BJPsych | The British Journal of Psychiatry (2013) 202, 383–386

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Edited by Kiriakos Xenitidis and Colin Campbell

Contents

IAPT is probably not cost-effective

The recent economic evaluation of an Improving Access to Psychological Therapies (IAPT) service conducted by Mukuria and colleagues[1] is a welcome addition to the evidence base pertaining to this programme. This was a non-randomised comparison but it appears that the authors have used appropriate methods to control for differences between areas. A casual reading of the abstract conclusion would lead one to assume that IAPT is likely to be cost-effective. Indeed, the cost per quality-adjusted life year (QALY) is below the upper threshold used by the National Institute for Health and Clinical Excellence (NICE), and below the lower threshold in a sensitivity analysis where the EQ-5D was used. However, the cost per QALY is somewhat misleading. The most useful results from this study are the cost-effectiveness acceptability curves shown in Fig. 2. Here it is revealed that at the NICE upper threshold of £30 000 per QALY, there is about a 38% likelihood that IAPT is cost-effective, increasing to just over 50% if the EQ-5D is used to generate QALYs. If the lower threshold is used, then there is even less chance that IAPT is cost-effective. The overall conclusion of this paper should be based on Fig. 2 and it should be that on the basis of this study IAPT was probably not cost-effective.

1 Mukuria C, Brazier J, Barkham M, Connell J, Hardy G, Hutten R, et al. Cost-effectiveness of an Improving Access to Psychological Therapies service. *Br J Psychiatry* 2013; **202**: 220–7.

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doi: 10.1192/bjp.202.5.383

Drop out from treatment in the World Mental Health Survey initiative

We read with interest the study by Wells *et al*[1] where the important issue of adherence to treatment services has been addressed. Although the study analysed the data generated from the robust methodology of the World Mental Health Survey, which is a landmark in the field of psychiatric epidemiology, it needs to address some of the conceptual issues of treatment adherence particularly relevant to the low-/lower-middle-income countries.

Long-term follow-up and regular treatment is mostly prevalent in high-income countries that have an organised mental healthcare service. In countries having lesser mental healthcare resources, such coordinated provision of treatment is lacking. When treatment is sought from general medical services, the patient is only provided symptomatic relief and neither the provider nor the client has any knowledge about long-term follow-up. Such lack of communication between them is mostly due to deficiency of mental health infrastructure in terms of either quality or quantity.[2] One may argue that traditional or non-conventional modes are the main treatment providers in such countries. But for them often the treatment proceeds on an 'as and when required' basis.[3] For spiritual and religious healers the client would often be attached to them in a special bond of faith or gratitude for generations, such as in the guru–chela relationship.[4] In such situations, a question such as 'Did you complete the full recommended course of treatment? Or did you stop before the [provider] wanted you to stop?' seems irrelevant. We propose that a little extra effort to standardise this question across different settings would have made the methodology of Wells *et al* more robust.

Slightly different definitions for mental health treatment drop out have been used in previous studies.[5,6] The authors have very rightly pointed out that this is one of the reasons for the differences between drop-out rates found in national surveys and corresponding subsamples of the present study. So, if such a 'slightly different definition' of drop out influences their rates in high-income countries where the determinants are less heterogeneous, we can obviously assume that its effect on the low-/lower-middle-income countries will be marked.

Although the authors have made elaborate attempts to find the predictors of drop out, they did not take into account many potentially relevant factors related to patient (e.g. stigma, functional impairment, satisfaction with treatment), professional (e.g. communication skills, clinical expertise) and service delivery (e.g. environmental obstacles). Apart from this, the fact that the centres in some countries were not representative of the whole population influenced generalisability of the study. Overall, this unique effort by the authors is praise-worthy and will go a long way in understanding the dynamics of treatment drop outs from a global perspective.

1 Wells JE, Browne MO, Aguilar-Gaxiola S, Al-Hamzawi A, Alonso J, Angermeyer MC, et al. Drop out from out-patient mental healthcare in the World Health Organization's World Mental Health Survey initiative. *Br J Psychiatry* 2013; **202**: 42–9.

2 World Health Organization. *Mental Health Atlas 2011*. WHO, 2011.

3 Chavan BS, Gupta N, Sidana A, Arun P, Jadhav S. *Community Mental Health in India*. Jaypee, 2012.

4 Neki JS. Guru-chela relationship: the possibility of a therapeutic paradigm. *Am J Orthopsychiatry* 1973; **43**: 755–66.

5 Edlund MJ, Wang PS, Berglund PA, Katz SJ, Lin E, Kessler RC. Dropping out of mental health treatment: patterns and predictors among epidemiological survey respondents in the United States and Ontario. *Am J Psychiatry* 2002; **159**: 845–51.

6 Wang J. Mental health treatment dropout and its correlates in a general population sample. *Med Care* 2007; **45**: 224–9.

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doi: 10.1192/bjp.202.5.383a

Author's reply: I thank Basu & Arya for their kind words about our paper and for their reaffirmation of the importance of addressing adherence to treatment. However, although they note that, 'In countries having lesser mental healthcare resources, such coordinated provision of treatment is lacking', our results (online

Table DS2) show that coordinated treatment is typically lacking even in higher-income countries. Indeed, the median number of visits in the past 12 months among patients receiving treatment for mental disorders in general medical services is no different in high-income (1.5) than in low-/lower-middle-income (1.4) countries and only slightly higher in upper-middle-income countries (2.1). We also found that the proportion of patients prematurely terminating primary care treatment of mental disorders is quite high in high-income countries (35.4%) as well as in lower-income countries (52.5% for both groups).

