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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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).

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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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