies reported the ages of patients, the weighted mean being 26 years (26.6 for EI and 24.8 for SC). Eight subgroups of pooled trials were created, depending on the type of intervention (EI or SC) and on the outcome (total positive and negative symptoms and global functioning). Table 3 provides a summary of the subgroups of pooled sample trials used to compare EI with SC.

EIs Compared With SC—Symptomatic Outcomes

Prior to assessing the statistical comparison between the subgroups, we calculated a Q value for each subgroup (that is, an index of heterogeneity of the pooled ESs within the subgroup). Every subgroup showed significant heterogeneity among their pooled ESs:

$$Q_{\text{EI total symptoms}} = 103.1, \text{ df } 6, P < 0.001$$

$$Q_{\text{EI positive symptoms}} = 227.5, \text{ df } 8, P < 0.001$$

$$Q_{\text{EI negative symptoms}} = 78.3, \text{ df } 9, P < 0.001$$

$$Q_{\text{SC total symptoms}} = 26.9, \text{ df } 3, P < 0.001$$

Table 1 Selected sample trials of patients presenting with a recent-onset psychosis and receiving specialized or enriched services (Total *n* = 1053)

| Study | <i>n</i> | Inclusion | Intervention | Randomization | Outcomes | Follow-up, months |
|---|----------|--|-------------------------------------|----------------|--|-------------------|
| Addington et al ⁵ | 180 | FEP | Calgary Early Psychosis Program | Nonrandomized | PANSS positive PANSS negative | 12 |
| Cullberg et al ⁶ | 175 | FEP | Integrated treatment | Nonrandomized | GAF | 12 |
| Garety et al ⁷ | 55 | FEP and few with second episode of psychosis | LEO treatment | Randomized | PANSS total PANSS positive PANSS negative GAF | 18 |
| Jackson et al ⁸ | 44 | FEP | COPE | Nonrandomized | BPRS SANS | 12 |
| Kuipers et al ⁴ | 11 | Early psychosis | COAST | Randomized | PANSS total PANSS positive PANSS negative GAF | 9 |
| Malla et al ⁹ | 66 | Nonaffective FEP | PEPP | Nonrandomized | Total SAPS SANS | 12 |
| Nash et al ¹⁰ | 22 | FEP | EPPINY | Nonrandomized | BPRS total BPRS positive SANS | 12 |
| Petersen et al ¹¹ | 227 | FEP | Integrated treatment (OPUS project) | Randomized | SAPS SANS GAF | 12 |
| Rosenbaum et al ¹² | 119 | FEP | Supportive psychotherapy | 36% randomized | PANSS positive PANSS negative GAF | 12 |
| Tarrier et al ¹³ (cognitive-behavioural therapy) | 75 | FEP or second episode of psychosis | CBT + SC | Randomized | PANSS total PANSS positive PANSS negative | 18 |
| Tarrier et al ¹³ (supportive counselling) | 79 | FEP or second episode of psychosis | Supportive counselling + SC | Randomized | PANSS total PANSS positive PANSS negative | 18 |

COPE = cognitively oriented psychotherapy for early psychosis; COAST = Croydon Outreach and Assertive Support Team; EPPINY = Early Psychosis Prevention and Intervention Network for Young People; FEP = first-episode psychosis; LEO = Lambeth early onset team; PEPP = Prevention and Early Intervention Program for Psychosis

Table 2 Selected sample trials of patients presenting with a recent-onset psychosis and receiving SC (Total $n = 500$)

| Study | n | Inclusion | Intervention | Randomization | Outcomes | Follow-up, months |
|-------------------------------|-----|------------------------------------|--------------|----------------|--|-------------------|
| Cullberg et al ⁶ | 51 | FEP | SC | Nonrandomized | GAF | 12 |
| Garety et al ⁷ | 44 | Early psychosis | SC | Randomized | PANSS total PANSS positive PANSS negative GAF | 18 |
| Jackson et al ⁸ | 21 | FEP | SC | Nonrandomized | BPRS SANS | 12 |
| Kuipers et al ⁴ | 9 | Early psychosis | SC | Randomized | PANSS total PANSS positive PANSS negative GAF | 9 |
| Rosenbaum et al ¹² | 304 | FEP | SC | 60% randomized | PANSS positive PANSS negative GAF | 12 |
| Tarrier et al ¹³ | 71 | FEP or second episode of psychosis | SC | Randomized | PANSS total PANSS positive PANSS negative | 18 |

