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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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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

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a framework developed by the Medical Research Council (MRC) for the development and evaluation of RCTs for complex interventions to improve health. Their prescription is, predictably, comprehensive and intelligent and is firmly aimed at funders. It spans the development of research capacity, support for large-scale pragmatic RCTs that address real-world questions and the evaluation of the use of routine data-sets as an alternative to the rigours of the RCT (a highly controversial issue requiring very careful consideration). Particular gaps in the evidence base are emphasised in training, dissemination and organisational change. These issues can only be effectively addressed within an RCT at the patient level by cluster randomisation.

Adoption of these recommendations would go a long way towards the goal of supporting evidence-based change in mental health services. A few punches are pulled. The enormous importance of the pharmaceutical industry in funding research and the consequent impact on the choice of research careers adopted by trainee psychiatrists and the RCTs that are carried out, is not discussed. Thornicroft *et al* (2002, this issue) allude to (in recommendation 9) but fail to emphasise the importance of theory in mental health services research, which has become a theory-free zone. Not only do we need a social science capacity in mental health research, we need to ensure that psychiatrists are as literate in the social sciences as they are becoming in neurobiology. Mental health care is a multi-disciplinary activity: there is an urgent need to develop research capability among occupational therapists, social workers and nurses – professions that largely lack a research basis.

Finally, there is the big unanswered question within the modernised managed mental health service: how do we identify, support and fund service innovation? Without the capacity to innovate, evidence-based change cannot occur.

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