We recently completed a study, similar to that by Bhandari,[1] exploring the readability of assessment letters being produced by an adult community mental health team (CMHT) in south-west England. We looked at all new assessment letters produced over a 3-month period. As the CMHT assessment is usually the first point of contact with services, we felt that the readability of assessment letters was particularly important with regard to engagement and promoting a shared understanding of a person's difficulties.

We used readability software available as a standard with Microsoft Word 2007 to establish the Flesch Reading Ease.[2] This is a validated tool widely used to assess readability, based on the syllabic and sentence structure of the text. Reading ease on this scale ranges from 0 to 100, with specific intervals categorised from 'very easy' (90–100) to 'very difficult' (0–29).

Like Bandari, we found that no letters were 'easy' or 'very easy' to read. However, we found that letters were significantly more readable ($P = 0.004$) if they were addressed to the patient with the general practitioner copied in, rather than *vice versa*. We speculate that this is because when dictating a letter to the patient, the patient and their understanding is borne in mind to a greater extent than when addressing a colleague.

In addition, the readability of letters varied by professional group. Whereas there was no significant difference in readability between junior doctors', occupational therapists' and social workers' letters, community mental health nurses and consultants produced significantly less readable letters ($P = 0.001$ and $P = 0.000$ respectively). The fact that no letters reached the standard of 'easy' or 'very easy' may reflect the difficulty of using simple terms to describe psychopathology. However, some authors produced much more readable letters than others, which suggests that improvement is possible.

We found it interesting that junior doctors wrote more readable letters than their consultant colleagues. We speculated that corresponding directly with patients is a skill with which consultants may lack historical experience as they have spent more of their careers corresponding principally with fellow health professionals. As a result they may be less familiar with methods to make letters more readable to the general public.

We concluded that assessment letters produced by community mental health workers do not score well for readability. We feel is of the utmost importance that the reading ability of our patients is borne in mind when writing such letters. Simple changes such as addressing the patient directly may help improve readability.

1 Bhandari N. Readability – writing letters to patients in plain English. *Psychiatrist* 2010; **34**: 454.

2 Flesch R. *The Art of Readable Writing*. Harper & Row, 1973.

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Risk to staff in a crisis resolution team

Crisis resolution and home treatment (CRHT) teams are now well established. There is significant evidence that they reduce bed use, are cost-effective and patients prefer them to admission.[1]

A CRHT team is dependent on the expertise and imagination of its staff to help understand and resolve a crisis. However, the risk to staff of working intensively with people who would otherwise be in hospital is not well documented. The evaluations of CRHTs have not considered the staff or the impact of frequent visits from different staff on people at high risk of acting violently.[1,2] Risk management is a continuous task in a CRHT team. There is some concern that risks to patients may increase with the introduction of a CRHT team, although this is far from established.[3]

We conducted an anonymous survey of the Hammersmith and Fulham Crisis Resolution Team in London. We asked whether they had felt physically vulnerable during community visits and encouraged them to describe any relevant incidents. Respondents included doctors, nurses, occupational therapists, support workers and bank staff. Duration of work with the team ranged from a few weeks to over 6 years. All had at least two jobs in psychiatric services before joining the crisis team and most had several years of previous mental health experience, in CRHT teams and on wards.

More than half of the respondents (13 of 20) had felt physically vulnerable while on a home visit. Their experiences ranged from feeling concerned about personal safety when with patients who were aroused or were experiencing psychosis, to being chased out of an abode when violence was threatened. No one had been physically harmed. The remaining seven people had all worked with the team for less than a year. Everyone working in the team for longer than a year reported feeling physically vulnerable during at least one visit.

We found that exposure to risk from patients was ubiquitous among all established CRHT staff in our study. It is particularly important to document risk to staff to avoid minimisation. As health services reduce costs, crisis teams will be asked to increase the threshold and reduce the duration of in-patient care further. Crisis resolution home treatment teams receive several hundred referrals a year. The short response times, high expectations and anxiety of referrers, as well as pressure to act and prevent admission all potentially reduce thinking about risk.

1 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochr Dat Syst Rev* 2007; issue 4. CD001087.

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

3 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.

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Polypharmacy: should we or shouldn't we?

Much has been written recently in *The Psychiatrist* about how psychiatrists should manage antipsychotic polypharmacy. Taylor[1] could hardly be more emphatic: 'evidence supporting antipsychotic polypharmacy has, if anything, diminished and