$Q_{SC \text{ positive symptoms}} = 24.1$, $df 3$, $P < 0.001$

$Q_{SC \text{ negative symptoms}} = 13.3$, $df 4$, $P < 0.001$

This heterogeneity suggests that the samples or studies within a given intervention (whether enriched or standard) differed significantly from one another.

Comparisons between EI and SC for symptomatic outcome revealed significant between-group differences. Figure 1 illustrates the magnitude of the ES for EI and SC on the reduction of total positive and negative symptoms and on a measure of global functioning. The mean ES of the reduction of total symptoms at follow-up was statistically different for the EI, compared with SC: EI = -1.53 (95%CI, -1.66 to -1.40); SC = -1.08 (95%CI, -1.30 to -0.86) ($Q_{\text{between}} = 11.8$, $df 1$, $P < 0.001$). Significant differences between EI and SC were also observed for the improvement of both positive and negative symptoms at follow-up: positive, EI = -1.54 (95%CI, -1.63 to -1.45) and SC = -1.07 (95%CI, -1.19 to -0.94) ($Q_{\text{between}} = 40$, $df 1$, $P < 0.001$); and negative, EI = -0.44 (95%CI, -0.53 to -0.35) and SC = -0.18 (95%CI, -0.31 to -0.05) ($Q_{\text{between}} = 10.6$, $df 1$, $P < 0.01$). See Table 3 for the mean follow-up period in months for each subgroup.

EI Compared With SC—Levels of Functioning as Outcome

Q indexes of heterogeneity among the pooled ESs were also calculated for the functional improvement of the subgroups:

$Q_{EI \text{ functioning}} = 44.2$, $df 3$, $P < 0.001$; $Q_{SC \text{ functioning}} = 47.5$, $df 3$, $P < 0.001$. Similar to the symptomatic improvement, we also observed a significant difference between the EI and SC for the functional improvement over the follow-up period (see Table 3 and Figure 1). Mean ESs obtained from the pooled ESs are as follows: EI = 1.11 (95%CI, 0.99 to 1.23) and SC = 0.63 (95%CI, 0.49 to 0.77) ($Q_{\text{between}} = 24.5$, $df 1$, $P < 0.001$). See Table 3 for the mean follow-up period in months for each subgroup.

EI Compared With SC—Randomized Samples Trials Only

Among the 11 EI sample trials that we selected for this metaanalysis, 5 were nonrandomized and 1 was partly randomized (36%). Likewise, among the 6 selected SC sample trials, 2 were nonrandomized and 1 was partly randomized (60%). We did a separate analysis to compare EI with SC, using the randomized sample trials only (the SC sample trial with 60% of randomized patients was also included in this analysis). Similar to the results obtained from the main analyses, $EI_{\text{randomized}}$ and $SC_{\text{randomized}}$ were statistically different for the mean ES of the total symptom reduction at follow-up:

$EI_{\text{randomized}} = -1.79$ (95%CI, -1.95 to -1.63) and $SC_{\text{randomized}} = -1.26$ (95%CI, -1.49 to -1.03) ($Q_{\text{between}} = 13.5$, $df 1$, $P < 0.001$).

