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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.

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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.

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The fundamental issue that seems to have prompted such vociferous response is whether psychiatrists can go on being Jacks and Jills of all (psychiatric) trades. My view is that our increased specialisation is a sign of the maturation of our profession and allows us to deliver better treatment, tailored to our patients' needs. This does not equate to support for some kind of anarchic service redesign with the aim of promoting turf wars and passing patients from pillar to post. We need to get on with the business of incorporating the evidence we have available from our research to design systems of care that are appropriate, effective and cost-efficient, and accept that the process is iterative and subject to socioeconomic and political vagaries. Perhaps we are more likely to succeed in this if we start with a focus on the areas where we have consensus.

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Maintain the momentum: bridging the undergraduate/graduate divide

O'Connor *et al*[1] showed that a more positive attitude towards psychiatry exists following final-year psychiatry clerkships at University College Dublin. This signifies the importance of exposure to the realities of working as a psychiatrist in influencing students' perception of the specialty. Whether this positive attitudinal change resulted from seeing the day-to-day psychiatric practice, exposure to relatable clinical role models or something else is unclear. However, it is unfortunate that such attitudes towards a career in psychiatry are not maintained when making post-internship specialty choices. This may suggest that the undergraduate pro-psychiatry outlook is not sufficiently robust or long-lived as to endure the first year(s) as a doctor.

Currently, there is a mismatch between the proportion of total foundation year (FY1/2) posts and core/specialty training year 1 (CT/ST1) posts in psychiatry in England. In comparison, the similarly sized specialty of paediatrics has a more favourable ratio of foundation to specialty training posts which would facilitate the maintenance of any undergraduate pro-paediatrics momentum (more detailed information available from the authors on request). Psychiatry has some ground to make up.

Assuming that exposure to the job is key and that endurance of the pro-specialty attitude gained in medical school is the issue, more work needs to be done to increase the number of psychiatry internships in Ireland and foundation posts in the UK to maintain this interest. Such work is already taking place in the UK through the Royal College of Psychiatrists' ambitious plans to increase the number of FY1/2 psychiatry posts to 7.5%.

If interaction with those 'doing the job' is important, then there may also be benefits from increasing the face-time that recent graduates get with psychiatrists, even in a non-clinical environment, especially as this a key time for influencing a new doctor's career choice.[2]

Although medical student internships produce positive attitudes towards psychiatry and stimulate enthusiasm for entering into the specialty, this momentum needs to be maintained post-graduation and not lost during the (Irish) internship or (UK) foundation programme.

Declaration of interest: A.M. was the BMA Junior Doctors Committee representative to the UK Foundation Programme Board and Foundation School Directors committee during 2011–2012.

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