secondary services. All clinicians will be familiar with such individuals, who present a therapeutic challenge where equipoise is acknowledged. One benefit of this research, therefore, is its potential to inform a non-pharmacological protocol of treatment, capitalising on the efficacy of cognitive–behavioural therapy in psychosis and emotional disorders.

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The International Early Psychosis Association would like to contribute to the debate on early intervention (Pelosi/Birchwood, 2003).

First, the international network promoting reform in early psychosis is led by clinicians and academics who have a record of commitment to evidence-based medicine and leadership in scientific research. The attempt to discredit this network as mere evangelism does not bear scrutiny. However, successful reform in health care is always a blend of logic, evidence and advocacy. The latter is not only a legitimate but an essential element.

> 'We should be active and loud advocates of the mentally ill and be in the forefront of their battle to realise their rights. This might require that we relinquish some of our professional role and add some political activism to our daily chores – a sometimes difficult but now ever more necessary reorientation for doctors in general and psychiatrists in particular' (Sartorius, 1998).

Second, Dr Pelosi seriously underestimates the weakness of existing generic models of care for early psychosis patients and their families (Garety & Rigg, 2001). Access to and quality of initial care for first-episode psychosis is poor in the UK setting, as it is in most affluent, developed countries. This indicates a structural as well as a funding problem. Services targeting 'serious and enduring mental illness' inevitably focus on the needs of 'prevalent' rather than 'incident' cases. The early intervention paradigm asserts that there is a need to subspecialise in relation to the needs of young early psychosis patients, both in terms of structure of the service and the content of interventions, according to a 'staging' model. This assertion has tapped into resistance to subspecialisation in general within psychiatry, which Dr Pelosi passionately expresses. However, excessive reliance on purely generic service models is not defensible and is bound to limit the quality of response in many areas of psychiatry. A balance should be sought.

Third, implementing overdue reforms inevitably creates secondary problems and 'perverse effects', which seem to lie at the heart of Dr Pelosi's concerns. Workforce supply, quality and morale are crucial issues. Without careful planning, there could indeed be adverse effects on pre-existing elements of the system. These second-order issues need to be tackled but do not seriously challenge the logic and urgent need for reform in early psychosis, and should not be allowed to delay or derail it. In the longer term, greater specialisation within an umbrella of integrated services is a pathway to better morale and quality. The successful emergence of other sub-specialty areas (e.g. old age psychiatry) illustrates this point. Looking further ahead, early intervention could ultimately represent a way station en route to a sub-specialty of youth psychiatry (McGorry & Yung, 2003).

Fourth, the emerging early intervention services are targeted from first-episode psychosis onwards and do not specifically include the prodromal phase, which remains a research issue. There are genuine issues involved in sub-threshold detection of a low-incidence disorder and these remain to be solved. However, the caution required in extending intervention to potentially prodromal patients cannot be used as an argument for delaying intervention to people with clearly diagnosable first-episode psychosis.

Far from being wishful thinking, this reform process is already leading to improved short-term outcomes for young people with psychotic illness in many centres around the world (Edwards & McGorry, 2002). The reform is delicately poised in the UK and there may well be secondary effects on mainstream systems, but these should not be seen as fatal flaws, rather as problems to be solved. In the UK setting, it is to be hoped that psychiatrists will play a leadership role in this vital endeavour, which should ultimately lead to a strengthening of the specialist mental health system. In other parts of the world we are looking to you to make a success of this important task and hope your pioneering reforms will help to guide our own efforts.

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Author's reply: The advocacy and political activism of the International Early Psychosis Association has clearly been successful in the UK since teams for their narrow sub-specialty have been introduced despite widespread shortages of trained mental health professionals. General psychiatrists also consider themselves to be advocates for people with mental illness. They may not have the public relations skills of the early intervention movement but they believe that clinical experience and knowledge of epidemiology and health economics should be more important in determining health policy.

The most ambitious aim of the early intervention specialists has been to identify and treat people during a pre-psychotic phase of illness. There now seems to be unanimous agreement that any such attempts to prevent the onset of, for example, schizophrenia could only lead to more harm than good. The International Early Psychosis Association should return to users, carers, policy makers and members of the public whom they have influenced (Goode, 1999) and explain the epidemiological and clinical errors behind their previous dreams of primary prevention.

There should also be unanimous agreement with your earlier correspondent that provision of care to young people who have recently developed a psychotic illness is not 'rocket science' (Owen, 2003). I have read and re-read accounts of the clinical methods

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