Figure 1 Magnitude of the effectiveness in ESs of the EI and the SC regarding total, positive, and negative symptoms reduction and global functioning improvement over the follow-up period of about 1 year

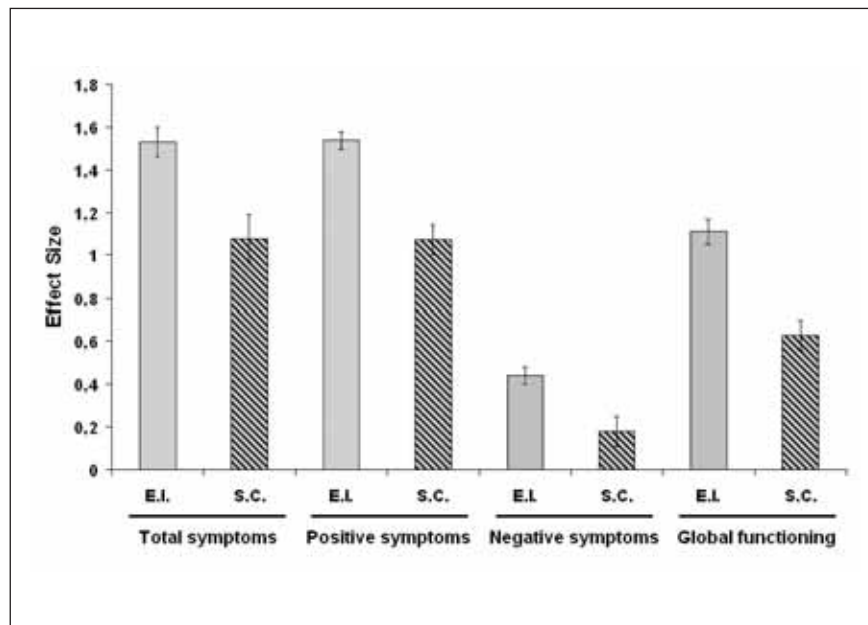


Table 3 Target subgroups of pooled sample trials used for metaanalytic calculations

| Outcome | Type of intervention | Independent trials and (or) groups, <i>n</i> | Patients, <i>n</i> | Improvement ES ^a | Mean follow-up period, months |
|--------------------|----------------------|--|--------------------|-----------------------------|-------------------------------|
| Total symptoms | EI | 7 | 352 | 1.53 | 15.66 |
| | SC | 4 | 145 | 1.08 | 16.70 |
| Positive symptoms | EI | 9 | 834 | 1.54 | 13.68 |
| | SC | 4 | 428 | 1.07 | 13.75 |
| Negative symptoms | EI | 10 | 878 | 0.44 | 13.48 |
| | SC | 5 | 449 | 0.18 | 13.53 |
| Global functioning | EI | 4 | 576 | 1.11 | 12.27 |
| | SC | 4 | 408 | 0.63 | 12.51 |

^aEvery ES is presented as a positive value, that is, as an index of the magnitude of the effectiveness

Significant differences between EI_{randomized} and SC_{randomized} were also observed for the improvement at follow-up of the positive and negative symptoms separately: positive, EI_{randomized} = -1.81 (95%CI, -1.93 to -1.69) and SC_{randomized} = -1.07 (95%CI, -1.19 to -1.00) ($Q_{\text{between}} = 74.4$, $df 1$, $P < 0.001$); and negative, EI_{randomized} = -0.67 (95%CI, -0.80 to -0.55) and SC_{randomized} = -0.18 (95%CI, -0.32 to -0.05) ($Q_{\text{between}} = 26.2$, $df 1$, $P < 0.001$). However, the comparison between EI_{randomized} and SC_{randomized} for the global functioning improvement at follow-up did not reveal any significant difference:

EI_{randomized} = 0.78 (95%CI, 0.61 to 0.95) and SC_{randomized} = 0.58 (95%CI, 0.43 to 0.73) ($Q_{\text{between}} = 3.02$, $df 1$, ns).

Discussion

Two recent reviews aimed to clarify the beneficial impact of early interventions and EIs for recent-onset psychosis. Penn and colleagues³ concluded that most of these studies are based on quasi-experimental designs using historical or prospective comparison groups or on single-group designs, making it difficult to directly compare EI with SC. However, 2 recent randomized controlled studies were included in a second review.¹ Our metaanalytic approach provides an important advantage over qualitative reviews: pooling every sample trial defined as EI in a specific subgroup (including those from single-group designs) allows a statistical comparison of this EI subgroup with another subgroup of pooled SC trials.

