

with a small number of beds as well as the introduction of CRHTT has supported the decrease in admissions to hospital.

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doi: 10.1192/pb.35.6.237b

Overstated 'clinical implications'

The study by Okorie *et al*¹ of an accident and emergency (A&E) unit in Galway, Ireland, was of some interest given our experiences in an A&E in Middlesbrough.² Interestingly, the authors did not mention the proportion of mental health service users presenting with self-harm, a well-known cause of frequent attendance in our neck of the woods.

Whether the authors include presence of self-harm as evidence of mental disorder is another matter. It is an interesting debate, one which needs to happen with regard to accepting the role of services in managing emotional distress and at what threshold it should be labelled as mental disorder, an issue which was highlighted before.³ Nevertheless, we know that self-harm and attempted suicide are represented at a higher rate in individuals with personality disorder, schizophrenia, bipolar disorder and alcohol/substance misuse. Yet Okorie *et al* have decided to disregard that particular and significant piece of the puzzle in those presenting to A&E seeking psychiatric assessment and care.

I am not sure how services are structured in Ireland. To appreciate the possible impact of a crisis team on local A&E services, it would have been useful to first describe how psychiatric assessments are currently made available to the attendees, including screening those not known to have previous involvement with mental health services. However, whether 'community-oriented teams' such as a home treatment team would lead to cost reduction (by reducing A&E attendances as the implication seems to be) might be stretching existing evidence and is evidently unsupported by this survey. This effort should also have accounted for a wide variety of variables which have an impact on individuals seeking psychiatric care and assessment in A&E and hence at least a replication should have been attempted before the study was submitted for publication.

Finally, Okorie *et al*'s conclusions, as stated in the clinical implications in the abstract, are quite surprising, despite the mentioned limitations. Their wording, in my opinion, is unfortunate and overestimates evidence, and is completely out of synch with the survey.

Declaration of interest

M.K. is Consultant Lead for an England-based crisis resolution and home treatment team.

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doi: 10.1192/pb.35.6.238

Matched or overmatched?

We read with interest the paper by Okorie *et al*,¹ which studied the characteristics of patients who present frequently to emergency services. Knowing the local profile of emergency presentation is critical to targeting improvements in service provision, and we were glad to see the authors tackle this matter. We do raise two issues with the study, one methodological and one regarding applicability of the conclusions.

First, age and gender were matched as part of the study between the two groups. These are important measures of demographics that may predict frequent attendance, as has been concluded in the previous studies referenced.^{2,3} We presume the authors were aiming to reduce confounding by these variables using a case–control design. Matching is used 'to ensure that controls and cases are similar in variables which may be related to the variable we are studying but are not of interest in themselves'.⁴ We think age and gender are of interest, and wonder whether controlling for these factors makes it less easy to decide the target group for community-oriented strategies. The previous studies were in different health systems, and it may be an unwarranted assumption that there will be similar gender and age relationships in an Irish population. It is unsurprising that the mean age and gender of the two groups are equal, as this was matched for at the start of the study. This led to an incorrect conclusion being made in the first paragraph of the Discussion – 'frequent attenders . . . had equal gender distribution as compared with single attenders'. From the data, it appears that one can only draw the conclusion that gender distribution was equal within the frequent attender group.

Second, it would be useful to know what other services are available in Galway. If no early intervention in psychosis team was present, then perhaps this is why people with schizophrenia present more often at the accident and emergency department according to this study data. Without this information, it would be difficult to apply the conclusions to other localities. We would like to know about the structure and nature of community teams in the area and the provision of substance misuse services.

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doi: 10.1192/pb.35.6.238a