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Letter to the Editor

Mind the translation gap: problems in the implementation of early intervention services

In recent years there have been calls for a paradigm shift in psychiatry from treating established illnesses towards early and preventive intervention (McGorry & Killackey, 2002). These calls have been associated with the development and proliferation of services providing early and preventive intervention for psychosis (Lester *et al.* 2009). However, it is often not appreciated that this is not a new approach: it was proposed at least 100 years ago (Maudsley, 1909). In his paper published in 1909 Maudsley outlined the need for psychiatric services to focus on treating people early in their illnesses because this is when he thought there was the best chance of recovery and cure, stating: ‘the right treatment is to stop the beginnings of mischief’ and ‘early treatment ... will prevent the necessity ... of placing some patients in a lunatic asylum’ (Maudsley, 1909). In the last 100 years considerable evidence has accrued indicating that he was right – early and preventive intervention is associated with better outcomes and reduced admission rates (for review see McGorry, 2005). However, there appears to be a gap in translation: many health services have implemented cheaper hybrid and hub-and-spoke models rather than the comprehensive stand-alone early intervention team structures evaluated in the evidence base (Lester *et al.* 2009). The study by Valmaggia *et al.* (2009) is striking in providing evidence that better outcomes can also be cost effective. We hope that health-care commissioners take note that this was achieved with a comprehensive stand-alone team (Valmaggia *et al.* 2009). Other team structures may not be as effective – a cheaper service may cost more in the long run. Hopefully it will not take another 100 years for the funding to follow the evidence.

Declaration of Interest

Dr Howes works in the OASIS service providing preventive intervention for people at clinical risk of psychosis.

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Letter to the Editor

Sharpe *et al.*'s (2009) study 'Neurology out-patients with symptoms unexplained by disease: illness beliefs and financial benefits predict 1-year outcome' presents in declarative statements three interdependent socio-psychological factors as indicative of poor outcome after 1 year of illness: illness beliefs, non-attribution to psychological causes and financial factors.

Whilst patients may be happy to engage with a biopsychosocial model it is the lack of available biological explanations that may well lead to poor outcome rather than illness beliefs *per se*. Terms such as 'functional weakness' and 'software error' are semantically vague and as Stone acknowledges elsewhere (see: www.neurosymptoms.org 'family and work') may well need to be re-worded in unhelpful psychological terms as 'conversion disorder' on official documents. For patients the biological is important as it provides social legitimacy for a physical illness and an objective entity that they can fight to overcome. Vuilleumier *et al.*'s (2001) study of hysterical paralysis showed poor recovery dictated by the level of activation in the contralateral caudate and

thalamus. Yet this study attempts no physiological or objective reassessment of patients. Instead it relies on subjective self-reported assessment. Objective assessment by an experienced physiotherapist or occupational therapist may well produce a different SF-12 score. As such, reported improvement or failure to improve may be merely the result of a cognitive compliance to the demands of the physician or indeed the breakdown and nihilism when faced with a discourse devoid of physical explanations. Kanaan *et al.* (2009) suggests that neurologists often decide within a few minutes of meeting a patient whether an organic explanation will be forthcoming. Do we assume patients are unaware of this through subsequent manner and rapport? What might the effect of this be on patient morale and presentation, especially those struggling with distressing symptoms?

Rather than work towards a therapeutic relationship of mutual trust and respect Sharpe *et al.* state that their data lends 'support to the idea that interventions which change these variables [*i.e. state benefits or opposition to physician imposed psychological explanations of physical symptoms*] may improve the outcome for this patient group'. Have Sharpe and colleagues considered how patients may interpret the fiscal side of this intervention?

In denying a correlation between SF-12 scored disability and receipt of benefit, Sharpe *et al.* inadvertently infer that patients with 'symptoms unexplained by disease' are guilty of benefit fraud. The DWP does not use SF-12 to allocate benefits such as disability living allowance (DLA) or incapacity benefit. It is therefore erroneous to use data as the authors do to state that: 'Illness beliefs and financial benefits are more useful in predicting poor outcome than the number of symptoms, disability and distress.' They also fail to assess the monetary value of any benefit with regard to severity of disability or map this against socio-economic status.

That there is a link has been noted by Rosato & Reilly (2006) who in contrast to Sharpe *et al.* correlate level of benefit with degree of disability. Indeed some studies of families with disabled children have shown that disability benefits actually improve social inclusion and in the long term allow independence within the family unit (Preston, 2005).

Of particular note from Preston's study is the improvement in mental health amongst DLA claimants with money spent on cinema trips, social activities as well as contributing to basic costs such as transport.

Sharpe *et al.* conceivably present a situation in which the most vulnerable within a population are further excluded from society. For the fact remains that in all patient groups socio-economic status is a greater predictor of ill health than the receipt of