Benefits of Enriched Interventions

Our results first suggest that both EI and SC improve clinical and functional outcome of patients who are being treated for their first episode of psychosis, or who are in the early course of the illness, after a period of about 1 year. Indeed, both subgroups show a mean ES of more than 1 for total symptomatic improvement from baseline to follow-up and an ES of more than 0.6 for global functioning improvement. Direct statistical comparisons between EI and SC revealed that the former is more effective for both positive and negative symptoms and global functional domains. Thus there is no apparent interaction between the type of intervention and the type of symptoms that are improved or reduced.

Both Malla et al¹ and Penn et al³ have reported the beneficial effects of EI on symptomatic and functional improvement. The present metaanalysis provides novel quantitative evidence from multiple studies and sites that a specialized and EI approach to treatment of recent-onset psychosis results in superior benefits, compared with SC for a wide range of patients over at least a relatively short period of time (about 1 year). The obvious question is whether the benefits of EI can be sustained over a longer time without continuing intensive intervention. A recent 5-year follow-up of young recent-onset psychosis patients treated in an early specialized intervention service for 15 months and then transferred to routine care in the community showed a rather poor outcome, with high rates of relapse and disability.²³ Thus further studies are required to determine what level of care needs to be provided after the initial intensive and specialized intervention to sustain benefits of an early enriched service.

Why Should EIs Influence Symptomatic and Functioning Outcomes?

While positive symptoms (delusions, hallucinations, and thought and behavioural disorganization) in patients with a recent-onset psychosis show a very high rate of response to antipsychotic medications (ES ≥ 1 or with standard treatment), variations in time and rate of response are related in large part to medication adherence.²⁴ EIs are likely to improve adherence to treatment through better engagement of patients early in treatment. In addition, enriched treatment may also involve other indirect mechanisms through which the improvement of positive symptoms is facilitated. For example, amelioration of positive symptoms may be enhanced by interventions provided directly to families, which result in significantly greater involvement of families in treatment¹¹; increased attention to patients' specific social or personal goals; and by increased attempts to reduce consumption of drugs, such as cannabis, through case management and psychosocial therapies.

Our results also suggest that EI may reduce negative symptoms to a greater magnitude, compared with SC. It is likely that negative symptoms may also be improved by increased attention to patients' social and environmental conditions, thus improving social contacts, family relationships, and occupational or educational pursuits. However, our results do not allow for a more detailed examination of the differential effect of EI compared with SC on primary compared with secondary negative symptoms.^{25,26}

Past studies of early, specialized interventions for recent-onset psychosis have often observed that, while symptomatic recovery at follow-up is usually significant, such recovery does not always correlate with improved functioning. In this metaanalysis, in addition to differences in symptomatic outcome, we also found a significant difference between EI and SC in magnitude of improvement in global functioning. Although global functioning improved modestly with SC (ES 0.63), the significantly greater improvement with EI services (ES 1.11) may be explained by a specific emphasis on improving domains of functioning in EI services. This difference was, however, no longer significant when we analysed the randomized trials only. The reasons for the latter finding may be twofold: only 2 randomized sample trials were available for each subgroup for measure of global functioning, and follow-up period was usually 1 year, whereas functional recovery may take much longer. It is clear that further validation is needed to confirm the beneficial impact of EI on global functioning and that evaluation of treatment effects on functioning may require longer than 1-year follow-up. Despite the provision of EI services, the relatively smaller ES of global functioning, compared with improvement in positive symptoms, may be partly a reflection of only limited improvement in negative symptoms. Aspects of negative symptoms, such as social withdrawal, are likely to overlap with aspects of functional outcome. In addition, few EI services have described any specific interventions directed at improving work and educational performance. Finally, the measure typically used to assess functional outcome, the GAF, does not allow an adequate measurement of functional outcome independent of symptom ratings.¹⁸

