Declaration of interest
These views are not those of my employer.

1 Holloway F. The Health and Social Care Act 2012: what will it mean for mental health services in England? *Psychiatrist* 2012; **36**: 401–3.

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Specialist community teams backed by years of quality research

In response to Dr Killaspy's invited commentary[1] on Dr Lodge's piece favouring gneralist *v.* specialist mental health teams,[2] professor Burns laments that 'every change, no matter how hare-brained, is hailed ''an innovation'' '.[3] He implies that it is 'hare-brained' to implement crisis response, early intervention and assertive community treatment (ACT) specialist teams, even though they all have unambiguously strong international evidence of both persistent effectiveness and economic advantage (e.g. Killaspy & Rosen,[4] McCrone *et al*[5]).

We share Dr Lodge's key concerns for continuity of care and the need to engage some individuals in long-term therapeutic relationships. For instance, ACT and early intervention psychosis (EIP) teams are specifically designed to amplify these functions, for those who need them and only while still needed. This has been readily addressed by having a generic front-end community mental health team (CMHT) co-located with primary care where possible and specialised back streams. This results in mutually supportive and often shared working between all these teams. Transfers, where they occur, are very slow, so continuity is preserved. Professor Burns and Dr Lodge argue from a false premise, as pitting generic against specialised teams is a 'straw-man' argument. They provide no evidence in support of retaining the generic status quo alone, just moral assertions. The status quo is often hailed as the 'tried and tested' condition to beat, when 'there is surprisingly little evidence to show that [CMHTs alone] are an effective way of organising [community] services', as stated in the National Institute for Health and Clinical Excellence guidance on managing schizophrenia in adults (CG82, p. 336).

Professor Burns accuses Dr Killaspy of being ungenerous, unjustified and disingenuous for standing up for systematised team approaches that have strong evidence internationally, in comparison with our more habitual comfort as clinicians with undifferentiated CMHTs and more traditional, hospital-centric and sedentary out-patient care. 'Newer is not necessarily better' he posits. Well, we appreciate his clinical conservatism. But, in stating that 'Nobody waits to see if it makes any difference, never mind delivers an improvement', how long does he wish us to wait, while depriving severely disabled UK citizens of an effective service delivery system (ACT) which has just been celebrated for more than 40 years since initial high-quality randomised controlled trials proved strongly favourable and cost-effective (e.g. studies by Stein, Test and Westwood), with waves of positive international replications since?

Over recent years, professor Burns and colleagues have muddied the waters by implying that indifferent results for even more diluted models of 'intensive case management' in the UK such as the UK700 and PRiSM studies somehow represented ACT, and proved that it did not provide any advantage in UK or Europe over CMHTs. They deem ACT to be unnecessary where, in comparison with other countries, there is an adequate health and Social Services 'safety net'. Yet its effectiveness in Australia and Canada has been demonstrated in the context of a public health and welfare system at least as good as the UK's at its best.[4] Meanwhile, these much-vaunted 'safety nets' are now unravelling in many parts of Europe.

This misleading position adopted by Burns and colleagues must bear some responsibility for this premature disinvestment, for the further dilution of these teams under financial pressure, and for the dampened enthusiasm for the UK research effort into ACT, when it has only just begun, with mixed results possibly owing to patchy team fidelity.[4]

Tragically, severely and persistently mentally ill Britons will suffer with neglect because of the partial dismantling or withdrawal of these essential integrative community care delivery systems. Community-based teams in the UK need their capacity to consistently follow the fidelity protocols of these specialist teams upgraded, not dismantled. This is a challenge to rigorous science, to sound commissioning, to communal action and ultimately to good government.

Declaration of interest
R.D. is editor of a consumer-oriented newsletter sponsored by Johnson & Johnson.

1 Killaspy H. Importance of specialisation in psychiatric services. Commentary on . . . How did we let it come to this? *Psychiatrist* 2012; **36**: 364–5.

2 Lodge G. How did we let it come to this? A plea for the principle of continuity of care. *Psychiatrist* 2012; **36**: 361–3.

3 Burns T. Newer is not automatically better (e-letter). *Psychiatrist* 2012; 22 October.

4 Killaspy H, Rosen A. Case management and assertive community treatment. In *Oxford Textbook of Community Mental Health (2nd edn)* (eds G Thornicroft, G Szmukler, K Mueser, R Drake): 142–50. Oxford University Press, 2011.

5 McCrone P, Park A-L, Knapp M. Early intervention for psychosis. In *Mental Health Promotion and Mental Illness Prevention: The Economic Case* (eds M Knapp, D McDaid, M Parsonage): 14–15. Department of Health, 2011.

A full list of references in available in an online version of this letter.

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