Although Basu & Arya consider the World Mental Health question on stopping treatment irrelevant to relationships with spiritual or religious healers, great care was taken in crafting the question sequence in which this question was embedded to be broadly applicable across treatment sectors and countries. The sequence began by asking respondents whether they ever in their life saw any of the professionals on a long country-specific customised list, for problems with their emotions, nerves, or use of alcohol or drugs. Respondents who reported having done so were asked whether they saw each type of professional for such problems in the past 12 months and, if so, number of visits, perceived helpfulness and whether or not they were still seeing the professional for these problems. Only those who said they had stopped seeing the professional were then asked, 'Did you complete the full recommended course of treatment? Or did you quit before the [provider] wanted you to stop?' I agree with Basu & Arya that the framing of this question and of the response options may not have been the most natural way to describe an on-going relationship with a spiritual or religious healer, and I agree that customisation might well yield important new information. However, we would expect reports of having 'stopped' to be lower-bound estimates of the extent to which care for on-going emotional problems lacked continuity, so the high proportions of patients in lower-income countries who gave such reports are cause for deep concern. Basu & Arya also note correctly that data on reasons for terminating treatment, including stigma, were not reported in the paper. Such data exist in the World Mental Health Surveys and will be presented in future reports.

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doi: 10.1192/bjp.202.5.383b

Psychological therapies in anorexia nervosa: on the wrong track?

Recently, in a randomised controlled trial, specialist supportive clinical management (SSCM) has proven to be more effective than the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), a treatment specially designed to address the disorder according to a rather complex rationale in comparison with SSCM.[1] Specialist supportive clinical management, originally 'non-specific supportive clinical management' administered to a control group in a previous randomised controlled trial,[2] was found to be more effective than two specialised treatments – cognitive–behavioural therapy and interpersonal therapy – and was as effective as these treatments at 5-year follow-up.[3]

Specialist supportive clinical management was originally defined as clinical management and supportive psychotherapy, as revealed by its original definition:

> 'Non-specific supportive clinical management was developed for the present study, and its aim was to mimic outpatient treatment that could be offered to individuals with anorexia nervosa in usual clinical practice. It combined features of clinical management and supportive psychotherapy. Clinical management includes education, care, and support and fostering a therapeutic relationship that promotes adherence to treatment. Supportive psychotherapy aims to assist the patient through use of praise, reassurance and advice. The abnormal nutritional status and dietary patterns typical of anorexia nervosa were central to non-specific supportive clinical management, which emphasised the resumption of normal eating and the restoration of weight and provided information on weight maintenance strategies, energy requirements and relearning to eat normally. Information was provided verbally and as written handouts.' (p. 742)[2]

In contrast, MANTRA claims to be novel in several respects: (a) it is biologically informed and trait-focused, drawing on neuropsychological, social cognitive and personality trait research; (b) it includes both intra- and interpersonal maintaining factors and strategies to address these; and (c) it is modularised with a hierarchy of procedures tailored to the individuals (as described in the authors' online Table DS1).[1]

Current treatment of anorexia nervosa is disheartening. Following successful weight restoration, almost 50% of patients relapse after 1-year follow-up, and pharmacological or psychological treatment persistently fails to neutralise the purported mechanisms underlying anorexia psychopathology.[4] Against this backdrop, according to the American Psychological Association Task Force criteria for the Promotion and Dissemination of Psychological Procedures, SSCM could be the first treatment for adult anorexia to attain the consideration of a well-established psychosocial intervention. However, the acronym SSCM disguises the fact that it has entered the stage through the back door of non-specific supportive treatments originally assigned to control groups, and SSMC efficacy over advanced treatments that have a sound theoretical basis raises perplexing questions. Maybe we are on the wrong track by persistently failing to understand either the fundamental features articulating the current concept of the disorder in terms of symptoms, personality traits, psychopathology and neuropsychological profile, or that these features are an epiphenomenon of malnutrition and are thus irrelevant as targets for treatment. Rather than delving into the self, perhaps the focus should be on the starvation side of self-starvation.[5]

1 Schmidt U, Oldershaw A, Jichi F, Sternheim L, Startup H, McIntosh V, et al. Out-patient psychological therapies for adults with anorexia nervosa: randomised controlled trial. *Br J Psychiatry* 2012; **201**: 392–9.

2 McIntosh VV, Jordan J, Carter FA, Luty SE, McKenzie JM, Bulik CM, et al Three psychotherapies for anorexia nervosa: a randomized, controlled trial. *Am J Psychiatry* 2005; **162**: 741–7.

3 Carter FA, Jordan J, McIntosh VV, Luty SE, McKenzie JM, Frampton CM, et al. The long-term efficacy of three psychotherapies for anorexia nervosa: a randomized, controlled trial. *Int J Eat Disord* 2011; **44**: 647–54.

4 Attia E, Walsh BT. Behavioral management for anorexia nervosa. *N Engl J Med* 2009; **360**: 500–6.

5 Gutierrez E. A rat in the labyrinth of anorexia nervosa: contributions of the activity-based anorexia rodent model to the understanding of anorexia nervosa. *Int J Eat Disord* 2013; doi: 10.1002/eat.22095. (Epub ahead of print.)

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doi: 10.1192/bjp.202.5.384

Authors' reply: We share Gutierrez & Carrera's frustration about the difficulty in treating adults with anorexia nervosa. However, we disagree with their interpretation of our findings, and several other points they make.

First, in our trial specialist supportive clinical management (SSCM) was not superior to our new treatment, the Maudsley Model of Anorexia Treatment for Adults (MANTRA). In fact, outcomes for both interventions were similar. Moreover, in the

https://doi.org/10.1192/bjp.202.5.383b Published online by Cambridge University Press