polypharmacy in a patient group that is often non-responsive to medication and usually has complex comorbidities.

Furthermore, we would dispute the notion that Taylor[1] suggested: that non-medical prescribers may improve the situation. We have concerns which are rather in contrast to this. Non-medical prescribers are more likely to follow guidance but if guidance changes or is flawed, as we have seen with the NICE guidelines for schizophrenia, non-medical prescribers are more likely to lack the flexibility to respond adequately to these challenges and may therefore contribute to suboptimal treatment rather than improve it. Lastly, we wholeheartedly embrace the recommendations that Langen & Shajahan put forward,[2] which ask for the regular review of all instances of polypharmacy including clear documentation as to why polypharmacy is continuously used.

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doi: 10.1192/pb.34.5.208

Let's not throw the baby out with the bath water

Tyrer *et al*'s study on the effectiveness of crisis resolution and home treatment teams (CRHTs) is a good addition to the debate on the evidence base of these teams. The authors concluded that the introduction of CRHTs in Cardiff was associated with an increase in compulsory admission, a decrease in informal admission and bed days, and an increase in the number of suicides in the area covered by CRHTs. In as much as the authors can be commended in their fairly robust appraisal of the research methodology employed, nonetheless it is hard to overlook the major deficiencies in the study design. The findings, but for the increased rate of suicides, are not new, and need not reflect negatively on CRHTs. The authors highlighted that none of the victims of suicide were under the care of the CRHT at the time of their death.

The often-cited North Islington Study[2] also showed that compulsory admission was not significantly reduced; however, in recent years a number of possible explanations for this finding have emerged. It is highly likely that a sizeable proportion of the patients who were compulsorily admitted were not only severely ill, but lacking in insight or capacity to consent to a treatment plan. Gould *et al*'s[3] study on patients presenting with acute onset of first-episode psychosis concluded that in this group of patients, although living in an area in which alternatives to admission were well developed, compulsory admission was still high.

Crisis resolution and home treatment teams exist within complex local systems and politics and it is inevitable that other key services such as the traditional community mental health team, in-patient service, mental health liaison team, primary care gateway service, assertive outreach and early intervention team in psychosis will play key roles in its effectiveness. An interesting enquiry is whether such specialist teams working jointly with CRHTs will be able to prevent compulsory in-patient admissions for these severely ill patients more effectively than CRHT alone.

A Cochrane review[4] continues to gather increasing long-term evidence to support the implementation of the CRHT worldwide. The evidence for reducing informal admission, bed usage and patient satisfaction has been replicated in various studies. Crisis resolution and home treatment teams should not be seen as a government-enforced innovation, but rather a viable and acceptable approach to treating people with severe mental illness. Evidence suggests that improvements in outcome of CRHTs are most convincing where psychiatrists have embraced this development and use their informal power to support them.[5] Let's not throw the baby out with the bath water.

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doi: 10.1192/pb.34.5.209

Confusing title and misleading assumptions

The title and the aim of the study by Tyrer *et al*[1] state that they had made a controlled comparison of two crisis resolution and home treatment teams (CRHTs). However, reading through the