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## Policy Implications of CATIE

***To the Editor:*** We contributed an article to the May issue's special section on interpreting the implications of CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) (1). As the section was being prepared for publication, the editor asked Richard Frank for a commentary on our article (2), which was also included in the CATIE special section. We are taking this opportunity to respond to Frank's commentary.

We agree that caution should be exercised in the implementation of formulary policies and that full consideration must be given to the concerns of advocates and consumers. We also think that mental health services researchers and economists are responsible to taxpayers and other purchasers of health care for offering a balanced consideration of the value of public expenditures. We think four issues may deserve further clarification.

First, Frank suggested that our appraisal of what is known may have been based too exclusively on the CATIE trial and that it may be premature to come to any conclusion about the cost-effectiveness of second-generation antipsychotics. However, the many studies we reviewed extend considerably beyond CATIE, which was only the most recent of a series of independent studies that have called into question the superiority of second-generation antipsychotics over older drugs. This perspective is perhaps most clearly reflected in the conclusion of the Texas Medication Algorithm Project authors, a distinguished group of schizophrenia experts, that second-generation antipsychotics should no longer be considered uniformly preferable to older drugs in the treatment of chronic schizophrenia (3). There are not likely to be additional large studies of these issues, so a broad consideration of current knowledge seems warranted.

Second, Frank expresses concern that the high drop-out rate from CATIE at 18-months seriously limits what can be concluded about these drugs. However, CATIE, like several other large trials that we cited, was substantially longer and had higher follow-up rates, at equivalent time points, than most previous trials and thus is more informative than previous studies, many of which lasted only six weeks (4) or stopped collecting data after the first medication change.

Third, Frank implies that we proposed placing strict restrictions on the use of second-generation antipsychotics. In fact, we suggested that a range of policy options be considered, most of which were not especially strict, and we sought to identify those that would be likely to be too precipitous or disruptive and thus should be avoided. Moreover, current practice is quite restrictive in that it relies predominantly on the five or six most expensive antipsychotics rather than on the full range of about 20 antipsychotic drugs currently available. One recent study showed that older drugs can offer new hope to patients who have failed to benefit from a second-generation agent (5). We believe that choices can be widened and costs lowered at the same time.

Fourth, we quoted a state Medicaid official who commented on the influence of coalitions between left-leaning advocacy groups and conservative businesses to highlight the political difficulties involved in considering cost-containment initiatives that would keep up with emerging research findings. Neither advocates nor businesses are focused on the cost concerns to the taxpaying public, and we think that mental health researchers should not ignore these concerns.

We agree that caution is warranted whenever health care policy is considered, but the need for caution should not, in itself, be a reason for inaction. The substantial public investment in government-funded studies such as CATIE can be justified only if new findings are carefully considered in developing policies that might better serve the public interest.

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***Jalpa A. Doshi, Ph.D.***

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## Problem Gamblers' Interest in Self-Help Services

***To the Editor:*** A difficulty encountered in efforts to help problem gamblers is that most gamblers never seek

face-to-face treatment. Estimates of the proportion of gamblers with identifiable problems who ever seek treatment range from about 10% to 30% (1,2). In the study reported here, we sought to determine the level of interest in various forms of help among such gamblers.

A two-stage random-digit dialing telephone survey was conducted between 2006 and 2007 across Ontario, Canada. A total of 8,467 persons age 18 and older responded, for a response rate of 51.7%. All participants provided verbal informed consent. The study was approved by the research ethics board at the Centre for Addiction and Mental Health. Sample sizes are presented as unweighted values; percentages and statistical tests are based on weighted values.

As part of the survey, respondents who acknowledged spending more than $100 ever on gambling (N=4,217) were administered the CLiP screener to identify those with potential gambling problems (3). The three CLiP items for both lifetime and past-year gambling experiences were included. Respondents endorsing one or more lifetime CLiP items were also administered the National Opinion Research Center DSM Screen for Gambling Problems (NODS) (4).

A total of 730 respondents had a score of 1 or more on the CLiP past-year gambling items, and this group constituted the study sample. Their mean±SD age was 45.3±14.8 years, and 377 (54%) were men. These respondents were asked whether they would be interested in four different types of services—a telephone call to help assess their gambling habits, a self-help book to help evaluate their gambling, a computerized summary comparing their gambling to that of other Canadians, and the same personalized summary available on the Internet.

Respondents were grouped into three categories on the basis of increasing severity of current gambling problem: those who scored 1 or more on past-year CLiP items but 0 on the NODS (N=500), those who met criteria as past-year risky gamblers (a NODS score of 1 or 2) (N=162), and those who were possible or probable past-year pathological gamblers (a NODS score of 3 or more) (N=68). There was a substantial positive relationship between each of the four types of help and the severity of the gambling problem ($p<.001$). Among the 68 possible or probable pathological gamblers, 25 (38%) were interested in a telephone call and about half (51% to 57%) were interested in each of the other three self-help options. Among the 500 respondents with a less severe gambling problem, interest in the alternate services ranged from 17% to 26%. [These and other survey results are shown in a table, which is available as an online supplement at ps.psychiatryonline.org.]

The results of this study suggest that one means of circumventing the reluctance of many gamblers to seek face-to-face treatment would be to expand the range of available self-help services. There have been several well-evaluated examples of brief, non–face-to-face interventions for problem gamblers (5). The findings reported here indicate that many problem gamblers are interested in secondary prevention materials, particularly interventions that do not require direct contact with a treatment agency, such as computerized summaries and self-help books. Evaluation of efforts to make such self-help interventions more available would determine whether problem gamblers who say they are interested in such services would actually use them.

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