advances
in psychiatric treatment

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Advances Volume 17, 2011 (six issues)
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Printed by Henry Ling Ltd, 23 High East Street, Dorchester, Dorset DT1 1HD.

ISSN 1355-5146

Prevention

FROM THE EDITOR

By Joe Bouch

It is hard to argue against Desiderius Erasmus's (1466–1536) simple maxim: prevention is better than cure. Indeed, in more recent times prevention has come to be used as an organising principle to create a framework that encompasses almost all medical activity (Bertolote 2009). Primary prevention aims to protect against the occurrence of disease; secondary prevention, to detect and treat early, thus ameliorating the consequences of disease; tertiary prevention, to minimise disabilities. Also described are 'primordial prevention' – preventing social and environmental conditions that predispose to disease – and 'quaternary prevention' – avoiding the consequences of excessive intervention of the health system (Starfield 2008).

This issue of *Advances* focuses on secondary prevention in psychosis, with two articles and an editorial from Melbourne, Australia, 'the cradle of early intervention' (Castle, pp. 398–400; Murphy & Brewer, pp. 401–407, 408–416). Do good intentions translate to effective treatments and to better and more efficient ways to organise services? Primary prevention in schizophrenia is tricky, as the prodrome is 'a classic area of uncertainty' and the majority of those at 'ultra high risk' do not develop a major psychotic disorder (Barnes 2011). Does intensive treatment during the so-called critical period lead to better outcomes, not just at the time but in the much longer term? Is reducing the duration of untreated psychosis (DUP) both a realistic goal and likely to alter the disease trajectory? Or is long DUP related to insidious onset and merely a marker of poor prognosis? Are youth-specific services an advantage? And how is transition from specialist to generic services best managed without disrupting continuity of care?

ADHD in adults

Transitions are a fraught issue in attention-deficit hyperactivity disorder (ADHD) too. Fifteen per cent of children diagnosed with ADHD will still meet diagnostic criteria at 25 years of age. Many more will have continuing subsyndromal symptoms (Crimlisk pp. 461–469). At a crucial developmental stage, young people may have to move from one service to another (Singh 2009). Adult mental health teams may be less familiar with the disorder. They may feel 'scepticism and anxiety' about the diagnosis and treatment in the same way that child and adolescent mental health services did 30 years ago. My Editor's pick this month describes the core symptoms of the disorder and how they may manifest differently in adults (Crimlisk, pp. 461–469). In describing how to manage a good transition, the author discusses how services are best integrated and signposts a number of helpful resources for clinicians working in adult mental health teams.

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