2 Burns T. End of the road for treatment-as-usual studies? *Br J Psychiatry* 2009; **195**: 5–6.

3 College of Occupational Therapists. *The Value of Occupational Therapy and its Contribution to Adult Social Service Users and their Carers*. College of Occupational Therapists, 2008 (http://www.cot.org.uk/MainWebSite/Resources/Document/The%20value%20of%20OT%20and%20its%20contribution.pdf).

4 Wright C, Burns T, James P, Billings J, Johnson S, Muijen M, et al. Assertive outreach teams in London: models of operation. Pan-London Assertive Outreach Study, Part I. *Br J Psychiatry* 2003; **183**: 132–8.

Adarsh Shetty, Cwm Taf Health Board, St Tydfil's Hospital, Merthyr Tydfil CF47 0SJ, UK. Email: dradarshshetty@yahoo.co.in

doi: 10.1192/bjp.196.1.77b

Killaspy *et al*'s longer-term follow-up[1] to the REACT study[2] replicated their original finding that ACT teams had no advantage over CMHTs in reducing in-patient care and concluded by questioning further investment in ACT in the UK. We found this interesting because we have evidence for a reduction in in-patient bed use locally, albeit using a different methodology.

The Sandwell Assertive Outreach Team has been operating for over 5 years, serving an ethnically and socioeconomically diverse urban population of approximately 280 000. The team has remained adherent to the Department of Health Policy Implementation Guide[3] and has a mean score of 3.7 on the Dartmouth Assertive Community Treatment Scale.[4] We retrospectively reviewed our performance in terms of number of admissions and bed-days for all 73 patients who have been with our service for over 3 years. We compared these results with data for the same population in a similar period prior to transfer of care to our team. The results are summarised in Table 1.

We are conscious of a local trend for referrals to our service to be initiated as patients relapse and therefore transfer of care often occurs on discharge from hospital. Improvements seen in 1-year figures may be due to a period of remission in keeping with the natural history of the illness, but the fact that improvements are maintained over 3 years in patients with frequent relapses would suggest that this is less likely to be a significant factor.

A possible explanation for the reduction in bed use might be that our assertive outreach team offers daily home treatment for patients in relapse and at risk of admission instead of involving the crisis and home treatment team. We are not aware of this aspect of assertive outreach being reported elsewhere in the literature about UK services and suggest it produces better outcomes by preventing patients with a history of disengaging from mental health services having to develop a therapeutic relationship with a new team at a time of crisis.

We feel that these before-and-after findings provide evidence to suggest that assertive outreach was locally responsible for reducing bed usage over several years in a population previously characterised by poor engagement and multiple admissions. Burns *et al*[5] found that fidelity to ACT staffing practices did not explain variation in outcome between trials and concluded that we should research the practices of teams. It would be interesting to know whether other services report a reduction of in-patient bed use and whether a programme of active daily visiting with medication in relapse played a part. We suggest that this aspect of assertive outreach could be incorporated in future research into effective components of the model.

Table 1 Bed usage for 73 patients of the Sandwell Assertive Outreach Team before and after transfer to the team

	Year prior to transfer	Year after transfer	3 years prior to transfer	3 years after assertive outreach treatment
Admissions per patient	0.92	0.48	2.39	1.21
Admissions per patient per year	0.92	0.48	0.8	0.4
Bed-days per patient	63.6	30.5	156.7	80.1
Bed-days per patient per year	63.6	30.5	52.2	26.7

1 Killaspy H, Kingett S, Bebbington P, Blizzard R, Johnson S, Nolan F, et al. Randomised evaluation of assertive community treatment: 3-year outcomes. *Br J Psychiatry* 2009; **195**: 81–2.

2 Killaspy H, Bebbington P, Blizard R, Johnson S, Nolan F, Pilling S, et al. The REACT study: randomised evaluation of assertive community treatment in north London. *BMJ* 2006; **332**: 815–20.

3 Department of Health. *The Mental Health Policy Implementation Guide*. Department of Health, 2001.

4 Teague G, Bond G, Drake R. Program fidelity in assertive community treatment. Development and use of a measure. *Am J Orthopsychiatry* 1998; **68**: 216–32.

