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Authors' reply

We agree with Beales that Pound *et al* (2005) is a valuable and comprehensive review. We have cited this article elsewhere (Mitchell, 2006, 2007). It highlights widespread and understandable caution about taking medication and brings to light 'the lay practice of testing medicines, mainly for adverse effects'. We recommend this paper for further reading.

We also agree with Kelbrick that it is important to have a good therapeutic relationship with detained patients. This area was underemphasised in our article. Owing to space restrictions we did not review compliance therapy in detail but good reviews are available elsewhere (McDonald *et al*, 2002; McIntosh *et al*, 2006; Nadeem *et al*, 2006).

Khokhar & Ali helpfully discuss cultural factors. We recently conducted a study on ethnic differences regarding treatment preferences (rather than adherence) in a cancer setting (Roy *et al*, 2005). More Asian than 'Caucasian' patients wanted to receive critical information from their GP rather than a hospital doctor. This was linked with their level of distress. More Asian patients received 'bad news' alone. We are currently trying to find out whether this has an effect on illness outcomes.

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Treatment of the victims of trauma

Adshead & Ferris (2007) emphasise how cognitive–behavioural approaches have become established as the core to treatment and quote recent National Institute for Health and Clinical Excellence (NICE) guidelines to support this (National Collaborating Centre for Mental Health, 2005). They are also clear that there are other models available for complex presentations of trauma-related pathology. It is unfortunate that NICE guidelines do not address the issues of the significant proportion of patients who discontinue treatment (which can average over 20%) or fail to respond. Cognitive–behavioural approaches continue to develop, with metacognitive therapy in particular seeking to address these issues (Wells & Sembi, 2004).

The development of cognitive–behavioural approaches that are primarily based not on exposure but on addressing individuals' difficulties in processing their response to trauma suggests the possibility of a rapprochement between different theoretical and therapeutic models. This would inform stepped-care approaches (Bower & Gilbody, 2005) supporting appropriate matching of patient need and problem complexity with services and intervention.

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Integrated community mental health teams for older adults: 20 years' experience

An innovation in the Welsh county of Cardiff and Eastern Vale of Glamorgan is the establishment of community mental health teams (CMHTs) for older adults which are fully integrated with social services. The teams (which have existed since 1989) are led by social services, unlike the more recent partnership trusts in other regions where social workers are 'seconded' into health trusts.

With an endorsement from the Department of Health's recently outlined National Dementia Strategy (Department of Health, 2007), joint health and social care CMHTs for older adults could become the norm.

There are likely to be initial teething problems in establishing these teams, with a perceived clash of cultures. In Cardiff, examples of reconciliation on the