of psychotherapy is undoubted, the evidence base for its effect size is less solid than that for antidepressants.[4] The main reason for this weaker evidence is the difficulty in definition of valid control groups and the fact that therapists, patients, and often even raters are not masked. Outcome in psychotherapy control groups has even been found to be significantly worse than that in pill placebo groups (the so-called nocebo effect), because patients are fully aware of their study situation.[10] Testing psychotherapy against a nocebo condition could therefore lead to artificially large group differences and effect sizes.

In summary, the present approach to estimation of the benefits of antidepressant treatments is likely to underestimate the clinical significance of antidepressants and overestimate that of psychotherapy. At the same time, we are experiencing an increasing tendency to medicalise individuals who have emotional reactions to difficult life circumstances but without any clinical signs of depression, and to offer them antidepressants or psychotherapy which might not be appropriate to their needs.[11] We should be careful not to offer our treatments to the wrong patients, but to provide them consistently to the right patients.

Mazda Adli, Ulrich Hegerl
Department of Psychiatry and Psychotherapy, Charité-Universitätsmedizin Berlin and Fliedner Klinik Berlin, 10117 Berlin, Germany (MA); and Department of Psychiatry and Psychotherapy, University of Leipzig, Leipzig, Germany (UH)
mazda.adli@charite.de

MA has received grants or research support from Aristo, Servier, and Bristol-Myers Squibb; honoraria for speaking from Deutsche Bank, the Johanniter Order, East German Savings Banks Association, Pusch Wahl Legal Lawyers, HRM Forum, Helios Media, Lundbeck, Bristol-Myers Squibb, Boehringer Ingelheim, Servier, Aristo, Viiv, and Gilead; travel grants from the Alfred Herrhausen Society, Lundbeck, and Servier; and has been a consultant to Deutsche Bank, Bristol-Myers Squibb, Aristo, Merz, and Lundbeck. UH has received funding from health insurance companies (Barmer BEK, Central Versicherung); is or has been a member of advisory boards for Lilly Deutschland, Lundbeck, Otsuka, and Takeda, and has received honoraria for speaking from Bristol-Myers Squibb, Medice Arzneimittel, and Roche Pharma.

1 NICE. Depression: management of depression in primary and secondary care. Clinical practice guideline No 23. London: National Institute for Clinical Excellence, 2004.
2 NICE. Depression: the treatment and management of depression in adults. National Clinical Practice Guideline 90. London: National Institute for Health and Clinical Excellence, 2009.
3 Guideline Group Unipolar Depression. S3-Guideline/National Disease Management Guideline Unipolar Depression. Long Version. Berlin, Düsseldorf: German Association for Psychiatry and Psychotherapy (DGPPN), German Association for Quality in Medicine (ÄZQ), Association of the Scientific Medical Societies (AWMF), 2009.
4 Hegerl U, Allgaier A-K, Henkel V, Mergl R. Can effects of antidepressants in patients with mild depression be considered as clinically significant? *J Affect Disord* 2012; **138:** 183–91.
5 Cuijpers P, Driessen E, Hollon SD, van Oppen P. The efficacy of non-directive supportive therapy for adult depression: a meta-analysis. *Clin Psych Rev* 2012; **32:** 280–91.
6 Kirsch I, Deacon BJ, Huedo-Medina TB, Scoboria A, Moore TJ, Johnson BT. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med* 2008; **5:** e45.
7 Kobak KA, Leuchter A, DeBrota D, et al. Site versus centralized raters in a clinical depression trial: impact on patient selection and placebo response. *J Clin Psychopharmacol* 2010; **30:** 193–97.
8 Leucht S, Hierl S, Kissling W, Dold M, Davis JM. Putting the efficacy of psychiatric and general medicine medication in perspective. *Br J Psychiatry* 2012; **200:** 97–106.
9 Fountoulakis KN, Veroniki AA, Siamouli M, Möller HJ. No role for initial severity on the efficacy of antidepressants: results of a multi-meta-analysis. *Ann Gen Psychiatry* 2013; **12:** 26.
10 Hegerl U, Hautzinger M, Mergl R, et al. Effects of pharmacotherapy and psychotherapy in depressed primary-care patients: a randomized, controlled trial including a patients' choice arm. *Int J Neuropsychopharmacol* 2010; **13:** 31–44.
11 Kleinman A. Culture, bereavement, and psychiatry. *Lancet* 2012; **379:** 608–09.

Challenges in rolling out interventions for schizophrenia

Published Online
March 5, 2014
http://dx.doi.org/10.1016/S0140-6736(14)60085-4
See Articles page 1385

The Global Mental Health (GMH) movement has played a pivotal part in bringing to attention the unmet needs of patients with mental disorders, particularly in low-income and middle-income countries.[1,2] Schizophrenia is of primary concern in view of the high level of associated disability and stigma, and the risk that, without treatment, patients will experience prolonged institutionalisation, neglect, and abuse.[3–5]

Sudipto Chatterjee and colleagues' multicentre, randomised controlled COmmunity care for People with Schizophrenia in India (COPSI) trial,[6] in *The Lancet*, represents a milestone by showing the benefits of a collaborative community-based care plus facility-based care model compared with conventional facility-based care alone for treatment of moderate to severe schizophrenia. However, implementation of collaborative community-based care in low-income and middle-income countries has several issues that need further consideration, such as ensuring continuity in supervision of community workers, safeguarding the physical health of patients, and embedding services within the local context and culture.

