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).

DEPARTMENT OF HEALTH (1994) *Working in Parnership*. London: HMSO.

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.

K. GOURNAY

Middlesex University
Middlesex EN3 4SF

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.

S. WEICH
G. LEWIS

Section of Epidemiology & General Practice
Institute of Psychiatry
London SE5 8AF

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

https://doi.org/10.1017/S000712500014351X Published online by Cambridge University Press

Table 1
Multivariate comparisons of actual costs for costed sample and predicted costs for uncosted sample

		Costs per patient week (£)	
		DLP sample	Control sample
Actual cost for costed sample	mean	173.0	253.5
	sd	191.9	259.5
	n	74	68
Predicted cost for uncosted sample	mean	174.0	322.3
	sd	115.5	196.5
	n	16	24

made, to allow predictions from the costed group onto the uncosted group. These equations are cited in the paper (*BJP*, August 1994, **165,** 195–203) and explained in more detail in Knapp (1994). The admission characteristics of every patient meeting the inclusion criteria for the study were entered into multiple regression analyses to predict costs 12–20 months after admission. Separate regression equations were estimated for the DLP and control groups. The results of the predictions are summarised in Table 1. The DLP patients for whom costs were missing in this 12–20 month period are predicted – on the best evidence available from the study – to be no more or less costly than the costed sample (P=0.952). In marked contrast, the uncosted control group patients are much *more* costly (P=0.046) than the costed sample. Had the uncosted patients been included in the final period of the evaluation, the cost-effectiveness advantage to the DLP sample would have been greater.

The generalisability of the DLP results is certainly open to discussion. In our paper we ourselves enter four caveats. The fifth caveat suggested by Drs Weich and Lewis – missing observation bias – is unfounded. They are, of course, quite right to argue for asylum (in the fullest, truest sense of the word) for people with acute mental health problems, and one spin-off from the multivariate analyses cited here is that they help to demonstrate who does and who does not benefit from community-based treatment.

KNAPP, M. R. J. (1994) Community mental health services: towards an understanding of cost-effectiveness. In *Evaluation of Community Psychiatric Services* (Eds F. Creed and P. Tyrer). Cambridge: Cambridge University Press.

M. KNAPP

University of Kent at Canterbury
Kent CT2 7NF
and Institute of Psychiatry

AUTHOR'S REPLY: Weich & Lewis seem to have misread our report. They write that the home-based DLP was "driven by the ideological view that patients should never be in hospital"; we wrote that "Patients were not strenuously kept out of hospital at all costs, being admitted briefly if warranted" (*BJP*, August 1994, **165,** p. 181).

Weich & Lewis identify only "two distinct interventions: 'acute' and 'post-discharge' care" – omitting the planning for discharge during in-patient phases, and the attempts to prevent relapse. They seem to dismiss ("if there were any benefits") the highly significant increase in satisfaction of both patients and relatives in the DLP compared to the control group. This was clear by month 11 in the first year and continued to the final rating 45 months after the start. Is user satisfaction a trivial benefit?

"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": This is a further misunderstanding. At the end of Phase I, at 20 months after trial entry, most DLP patients who had been admitted were still under the care of the DLP team, not of another clinical team. The transfer of responsibility for crisis admissions to other teams took place only in the third year of patient intake late in the study, and so affected few patients in their first year after trial entry, by which time the DLP was already superior to the control group not only on satisfaction but also on length of stay and on some clinical and social variables. The transfer of responsibility was a salutary natural experiment; it was followed by a trebling of the duration of those crisis admissions.

Our Audini *et al* report (*BLP*, 1994, **165,** 204–210) indicated the problems of maintaining gains from community care beyond the first couple of years. The problem the DLP had in this regard may

https://doi.org/10.1017/S000712500014351X Published online by Cambridge University Press