opinion & debate

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S. P. SASHIDHARAN

Commentary: rethinking research in community mental health – service change first, research later?†

If we wish to establish a sustainable research agenda within mental health, is it wise to ask a group of eminent researchers how we should go about it? It will not be a great surprise if the answer that such a group will come up with is that we should have more research. It appears to be part of the grand British academic life that, from time to time, we have the great and the good coming together to make pronouncements on the state of play, and how the future should be planned on the basis of what has gone before. Usually, the answer is more of the same but with extra helpings all around. The paper by Thornicroft *et al* (2002, this issue) is in that grand tradition, with some of the UK's pre-eminent researchers in the field of social psychiatry coming together to identify a potential research agenda for mental health. Predictably, they conclude that we need more research, much the same way as previous attempts to take stock of research within the sector have concluded.

The purpose of this paper is not entirely clear. Although the authors set out by saying that they want to identify 'the important gaps in research coverage, particularly in areas key to the National Service Framework for Mental Health and the NHS Plan', what they appear to end up highlighting are the problems with research infrastructure in mental health in general, rather than anything specifically linked to the national policy initiatives. Also, it is difficult to establish how the authors actually arrived at their conclusions because there is only a passing mention of their methodology, that is conducting a series of expert assessments. We are not privileged to know who these experts were, how they were chosen, what kind of expertise in mental health they had and how they carried out their assessments. In any other research, say, for example, if we were interested in establishing patient preferences of the direction of mental health research, these most rudimentary methodological details would have been made available before submitting the findings for publication. Given that at least one of the source materials used in the assessments was prepared by some of the authors of this paper, there are also bound to be questions about the independence of the findings reported here.

Notwithstanding these criticisms, most people would find the 11 recommendations advocated by the authors to be sensible, but hardly new. The continuing attachment to positivistic and empirical approaches to mental health research within which the randomised controlled trial rules the roost might be comforting within the current research culture, but this hardly breaks new ground in advancing the case for patient-centred or meaningful outcome research, a major weakness within social and community psychiatry in Britain at present. In particular, there is little mention of the need for patient involvement in setting the research agenda, in addition to patient participation, perhaps indicative of the experts' view about who has the expertise in mental health.

Finally, exercises like this would be far more rewarding if academics and researchers were prepared to adopt a more realistic view of our relevance to the way mental health services are developing and the impact our academic work has on patients' lives. One of the most sobering thoughts for academics must be that, by and far, the fundamental changes that are currently sweeping across mental health services in this country, as a result of government policies such as the National Service Framework and the NHS Plan, are not the crowning achievements of research or other academic initiatives. These changes, of a magnitude and scope that is unprecedented within British psychiatry, are the result of patient and community aspirations, given articulation through a political process, within which equal weight has been given to values as well as evidence, the latter not necessarily a product of empirical research. Surely, there is a lesson here for all of us, more important than the recommendations arising out of any academic exercise.

Reference

THORNICROFT, G., BINDMAN, J., GOLDBERG, D., *et al* (2002, this issue) Creating the infrastructure for mental health research. *Psychiatric Bulletin*, **26**, 403–406.

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TOM BURNS

Commentary: the top three plus one†

†See pp. 403–407 and pp. 409–410, this issue.

Current government mental health policy includes a clear commitment to set the agenda for research and to manage the national research and development (R&D) portfolio proactively. Although most of us regret the demise of responsive funding, which permitted research driven by personal curiosity and creativity, the

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wastefulness of underpowered and repetitive studies was all too obvious. Thornicroft and his colleagues (2002, this issue) do us a service by bringing a multi-disciplinary research perspective to this thinking and providing a framework to develop a research strategy. They have done a very good job and deserve our thanks.

They make 11 recommendations. Because their approach is admirably thorough and transparent without expressing personal convictions and hunches, it could appear that all 11 have equal weight. Freed from their scientific constraint, I would suggest that three of the recommendations are of the highest priority.

Their observation of the UK's weakness in social science capacity and the need to fund training and posts (recommendation 1) is spot on. For all its failing, UK mental health care has a tradition of highly integrated multi-disciplinary working (Burns & Priebe, 1999). Outcomes research of sufficient quality to answer current questions (e.g. those about different team configurations) requires research teams who can construct and test sharply-focused hypotheses. The alternative is a series of mechanical head-to-head studies that get us nowhere. This links in with recommendation 8 on the development of realistic definitions of key concepts such as accessibility and continuity. The authors may be pleased to note that the National Co-ordinating Centre for Service Delivery and Organisation has just commissioned a 5-year study into a better understanding of continuity of care in mental health. Such a study would simply not be possible without highly-qualified social scientists.

There really is no alternative to large-scale randomised controlled trials (RCTs) to resolve important questions that remain ambiguous despite other attempts. Following recommendation 3 for funding such studies would go a long way to improve rigour in mental health research and force the growth of genuinely collaborative multi-centre research initiatives that have been so successful in other branches of medicine.

The one recommendation missing from the list that I would have liked to see is for a strengthening of capacity in theory building. The British tradition of pragmatism in research is likely to be further entrenched by a more centrally steered research agenda, explicitly devoted to evaluating the NHS Plan. Recommendation 1, about building social science capacity, and recommendation 8, about refining key concepts, may go some way to achieving this. If we are going to fund large-scale RCTs (which will cost millions of pounds, take several years to conduct and are rarely repeatable) then it is crucial that adequate time and status is invested in developing and refining the questions asked. A recent systematic review into home treatment for mental illness (Catty *et al*, 2002) found the two significant variables in reducing hospitalisation were integration of health and social care in the same team and regularly visiting at home. It found no effect for case-load size. Had that work been commissioned before the UK700 trial (Creed *et al*, 1999) would we have selected case-load as the independent variable?

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FRANK HOLLOWAY

Commentary: putting mental health services research on the map†

There are two consistent themes in the current modernisation agenda for health and social care in England: the imperative to embrace change and abandon long-accepted traditional modes of working and the requirement to engage in evidence-based practice. Mental health, as one of the Government's key clinical priorities, is at the forefront of change. The difficulty for practitioners and policy makers alike is that little of what we have traditionally done in the mental health field and few of the prescriptions for change ordained by Government have been evaluated to currently accepted standards for evidence-based medicine (NHS Centre for Reviews and Dissemination, 2001). This partly reflects the generally poor standard of randomised controlled trials (RCTs) carried out within mental health and the methodological complexities surrounding mental health research (Richardson *et al*, 2000). Some very important issues may be difficult, if not impossible, to address using the RCT methodology. Others require the use of cluster-randomisation, a technique that is statistically complex, ill-understood by both researchers and funders, ethically challenging and potentially very expensive (Ukoumunne *et al*, 1999).

Thornicroft *et al* (2002, this issue) have produced 11 recommendations aimed at filling the palpable evidence gap within mental health policy and practice, drawing on

†See pp. 403–409, this issue.

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