convulsion length was 7.4 seconds (95% CI, 3.7 to 11.1 seconds) or 34% (95% CI, 17 to 51%).

The present findings support the hypothesis and hence the supposition that the anticonvulsant as well as anaesthetic effects of methohexitone decline rapidly after bolus injection. The implications for the practice and theory of ECT require further investigation, but the findings ought to re-emphasise how important anaesthetic technique is in the practice of ECT. An increased delay between induction and electrical stimulation may be of value in some patients as a technique for seizure augmentation, that is, when a patient fails to have an adequate convulsion after stimulation with the maximum output of an ECT machine.

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Counselling and community psychiatric nurses

SIR: There is an urgent need for studies of the efficacy of counselling in primary medical care, and a need to establish the most effective deployment of community psychiatric nurses (CPNs). While Gournay & Brooking's study (*BJP*, February 1994, **164**, 231–238) was welcome, few conclusions can be drawn from the results due to a design failure.

The data for the two samples of patients who were randomised differently were merged at the six month follow-up point. This is inappropriate as the patients who were kept on a waiting list before entering counselling had received less therapy at follow-up. Controlled trials in general practice are difficult to do (Tognoni *et al*, 1991) and careful piloting is required before embarking on a large investigation (King *et al*, 1994).

The figures given in the paper are confusing. According to the flow diagram 106 patients were randomised to CPN care, whereas in the text this number becomes 92. Whether drop out occurred from CPN care, from the research assessments or both is not clear. It is stated that 50% of patients randomised to CPN care dropped out. We realise it is difficult to measure GP care, however, only 55% of patients randomised to the GP completed the third research assessment. No intention to treat analysis appears to have been carried out, even when the data for the practice consultation rates for all patients entering the trial must have been available. No attempt was made to determine the type of intervention carried out by the CPNs.

Despite these limitations, Gournay & Brooking (1994) conclude that CPNs are ineffective as counsellors in general practice and would be more appropriately deployed in the care of the severely mentally ill. We sympathise with the difficulties of conducting good controlled research of brief psychotherapies in general practice. Unfortunately these data simply do not bear out the authors' sweeping conclusions.

KING, M., BROSTER, G., LLOYD, M., *et al* (1994) Controlled trials in the evaluation of counselling in general practice. *British Journal of General Practice*, **44**, 229–232.

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AUTHOR'S REPLY: We are grateful to Friedli & King for drawing attention to the apparent discrepancies in the text. The flow diagram shows 106 randomised to CPN care and the figure in the text of 92 refers to the number of patients who actually took up the offer of this intervention. We can confirm that 50% of patients who commenced CPN intervention dropped out.

With regard to our comparison of patients receiving CPN interventions and patients attending their GP, we only used patients who had been assigned to immediate CPN intervention in this analysis – we omitted the group of eight patients who were still in CPN treatment after a period on the waiting list. Thus, our comparison involved patients allocated to exactly the same conditions of treatment. Friedl & King are incorrect in their assumptions, (a) that there was no intention to treat analysis carried out; or (b) that we made no attempt to determine the type of interventions carried out by CPNs. We videotaped a selection of assessment interviews and collected a considerable amount of other data – including CPNs' intention for treatment. The results of some of these data are reported elsewhere (Gournay *et al*, 1993), and further analyses of the process data are being carried out. It must be

https://doi.org/10.1017/S0007125000143491 Published online by Cambridge University Press

appreciated that studies of this kind often yield amounts of data which cannot all be used in summary reports.

We accept that a study such as ours can hardly be definitive. However, Friedli & King cannot dismiss the literature which we considered alongside our data, which highlights the scandalous situation wherein community psychiatric nurses have abandoned the seriously mentally ill in favour of their work in primary health care. The recent Mental Health Nursing Review estimated that 80% of people with schizophrenia in the UK had not been on the caseload of a mental health nurse working in the community (Working in Partnership, 1994).

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GOURNEY, K. J. M., DEVILLY, G. & BROOKER, C. (1993) The CPN in primary care: A pilot study of the process of assessment. In *Community Psychiatric Nursing* (Eds C. Brooker & E. White). London: Chapman & Hall.

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Home- v. hospital-based care for people with serious mental illness

SIR: The 'DLP papers' of Knapp *et al* (*BJP*, August 1994, **165**, 179–194; 195–203; 204–210) provide a reminder that it is not necessarily better to treat all acute mental illness at home. In fact the Daily Living Programme (DLP) study combined two distinct interventions: 'acute' and 'post-discharge' care of the mentally ill. Their results indicate that if there were any benefits, these were for the latter. Indeed, the DLP group fared better in relation to the control group at the end of the trial, when discharge was under the control of other clinical teams and the DLP group was not driven by the ideological view that patients should never be in hospital.

Although the clinical benefits were borderline, Knapp *et al* concluded that home-based treatment was more cost-effective than routine hospital-based care over 20 months. We would urge caution in accepting this finding, particularly since neither the clinical nor the economic outcome of the trial were analysed on an intention-to-treat basis. Instead of substituting missing data with values from previous data points in the trial, results were analysed only for those subjects compliant with assessment. In the cost-effectiveness analysis data were reported for approximately 70% of the original subjects for the first year, but for only 54% of subjects for the entire 20 months. The missing cost data were not accounted for, even though the companion paper reported clinical outcome data on 75% of subjects over 20 months. It is conceivable that non-compliance with treatment and/or interview may have had different effects on costs in the two groups, particularly given the lower rate of previous in-patient treatment in the DLP group. It should also be borne in mind that the standard of routine post-discharge care at the Maudsley (the control treatment) was notoriously bad at the time. Other methodological weaknesses of the study were the use of repeated tests of statistical significance, and satisfaction ratings by assessors who were not blind to treatment status.

Benefits derived from the Madison model of community care have never proven sustainable beyond the first year or two, often because of staff burnout. Despite more 'realistic' approaches to community mental health services (Merson *et al*, 1992; Burns *et al*, 1993; Tyrer *et al*, 1993), we believe there is still a powerful argument in favour of asylum for the acutely mentally ill, particularly in our inner cities (Dedman, 1993; Phelan & Myers, 1993).

BURNS, T., BEADSMOORE, A., BHAT, A. V., *et al* (1993) A controlled trial of home-based acute psychiatric services. I: Clinical and social outcome. *British Journal of Psychiatry*, **163**, 49–54.

DEDMAN, P. (1993) Home treatment for acute psychiatric disorder. *British Medical Journal*, **306**, 1359–1360.

MERSON, S., TYRER, P., ONYETT, S., *et al* (1992) Early intervention in psychiatric emergencies: a controlled clinical trial. *Lancet*, **339**, 1311–1314.

PHELAN, M. & MYERS, S. (1993) Home treatment for acute psychiatric disorder. *British Medical Journal*, **307**, 201.

TYRER, P., MERSON, S., GHANDI, N., *et al* (1993) Home treatment for acute psychiatric disorder. *British Medical Journal*, **307**, 200.

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AUTHOR'S REPLY: I will concentrate on the economic evaluation queried by Weich & Lewis. They "urge caution" in accepting the finding that the DLP was more cost-effective than the control service (in-patient treatment followed by standard care) because of missing values. Their suggestion that previous values be substituted for missing data points in a longitudinal study would be a very crude way around this. Interpolation between observed costs would be more sensible. A much better way is to examine the characteristics of those people for whom one does and does not have costs data for various periods. Multivariate comparisons can be

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