companies to attend educational meetings. M.T. has received fees for making educational contributions to meetings sponsored by pharmaceutical companies.

Bianchetti, A., Frisoni, G. B., Ghisla, K. M., *et al* (1998) Clinical predictors of the indirect costs of Alzheimer's disease. *Archives of Neurology*, **55**, 130–131.

Jönsson, L., Lindgren, P., Wimo, A., *et al* (1999) The cost-effectiveness of donepezil in Swedish patients with Alzheimer's disease: a Markov model. *Clinical Therapeutics*, **21**, 1230–1240.

Trabucchi, M. (1999) An economic perspective on Alzheimer's disease. *Journal of Geriatric Psychiatry and Neurology*, **12**, 29–38.

__, Ghisla, M. K. & Bianchetti, A. (1996) CODEM: longitudinal study on Alzheimer disease costs. In *Alzheimer Disease: Therapeutic Strategies* (eds E. Giacobini & R. Becker), pp. 561–565. Boston, MA: Birkhäuser.

Wolstenholme, J., Fenn, P., Gray, A., *et al* (2002) Estimating the relationship between disease progression and cost of care in dementia. *British Journal of Psychiatry*, **181**, 36–42.

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CBT for psychosis

I am writing to reply to Turkington *et al* (2002: p. 525), who claim in their interesting and recently published paper on cognitive–behavioural therapy (CBT) for psychosis, that 'The NNT [numbers needed to treat] of 13 for improvement in overall symptoms was compatible with the results achieved when CBT was delivered by expert therapists (Kuipers *et al*, 1997)'. We do not think this claim is justified.

First, in our study 64% of the CBT group achieved clinical improvement compared with 47% of the controls (Kuipers *et al*, 1997). We did not present the NNT but they are 6 at the end of treatment and 3 at the end of follow-up (Kuipers *et al*, 1998).

Second, the two studies address different questions in different samples. Our study tested whether CBT for psychosis could improve outcome compared with treatment as usual, in a sample comprising subjects deliberately chosen to have at least one distressing, positive, medication-resistant symptom of psychosis (not from 'lists of patients with schizophrenia receiving treatment'; Turkington *et al*, 2002: p. 523). We were aiming at a treatment-resistant group, a rather different sample from that recruited by Turkington and colleagues. Neither study compared 9 months of CBT with a briefer intervention. Nor did they test the efficacy of two different kinds of CBT.

We believe that it is misleading to claim comparability of trials between 'expert' and 'non-expert' therapists, and between results from 6 sessions and 20 sessions. Evidence for the efficacy of CBT for psychosis is at an early and promising stage; we think it is unhelpful to make unsubstantiated comparisons across trials, and hope that these comments provide some clarification.

Kuipers, E., Garety, P., Fowler, D., *et al* (1997) London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis. I. Effects of the treatment phase. *British Journal of Psychiatry*, **171**, 319–327.

__, Fowler, D., Garety, P., *et al* (1998) London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis. III. Follow-up and economic evaluation at 18 months. *British Journal of Psychiatry*, **173**, 61–68.

Turkington, D., Kingdon, D., Turner, T., *et al* (2002) Effectiveness of a brief cognitive–behavioural therapy intervention in the treatment of schizophrenia. *British Journal of Psychiatry*, **180**, 523–527.

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Author's reply: Our study was designed specifically to answer the question raised by Jones *et al* (1999) of whether the benefits achieved by expert therapists in research settings could be replicated by non-expert therapists working in community mental health teams. An end-of-therapy comparison was therefore necessary with one of the methodologically robust studies quoted in the above review. Kuipers *et al* (1997) was chosen because a similar, good clinical outcome analysis on overall symptoms had been reported at end of therapy. The appropriate end-of-therapy comparison is 14/28 (50%) for cognitive–behavioural therapy (CBT) as measured at the level of 20% improvement in overall symptoms in the original Kuipers *et al* (1997) paper compared with 112/257 (44%) as measured at the level of a 25% improvement in our study. These results show a comparable effect size for CBT in the two studies, considering that our study had to satisfy a more stringent criterion for a good clinical outcome. The difference in the numbers needed to treat is solely due to an improved performance in our treatment as usual group compared with standard care.

It is certainly correct to state that the two study populations were different by definition. However, consideration of the demographics as reported in the two papers shows that there was little difference in those who actually ended up being enrolled in the two studies. The mean number of admissions in Kuipers *et al* (1997) was 5.2 for the CBT group and 4.3 for standard care and in our study 4.71 for CBT and 5.18 for treatment as usual. We ended up enrolling a more treatment-resistant group because of the fact that patients with schizophrenia whose symptoms were well controlled with medication often did not see the need to enter the study when it was offered to them.

It is certainly true that the CBT delivered by Kuipers and colleagues was of 20 sessions' duration with a more sophisticated treatment manual. This makes the result of our brief CBT intervention as delivered by psychiatric nurses all the more impressive. We await the analysis of our short-term follow-up results to see whether the impressive durability results reported above can be equalled. If CBT is to make a real impact in terms of the management of schizophrenia, it will need to be delivered by non-expert therapists in community mental health teams. The real issues for expert cognitive therapists are to organise training courses, provide supervision and to deliver more complex CBT for those patients with schizophrenia who are more psychologically difficult or who have comorbidity such as post-traumatic stress disorder, alcohol dependence and social phobia. There is therefore a potential role for both expert and non-expert therapists in the management of every patient with schizophrenia.

Jones, C., Cormac, I., Mota, J., *et al* (1999) Cognitive behaviour therapy for schizophrenia. In *Cochrane Library*, issue 4. Oxford: Update Software.

Kuipers, E., Garety, P., Fowler, D., *et al* (1997) London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis. I. Effects of the treatment phase. *British Journal of Psychiatry*, **171**, 319–327.

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