Collaborative community-based care makes sense: physical facilities (eg, clinics and hospitals) are not needed, demand on professional skills is low, and the family remains the core unit of care. COPSI is the first trial to test collaborative community-based care rigorously in a developing country, India.[6] 187 participants were

randomised to receive community-based care, and 95 to facility-based care alone. At 12 months, the collaborative community-based care intervention showed a non-significant improvement in symptoms of psychosis as measured by the positive and negative symptom scale (PANSS), and a clearer difference in improvement of disability according to the Indian disability evaluation and assessment scale [IDEAS]; (PANSS adjusted mean difference –3·75, 95% CI –7·92 to 0·42; p=0·08; IDEAS –0·95, –1·68 to –0·23; p=0·01). Furthermore, adherence to treatment was higher in the intervention group (adjusted odds ratio 2·93, 95% CI 1·34–6·39; p=0·01). Collaborative community-based care was no more effective than facility-based care alone for reducing stigma and discrimination, alleviating carer burden, or improving illness-relevant knowledge amongst family members. In assessment of these outcomes, it is important to keep in mind that chronic schizophrenia is a disabling disorder that is difficult to treat in any situation. Noteworthy, therefore, is that findings from COPSI were broadly the same as those from similar trials of collaborative community-based care done in high-income countries.[6]

What lessons can be learned from COPSI? Supervision was the most costly component of the collaborative community-based care intervention. Maintenance of supervision in very low resource settings is a major challenge, because of cost and the perennial issue of loss of skilled professionals. In Timor-Leste, for example, discontinuation of donor funding in 2005 left 15 national community mental health workers with no professional supervision for 3 years, until the return of the first trained Timorese psychiatrist.[7] Scarcity of supervision results in worker isolation, demoralisation, and attenuation of skills. Assessments can become cursory, leading to misdiagnosis and inaccurate prescribing of psychotropic drugs, which are commonly dispensed for indefinite periods without critical review. These practices increase the prevalence of serious adverse effects, particularly the metabolic syndrome with modern atypical antipsychotic drugs.[8]

India offers an important case in point. The population is at increased genetic risk for type 2 diabetes, with rising obesity in adolescents and young adults adding to the epidemic.[9] Prescription of antipsychotic drugs for schizophrenia—a disorder for which onset peaks in adolescence and young adulthood—greatly increases risk of the metabolic syndrome.[10] People with schizophrenia are at risk of cardiovascular disease because of their high rates of smoking and poor attention to diet and exercise.[11] Therefore, the GMH movement needs to confront the reality that rollout of collaborative community-based care for schizophrenia, particularly in poorly supervised settings, might add to the looming epidemic of cardiovascular disease. There can be no mental health without physical health, and the challenge is to devise strategies to support community mental health workers in monitoring and responding to the health risks associated with treatment of schizophrenia in low-resource environments—a formidable task.


Stuart Freedman/Panos

A key criticism of the GMH movement is that it has blinded itself to the complexity of culture in its haste to roll out packaged programmes of care in low-income and middle-income countries.[12] In many cultures, psychotic symptoms are still attributed to curses, spirit possession, and communication with ancestors, and patients commonly first consult a traditional or religious leader for assistance.[13] Introduction of evidence-based treatments without acknowledgment of the cultural meaning of illnesses and traditional approaches to healing can result in confusion amongst patients and carers. At worst, competition and even tension might develop between clinical services and traditional healers. Unfortunately, however, the stridency with which the cultural message has been presented risks blunting its effect on mainstream psychiatry.[12] A strong consensus already exists that the first step in initiation of mental health services in low-income and middle-income countries includes a comprehensive analysis of the culture, context, history, prevailing health belief systems, social structures, and politics of funding in each setting.

Sustaining of mental health initiatives, particularly in low-resource settings, needs a comprehensive, multisectoral approach based on genuine engagement with the community. The sense of local ownership and involvement is essential to ensure that the complexities of disorders such as schizophrenia are addressed at both a clinical and wider social level. Social programmes are needed to overcome stigma and discrimination, relieve carer burden, and educate families about the nature of the disorder—areas in which COPSI was notably less successful. These social components of interventions are often best provided by local non-government agencies and voluntary associations, whereas core services attend to the direct clinical needs of patients.

The active involvement of local leadership and stakeholder groups is crucial to sustain and develop programmes; mental health for all means all need to play a part. Therefore, as services are rolled out across low-income and middle-income countries, the global must engage with the local to forge an equal partnership to improve the lives of people with schizophrenia and their families.