An important aspect of our results (that is, the presence of significant heterogeneity among the different ESs calculated within our subgroups of trials) requires additional comments. In brief, significant heterogeneity within a given subgroup suggests that the different trials forming this subgroup are not composed of the same homogenous sample or may differ from one another. Even if, at first glance, this heterogeneity appears problematic for the interpretation of our results, it is in fact absolutely consistent and predictable because our definitions of EI and SC imply that the inclusion of different enriched and standard services are from different clinical centres and

countries and involve different symptomatic measures. Moreover, the fact that our EI group comprised both comprehensive programs and psychological treatments has likely contributed to this significant heterogeneity. However, we believe that these definitions of EI and SC, while allowing us to select a sufficient number of studies for metaanalytic calculations, were conservative enough to allow for the accurate categorization of specialized EI and SC.

Conclusion

The burgeoning interest in early intervention and EI in psychotic disorders in the last decade has been stimulated in part by the frequently replicated observation that outcome at 1 or 2 years after treatment of a first episode of psychosis is highly predictive of long-term (11 to 15 years) outcome.^{27,28} Recent studies have confirmed that most outcome trajectories for psychotic disorders are established early in the course of illness,^{29–33} with the clear implication that there is a critical period extending over the first 2 to 5 years following the onset of a psychotic disorder, during which treatment is likely to have the most significant impact on long-term outcome.³⁴ This metaanalysis has provided novel quantitative evidence that, across multiple studies and sites, EI has a significant beneficial impact on symptom reduction, over and above SC, after a follow-up period of about 1 year. Thus EI might be particularly relevant for the improvement of long-term outcome. However, there is still a need for a better understanding of the variable adherence to, and efficacy of, these EIs across patients and of the sustainability of such benefit over the longer-term course of recent-onset psychosis. Indeed, it may be important for further studies to focus on the identification and characterization of patients who are nonresponders to EI. Clearly, an EI is not necessarily tailored to every specific and individual need. In addition, more studies are needed to clarify the specific impact of different psychotherapies on symptom reduction, specifically on the reduction of negative symptoms, which is still modest even for patients involved in an enriched program.

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Résumé : Les avantages d'une intervention enrichie comparée aux soins réguliers pour les patients souffrant d'une psychose d'apparition récente : une approche méta-analytique

Objectif : Évaluer l'efficacité d'une intervention enrichie (IE) sur les résultats symptomatiques et fonctionnels comparativement aux soins réguliers (SR).

Méthode : Les études ont été extraites des moteurs de recherche et, à l'aide d'une approche méta-analytique, nous avons comparé les essais IE avec les essais SR. Onze essais d'échantillons IE (1 053 patients) et 6 essais d'échantillons SR (500 patients), totalisant des données de 1 553 patients (69 % masculins), ont été examinés. Nous avons calculé l'ampleur de l'effet (AE) de l'amélioration tant symptomatique que fonctionnelle sur une période de suivi d'environ 1 an.

Résultats : Des différences significatives ont été observées entre IE et SR au suivi concernant l'amélioration des symptômes positifs et négatifs, respectivement : positifs, IE = -1,54 (95 % IC, -1,63 à -1,45) et SR = -1,07 (95 % IC, -1,19 à -0,94) ($Q_{\text{entre}} = 40,3$, dl 1, $P < 0,001$); négatifs, IE = -0,44 (95 % IC, -0,53 à -0,35) et SR = -0,18 (95 % IC, -0,31 à -0,05) ($Q_{\text{entre}} = 10,6$, dl 1, $P < 0,01$). Nous avons aussi observé une différence significative entre les groupes IE et SR pour ce qui est de l'amélioration fonctionnelle sur la période de suivi, avec une moyenne IE = 1,11 (95 % IC, 0,99 à 1,23) et SR = 0,63 (95 % IC, 0,49 à 0,77) ($Q_{\text{entre}} = 24,5$, dl 1, $P < 0,001$).

Conclusions : Il y a maintenant des données probantes quantitatives dans de multiples études et sites qui indiquent que les IE pour les patients souffrant de psychose d'apparition récente sont plus efficaces que les SR en ce qui concerne l'amélioration symptomatique et fonctionnelle sur une période d'environ 1 an.