article the data-set they looked at applies only to one CRHT. The second CRHT was not in existence in the two time periods when the data were collected.

There are inaccuracies in the reporting; in the results section the authors report duration of bed use and refer to Table 2 which is occupied bed days. The duration of bed use and number of bed days are two different measures. Also, numbers do not add up in Table 2, however they do add up in Table 1.

In summary, the study reports no statistically significant difference in number of admissions or number of bed days following introduction of a CRHT when compared with an area without the team. However, raw figures demonstrate a decrease in informal admissions and bed days, and an increase in formal admissions in the area where there is a crisis team.

The authors make assumptions that the increase in compulsory admissions following the introduction of a CRHT was because some patients who would otherwise have been admitted to the hospital and then detained under Section 5(2) of the Mental Health Act were taken on by the CRHT and then getting admitted through mental health assessments and on a section. This assumption is not supported by the data-set or anecdotal evidence.

The study also found that there is an increase in suicide in the catchment area where there is a CRHT. However, none of these suicides happened when the patients were under the CRHT. As it stands, it is difficult to explain that the increase in suicide is somehow connected to the introduction of the CRHT.

It is safe to assume that in Cardiff as the experience of the team grows and the teams get more embedded they will have a significant effect on both number of admissions and bed usage as demonstrated by the National Audit Office report.[2]

1 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

2 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. TSO (The Stationery Office), 2007.

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Authors' reply Dr Mahadun & Sadiq are right on both counts. The title 'A controlled comparison of the introduction of a crisis resolution and home treatment team' should be the proper title of the article. The top two lines of data in Table 2 are also incorrect, and should read as shown here.

These data illustrate an effect of the crisis resolution team (CRT) overall in reducing bed days. We agree that the interpretation of the data cannot provide a causal pathway between the experience of seeing a CRT and then having a higher risk of being admitted compulsorily, as we were not following the experience of individual patients through the care system. However, it is a reasonable hypothesis to posit that the increase in compulsory admissions following the introduction of the CRT was a direct consequence of the change in service provision across the trust. The same conclusion might be made about the change in suicide rates, but of course we stress that this was not a significant difference. The conclusion we are putting forward, and this was not one we were expecting when we started the study, is that the service configuration that follows the introduction of a CRT is one that tends to limit admissions and may possibly be directly associated with more compulsory admissions and more suicides. This is an important hypothesis to test, but we agree it cannot be confirmed from our data.

Table Number of bed days occupied in two 9-month study periods before and after the introduction of a crisis resolution (CRT) team

Patient status	Team	CRT service (number per 1000 population	Control service (number per 1000 population)
Total	Pre-CRT	6133 (74.2)	15 525 (72.4)
	Post-CRT	5542 (67.1)	15 352 (71.6)

Drs Ogunremi & Talat argue from the position of enthusiasts for the CRT policy and we do not disagree with their opinion that it is a 'viable and acceptable approach to treating people with severe mental illness'. But all policies have to be tested and evaluated, and clearly all your correspondents would agree that if a CRT, for whatever reasons, makes decisions that lead to greater compulsion and more suicides in either the shorter or longer term, their implementation should be questioned. In this context it could also be argued that a reduction in bed usage is probably a poor outcome measure; quality of life, patient satisfaction and clinical improvement over a reasonable period (e.g. probably about a year to cover all aspects of an illness episode) are much preferred.

Declaration of interest

J.M. is currently a consultant in one of the Cardiff crisis resolution teams.

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Improving physical health monitoring in psychiatry – change we need?

Gonzalez *et al*[1] highlight the very important issue of routine blood testing of patients on antipsychotics, which currently is under-monitored in a psychiatric setting, particularly so in out-patients. However, the audit was conducted between 2004 and 2005, and it might not represent the current practice in UK. But physical health monitoring of patients with mental health problems still remains unsatisfactory. Some studies in 1986 and 2004 reported recording of physical examination carried out on admission by psychiatric trainees to be 'uniformly poor' to 'variable'.[2] The age-adjusted annual death rates from all causes among individuals with a psychiatric diagnosis is two to four times higher than in the general population.[3] This makes it even more pertinent for us to take extra measures in order to provide the best care for our patients.