people with severe mental illness, flexibility and longitudinal continuity are the most important aspects' (p. 102). Flexibility is defined as 'to be flexible and adjust to the needs of the individual over time' and longitudinal flexibility as 'care from as few professionals as possible', a key element of the continuity which I value. A more careful reading of this 140-page review and re-interpretation of 10 studies, of which only 2 relate to mental health, reveals more evidence in support of my case. Interestingly, 'the most striking thing to emerge' from questionnaires from professionals was 'the relative lack of enthusiasm for specialist teams such as home treatment (crisis resolution) teams or assertive community treatment (assertive outreach) teams' (p. 68).

It is a truism that specialists tend to do what they do better than generalists. However, against this should be balanced the impact of the short duration of contact these specialists will have with a patient, something unlikely to foster the good relationships the Parker *et al* study says patients and carers value. Patients' experience 'was often that repeated staff changes led to feelings of helplessness and isolation. Having continually to retell their story to new staff was experienced as devaluing the story' (p. 43).[5] The result can be that the story is never fully told or recorded, thus reducing the chances of an effective patient-centred care package.

Dr Killaspy expresses the concern that it is 'unrealistic' for every psychiatrist to 'remain fully informed and competent to treat all mental health conditions in accordance with the best available evidence'. However, in my experience, teamwork can provide specialists from within the team or specialists can be called in from outside, when needed, without having to change the whole team.

I have made it clear that I support the principles of helping patients to remain at home, of psychoeducation and family interventions. What I object to is the disjointed way in which services are typically provided today, which, in my experience, is inefficient and often ineffective.

1 Hospital Episode Statistics Online. Primary diagnosis: summary 2010–11. NHS Information Centre, 2011 (http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=202).

2 Mental Health Network. *Mental Health and the Market – Briefing*. NHS Confederation, 2012.

3 National Institute for Health and Clinical Excellence. *Schizophrenia: The NICE Guideline on Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care* (Updated Edition). British Psychological Society, Royal College of Psychiatrists, 2009.

4 NHS Institute for Innovation and Improvement. Joined-up care: delivering seamless care. NHS Institute for Innovation and Improvement, 2012 (http://www.institute.nhs.uk/qipp/joined_up_care/joined_up_care_homepage.html).

5 Parker G, Corden A, Heaton J. *Synthesis and Conceptual Analysis of the SDO's Programme's Research on Continuity of Care*. National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre, 2010.

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doi: 10.1192/pb.36.12.475a

Personal therapeutic relationship does matter

The commentary by Killaspy[1] rather dismisses literature evidencing the value of the personal therapeutic relationship. It refers to a single publication which provides a qualitative theoretical classification of continuity issues by synthesising nine studies, most of which have no mental health component. The personal therapeutic relationship is the vehicle for delivering one of the most potent interventions in clinical medicine – the care (or 'placebo') effect.[2]

Killaspy talks up the scientific basis for new developments, but the nature of randomised controlled trials is that they have significant exclusions which limit generalisability: the difference between efficacy and effectiveness. In particular, multimorbidity is common in the community and greatly diminishes the applicability both of a single trial and of guidelines which synthesise research findings. Killaspy appears not to respond to the issue that novel services developed by enthusiastic champions tend to lose efficacy when foisted on reluctant or inexperienced staff by government policy and/or managerial bureaucracy. She makes no reference to the poor implementation of proven research and the fact that government policies are not merely without evidence base but devoid of the mentality of scientific evidence. Scientists should be clear about generalisability, implementation and other caveats.

Further, the commentary does not answer the point that any change involving reduction in available beds will be associated with reduced bed usage. It claims that tariff-based healthcare will bring increased efficiency, whereas there is evidence that marketisation leads to financial inefficiencies and gaming the system, fragmentation of healthcare and blinkered specialism;[3] whereas what patients want is some continuity and someone to see the 'big picture'.

The current multiplicity of teams inevitably increases interface issues which are often highlighted as causing problems in high-profile inquiries. It calls into question the claim Killaspy makes that 'the service-line approach will reduce the need for many patients to move between services'.

I endorse the value of a therapeutic relationship with a single practitioner, particularly for long-term conditions (often multimorbid), and which often entails the other benefits noted by the commentary, including the efficiencies of personal knowledge standing astride balkanised interfaces. I do not wish to portray therapeutic relationships as a panacea free of side-effects – we know they are not always good and can even be damaging – but it is a recognised starting point with strong positive elements.

Of course, there are trade-offs between personal knowledge and other desiderata such as rapid access or specialist skills. We also know that re(dis)organisations have destructive elements and often overestimate the speed and magnitude of their benefits.[4]

One conclusion might be that secondary care workers should abandon any intention to reap the benefits of continuity, and delegate this important role to our primary care colleagues. I personally consider that primary care, too, has its interfaces and discontinuities, and that mental healthcare for long-term conditions without long-term relationships would be sterile, soulless and counterproductive. As the National Health Service budget is being cut by 4% annually, the era of separate specialist teams may already be over.

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 Moerman DE. *Meaning, Medicine, and the 'Placebo Effect'*. Cambridge University Press, 2002.

