functionality before ploughing ahead and dismantling an evidence-based superior service.

Declaration of interest
A.S.H. is a consultant in an early intervention team.

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Assertive community treatment: keeping what works

The excellent editorial by Rosen *et al*[1] highlights the dilution of assertive community treatment (ACT) research in European settings, leading to a failure to demonstrate reductions in bed use in efficacy studies. Effectiveness studies in the UK have shown that ACT leads to reductions in bed use.[2,3] Furthermore, our experience of 93 patients followed up for a mean of 6.5 years after starting ACT showed a reduction from a mean of 72 days per year prior to ACT to 44 days per year during ACT (P=0.002). Repeated measures using the Dartmouth Assertive Outreach Fidelity Scale[4] demonstrated the team had high fidelity to the assertive outreach model.

The evidence supports the importance of trying to incorporate the effective components of ACT into new services. Despite these benefits, ACT teams continue to be dismantled.

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Looking at vanishing treatment effect in Europe

The article by Rosen *et al*[1] is a thought-provoking piece on the perception of the effectiveness of assertive community treatment in Europe. I write as a psychiatrist who has worked within assertive community teams (ACTs) on both sides of the Atlantic (the UK and Canada). Although the economic downturn and cutbacks are equally shared in both UK and Canadian health systems, the investment in specialist mental health programmes including ACT continues to gather pace in Canada due to the robust and demonstrable effectiveness of the teams. In Canada, there is a stronger fidelity to the original ACT model and a shift from the paternalistic to a more collaborative relationship with patients. There is greater emphasis on relationship building through varieties of psychosocial strategies, easier access to specialist and subsidised housing facilities and vocational opportunities.

The ACT service delivery in Canada is a true representation of the standard originally described in 1973 after 20 years of field testing in the USA.[2] It includes peer support workers who have life experience and can provide expertise that professional training cannot replicate. The peer support workers are fully integrated team members functioning in the team's generalist role. There is a 24-hour on-call service and treatment intervention is intensive with two or three face-to-face visits daily.

Undoubtedly, ACT is a clinically effective approach to managing the care of severely mentally ill people in the community. If aimed at the right patient population and when the model of care is fully adhered to, ACT can substantially reduce the costs of hospital care while improving the outcome and patient satisfaction.[3]

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Quality of risk assessment prior to suicide and homicide

We are grateful to Large & Nielssen[1] for their interest in the report from our pilot study,[2] but think they may have misunderstood its main purpose. We wished to investigate the 'low risk paradox' – the fact that in the National Confidential Inquiry data, risk is nearly always reported as low prior to suicide and homicide.[3]

We agree that risk assessment in people who do not die is of interest but our study was not set up to investigate this. Equally, contradictory risk factors are of interest but our focus was on the risk assessment process itself, not on a tally of risk factors or whether they were the 'right' ones. Last, our study was not an investigation of the predictive utility of risk assessment. We are familiar with the low base rate problem and have written about this elsewhere.[4]

We would wholeheartedly agree with Large & Nielssen's suggestion that assessments should be compassionate, ethical and needs-focused. However, we would take issue with their