Statistical design, analysis and further correspondence

SIR: It is heartening to read that "powerful and sophisticated modelling techniques are now available . . . (for) informative and appropriate analyses of longitudinal data, including dealing with missing observations in the correct fashion" (Everitt, *BJP*, **166,** 540). The type of analysis done in the study of home-based *v.* in/outpatient care some years ago actually resembled that done by Everitt himself in a previous controlled study (Alkubaisy *et al*, 1990) to answer a similar question about between-treatment differences which have different clinical import at one time than at another.

It is puzzling why Van Os *et al* (*BJP*, **166,** 543–545) think that "rather better" contrasts with "superior" and raise the red herring of multiple significance tests. Not every measure used in the study had the same logical status. Different types of measure tapped different aspects of function which regardless of the statistical minutiae had coherent patterns of outcome over the 45 months of the study (Audini *et al*, 1994; Knapp *et al*, 1994; Marks *et al*, 1994). Compared to in/out-patient care, on measures of:

clinical and social outcome: home-based care did only marginally better to 20 months post-entry, and no better subsequently to month 45 post-entry.

number of in-patient bed days and the related variable of cost: home-based care did substantially better to 18–20 months post-entry irrespective of baseline differences between groups on first admission status. These benefits disappeared once the community (home-based) care team lost its extra responsibility for crisis admissions; from months 30 to 45 post-entry, home-based care used similar numbers of in-patient days and lost its cost advantage.

satisfaction of patient and of relative: home-based care did substantially better from 11 months post-entry all the way through to month 45. This was true not only for total scores but also consistently for almost every item in the satisfaction measures.

Understanding the results of the controlled study of home-based *v.* in/out-patient-based care for serious mental illness requires a detailed grasp of its design and its execution. The main conclusions stand unaltered. Up to 20 months post-entry, home-based care helped clinical and social function only marginally but reduced in-patient admission times greatly and cost to some extent. Thereafter to month 45 nearly all advantages were lost, during which time the home-based team had lost its responsibility for care of crisis admissions. Of the 189 patients who entered the study, seven died from self-harm over the next 45 months, three from each group and one in transition from one group to the other. Patients and relatives remained more satisfied with home-based care from month 11 right through to month 45.

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I. MARKS

Institute of Psychiatry
London SE5 8AF

A HUNDRED YEARS AGO

The New Inebriates Bill

The Bill introduced into the House of Lords by the Lord Chancellor on behalf of the Government concedes the leading proposals which the British Medical Association has urged for nearly thirty years for the treatment of habitual drunkenness. Power is given to the High Court and to county courts to commit to a licensed retreat an habitual drunkard for from six months to two years on application of a relative or friend supported by evidence on oath. Power is given to county councils to establish and maintain retreats. The expression "habitual drunkard" is extended to include any person who is rendered dangerous to himself or others, or incapable of managing himself or his affairs, through habitual use of opium or any other drug. Thus the Association's demand for compulsion, provision for the poor, and for every form of habitual drunkenness, has been endorsed by the Government. Voluntary applicants are to be at liberty to appear before one justice instead of two as at present.

Reference

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

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