*Derrick Silove, Philip B Ward
Psychiatry Research and Teaching Unit (DS) and Schizophrenia Research Unit (PBW), School of Psychiatry, University of New South Wales, Mental Health Centre, Liverpool Hospital, Sydney, NSW 2170, Australia
d.silove@unsw.edu.au

We declare that we have no competing interests.

1 Prince M, Patel V, Saxena S, et al. No health without mental health. *Lancet* 2007; **370:** 859–77.
2 Collins PY, Patel V, Joestl SS, et al. Grand challenges in global mental health. *Nature* 2011; **475:** 27–30.
3 Gore F, Bloem P, Patton G. Global burden of disease in young people aged 10–24 years: a systematic analysis. *Lancet* 2011; **377:** 2093–102.
4 Silove D, Ekblad S, Mollica R. The rights of the severely mentally ill in post-conflict societies. *Lancet* 2000; **355:** 1548–49.
5 Patel V, Kleinman A, Saraceno B. Protecting the rights of people with mental illness: a call to action for global mental health. In: Dudley M, Silove D, Gayle F, eds. Mental health and human rights. Oxford: Oxford University Press, 2012: 362–75.
6 Chatterjee S, Naik S, John S, et al. Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): a randomised controlled trial. *Lancet* 2014; published online March 5. http://dx.doi.org/10.1016/S0140-6736(13)62629-X.
7 WHO. Timor-Leste. In: Silove D, Tilman T, Hawkins Z, eds. Building back better: sustainable mental health care after emergencies. Geneva: World Health Organization, 2013: 83–88.
8 Mitchell A, Davy V, Kim S, et al. Prevalence of metabolic syndrome and metabolic abnormalities in schizophrenia and related disorders—a systematic review and meta-analysis. *Schizophr Bull* 2013; **39:** 306–18.
9 Khandelwal S, Reddy K. Eliciting a policy response for the rising epidemic of overweight-obesity in India. *Obes Rev* 2013; **14:** 114–25.
10 Pérez-Iglesias R, Martínez-García O, Pardo-Garcia G, et al. Course of weight gain and metabolic abnormalities in first treated episode of psychosis: the first year is a critical period for development of cardiovascular risk factors. *Int J Neuropsychopharmacol* 2014; **17:** 41–51.
11 Wildgust H, Beary M. Are there modifiable risk factors which will reduce the excess mortality in schizophrenia? *J Psychopharmacol* 2010; **24:** 37–50.
12 Summerfield D. "Global mental health" is an oxymoron and medical imperialism. *BMJ* 2013; **346:** f3509.
13 Silove D, Bateman C, Brooks R, et al. Estimating clinically relevant mental disorders in a rural and an urban setting in postconflict Timor Leste. *Arch Gen Psychiatry* 2008; **65:** 1205–12.

Cognitive therapy: at last an alternative to antipsychotics?

Wavebreak Media Ltd./Corbis

Published Online
February 6, 2014
http://dx.doi.org/10.1016/S0140-6736(13)62569-6

See Articles page 1395

Schizophrenia causes substantial disability and premature mortality, and is one of the top causes of disease burden worldwide.[1] Antipsychotic drugs revolutionised schizophrenia treatment when introduced in the 1950s, and numerous studies have shown that antipsychotics are effective for acute episodes, and as maintenance treatment, with a number needed to treat of 3 to prevent relapse.[2] Evidence has also shown that some drugs could reduce mortality, mainly through a reduction in suicide rates.[3] However, the clinical reality is that many patients stop taking antipsychotics for various reasons: side-effects, absence of benefit, disorganisation, and because they do not perceive they have an illness.

Although more than 20 different antipsychotics are in use for first-line treatment of schizophrenia, all essentially use the same mechanism, and drugs that use alternative mechanisms have yet to reach the market.[4,5] Consequently, patients are faced with Hobson's choice: antipsychotic treatment or nothing. This choice is further complicated because antipsychotics are associated with several distressing and potentially serious side-effects, including tardive dyskinesia, endocrine and sexual dysfunction, and cardiac dysrhythmia.[6–9] Therefore, a viable treatment alternative is needed.

In *The Lancet*, Anthony Morrison and colleagues' randomised trial[10] provides ground-breaking evidence that cognitive therapy might be such an alternative. Cognitive therapy is a structured time-limited treatment that involves the therapist working collaboratively with the patient in weekly sessions over several months to reappraise psychotic experiences and modify unhelpful thought patterns and behaviours. Cognitive therapy is established as effective in treatment of schizophrenia, but in the past has always been used as an adjunct to antipsychotic treatment for patients with residual symptoms.[11] Morrison and colleagues assessed the benefit of cognitive therapy for treatment of schizophrenia in patients who chose not to take antipsychotic drugs. The investigators randomly assigned 37 patients to cognitive therapy plus treatment as usual and 37 patients to treatment as usual alone, with a primary endpoint of total score on the Positive and Negative Syndrome Scale (PANSS). Patients received follow-up over at least 9 months. Cognitive therapy proved to be highly effective in reducing psychotic symptoms, and in improving function compared with treatment as usual; mean PANNS total scores were consistently lower in the cognitive therapy group than in the treatment as usual