3 Woolhandler S, Himmelstein DU. Competition in a publicly funded healthcare system. *BMJ* 2007; **335**: 1126–9.

4 Fulop N, Protopsaltis G, Hutchings A, King A, Allen P, Normand C, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ* 2002; **325**: 246.

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doi: 10.1192/pb.36.12.476

Newer is not automatically better

It is ungenerous and unjustified for Helen Killaspy[1] to accuse George Lodge[2] of nostalgia and wearing rose-tinted spectacles just because she disagrees with him. Newer is not automatically better. We have had altogether too much frenetic reorganisation of mental health services where every change, no matter how hare-brained, is hailed 'an innovation'. Nobody waits to see whether it makes any difference, never mind delivers an improvement. It is whether an idea is right or not that matters, not how long it has been around. Similarly, it is disingenuous of her to claim that the service changes she describes were 'informed by research'.

New developments arise from a mixture of creative thinking and professional ambition, and there is nothing wrong with that. By the very nature of the beast, evidence comes later. We need the new services in place to research them rigorously or make judgements from mature experience. The National Service Framework is a case in point. Only one of the new teams imposed had any evidence for it at the time, and assertive outreach teams' international evidence was unravelling in the UK context as they were being rolled out.[3]

There was not a single randomised controlled trial of crisis teams until Johnson's excellent, but still unrepeated, 2005 study.[4] The only two randomised controlled trials of early intervention teams also came later, and neither found a significant advantage in their declared primary outcomes. A more measured position is probably justified.

Continuity of care can be a complex concept to define[5] but it is not that difficult to recognise. We can all grasp the importance of being treated by familiar individuals who know our situation and illness, of not being passed on, and not having to repeat our history to an endless stream of new staff whom we then have to learn to trust. Everybody who is asked, patients, staff or families, insists that they value continuity. I know I do.

Whatever else mental illnesses are, they are experienced, expressed and treated in relationships. George Lodge is right that these relationships have been given altogether too low a priority in recent planning and strategy. Our decade of fragmentation may have contributed some improved understanding of process, but undoubtedly at a cost of simple humanity and attention to the unique individuals for whom the whole edifice exists. Helen Killaspy is right that we have a progressive discipline, responsive to an expanding evidence base. That does not mean that every change is improvement, nor that more specialised services (with their inevitable fragmentation of care) are necessarily better for patients.

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, Creed F, Fahy T, Thompson S, Tyrer P, White I. Intensive versus standard case management for severe psychotic illness: a randomised trial (UK 700 Group). *Lancet* 1999; **353**: 2185–9.

4 Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, et al. Randomised controlled trial of acute mental healthcare by a crisis resolution team: the north Islington crisis study. *BMJ* 2005; **331**: 599.

5 Burns T, Catty J, White S, Clement S, Ellis G, Jones IR, et al. Continuity of care in mental health: understanding and measuring a complex phenomenon. *Psychol Med* 2009; **39**: 313–23.

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doi: 10.1192/pb.36.12.477

Author's response: Dr MacMillan (p. 475, this issue) is quite right to point out the importance of appropriate access to in-patient beds as a critical component of mental health services. That mental health systems should provide a balance of in-patient beds and community services tailored to the mental health needs and resources of the local community being served is something all mental health practitioners across the world can probably agree on. My commentary did not suggest that increased specialisation means we should do away with in-patient services, it simply stated the fact that investment in specialist community mental health teams (particularly crisis teams) through the National Service Framework for Mental Health was associated with a reduced need for in-patient admissions. Where I believe Dr Lodge and I also agree is on the need for continued investment in mental health rehabilitation services to prevent the inappropriate use of out-of-area placements for the small number of people with particularly complex and long-term psychoses.[1,2]

Professor Burns' response (see letter above) states: 'It is ungenerous and unjustified for Helen Killaspy to accuse George Lodge of nostalgia and wearing rose-tinted spectacles just because she disagrees with him. Newer is not automatically better.' This accusation is not only unjust and ungenerous to those who have been working without feeling conflicted in both specialist and generalist services for many years, but it is without basis in fact. My commentary made clear, evidence-based justification for my view. I included reference to the lack of evidence for the effectiveness of assertive community treatment in the UK context that probably influenced subsequent disinvestment in this model. However, our research group, while contributing to such findings, simultaneously participated in a multicentred international study which suggested that assertive community treatment in the UK may have not performed as effectively as in Australia owing to lack of implementation of critical components that Professor Burns' own team identified through meta-analyses.[3,4] His further accusation that I was 'disingenuous' is a little ironic given his lack of reference to the robust international evidence on which investment in the new specialist teams was made, not to mention the expanding evidence base for early intervention services.

Dr Dodwell's response (pp. 476–7, this issue) accuses me of dismissing evidence on therapeutic alliance, yet I did not mention it. It is a truism to say that the therapeutic alliance is important. Who would argue against the importance of being treated with humanity and respect in the therapeutic encounter? However, therapeutic alliance is not the same as continuity of care, which was, after all, the focus of Dr Lodge's piece.