5 Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* 2007; **335**: 336.

Panthratan S. Grewal, Birmingham & Solihull Mental Health NHS Foundation Trust, Osborn House, 55 Terrace Road, Handsworth, Birmingham B19 1BP, UK. Email: psgrewal@doctors.org.uk; **Colin Cowan**, Sandwell Mental Health Foundation Trust, West Midlands

doi: 10.1192/bjp.196.1.78

Author's reply: The 36-month outcomes of the REACT trial[1] that ACT shows no clinical advantage over support from standard CMHTs bemuses ACT proponents. Grewal & Cowan report reductions in in-patient service use for ACT patients in Sandwell, but their results are confounded by the national reduction in bed use since the implementation of the National Service Framework for Mental Health, a common problem with before-and-after studies of ACT in the UK. Glover *et al*[2] showed how crisis resolution teams reduced admissions across the country, but ACT teams failed to impact further on this. The Sandwell ACT team's provision of a crisis service may therefore have influenced their outcomes. Nevertheless, it is noteworthy that although in-patient service use was the primary outcome in the REACT study, there were no statistically significant differences in other outcomes between the two treatments, including social functioning, symptoms, needs, attitudes towards medication, adverse events, substance misuse and quality of life.[3]

The lack of efficacy for ACT in the UK appears to be related to the degree to which comparison services replicate critical aspects of ACT.[4] In the REACT study, the CMHTs shared with the ACT teams four of the seven key components: primary clinical responsibility; community-based; team leader doing clinical work; time-unlimited service (the others being daily team meetings, sharing of case-loads, and operating 24 hours a day).

A consistent finding in studies of ACT is that it is more acceptable to 'difficult to engage' patients than standard care, but although UK ACT services are engaging patients, as Shetty rightly states, they are not building on this to deliver the evidence-based interventions likely to improve clinical outcomes. In some cases this is due to inadequate specialist staffing, although this was not an issue in the REACT study. A survey of 222 English ACT teams in 2003 found that only half had a psychiatrist, a fifth had a psychologist and very few had a substance misuse or vocational rehabilitation

https://doi.org/10.1192/bjp.196.1.78a Published online by Cambridge University Press

specialist. In addition, only 12% were operating with high model fidelity and many did not operate outside office hours (C. Wright, personal communication, 2009). A comparison of ACT in London and Melbourne, Australia, found that London teams had around a quarter of the input from a psychiatrist, only half operated outside office hours (versus most Melbourne teams), only a third made the bulk of their contacts away from the office (versus the majority of Melbourne teams), and they scored lower for case-load sharing (C. Harvey, personal communication, 2009).

Inadequate implementation of the ACT model, inadequate delivery of evidence-based interventions, and similarities between key elements of ACT and standard care therefore appear to explain the variation in its effectiveness reported in the international literature. In the UK, ACT teams need to be staffed appropriately and operate with the critical components likely to result in improved outcomes. Otherwise, their lack of cost-effectiveness[5] will make them vulnerable to closure.

1 Killaspy H, Kingett S, Bebbington P, Blizard R, Johnson S, Nolan F, et al. Randomised evaluation of assertive community treatment: 3-year outcomes. *Br J Psychiatry* 2009; **195**: 81–2.

2 Glover G, Arts G, Babu KS. Crisis resolution/home treatment teams and psychiatric admission rates in England. *Br J Psychiatry* 2006; **189**: 441–5.

3 Killaspy H, Bebbington PE, Blizard R, Johnson S, Nolan F, Pilling S, et al. The REACT study: randomised evaluation of assertive community treatment in north London. *BMJ* 2006; **332**: 815–20.

4 Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* 2007; **335**: 336.

5 McCrone P, Killaspy H, Bebbington P, Johnson S, Nolan F, Pilling S, et al. The REACT study: cost-effectiveness of assertive community treatment in north London. *Psychiatr Serv* 2009; **60**: 908–13.

Helen T. Killaspy, Department of Mental Health Sciences, University College London Medical School, Hampstead Campus, London NW3 2PF, UK.
Email: h.killaspy@medsch.ucl.ac.uk

doi: 10.1192/bjp.196.1.78a