Early intervention in psychosis is based on the assumptions that psychosis is a (neuro)degenerative illness and that its progress can be arrested or reversed by treatment. These assumptions suggest that it may be possible to detect people who will develop psychotic illness in the future and prevent transition to psychosis (the ultra–high-risk paradigm), that reducing the duration of untreated psychosis in people with frank psychotic illness will improve outcomes (the duration of untreated psychosis paradigm), and that more intensive treatment starting at the time of detection of psychosis will improve outcomes (the early intervention paradigm).

Around 20% of patients with a first psychotic episode will have no further episodes; this means, however, that symptoms do recur in the great majority of patients. Studies have demonstrated that individuals who receive early intervention including guidance on how to improve their adherence to treatment, insight into their illness and self-management and how to minimise substance use have a better course. Further, early intervention services with an outreach component may reduce hospital admission, relapse rates and symptom severity, and improve access to and engagement to treatment. This is of utmost importance, since non- or partial adherence to treatment is frequent in the critical period, and may have a profound impact on prognosis. In fact, the critical period of the disease (the first 5 years) is a relatively reliable indicator of the long-term course of the disease.

In this sense, earlier detection is expected to lead to quicker access to the effective treatment that is necessary during the ‘critical period’ and is one of the main incentives for setting up early intervention in psychosis (EIP) services.

Overall, it seems that interventions carried out as early as possible, namely psychosocial interventions adjunctive to pharmacotherapy, may contribute to symptomatic and functional recovery, and improve prognosis and quality of life in these patients.