editorials

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The role of atypical antipsychotic drugs in schizophrenia†

This issue of the *Bulletin* contains a series of thought-provoking articles concerning the choice of antipsychotics in schizophrenia (Adams & Gilbody, this issue; Bebbington, this issue; Healy, this issue; Hogman, this issue; Mortimer, this issue). In other words, atypicals or not and if so when. This is an argument that has gone on since the reintroduction of clozapine in 1990 (Kerwin, 1996). I will not, of course present my own views in this editorial, rather try and set the scene.

The atypical antipsychotic market-place is becoming overcrowded and therefore frenetically complicated by an ever increasing clamour and counter-clamour of vested interests. Two to three more new drugs in this class are to enter the scene in the next few years. There are widely divisive opinions and widely differing practices in the use of novel antipsychotics. In the US atypical antipsychotic prescribing now far outweighs typical antipsychotic prescribing, with risperidone and olanzapine being the most popular drugs. In the UK only a minority of patients are receiving atypical drugs and there is widespread poor prescribing of antipsychotics that will need to be corrected before any implementation of guidelines can be instituted (Taylor *et al*, 2000).

The open question in this debate is where lies the point of clinical equipoise? In other words, where do the genuine uncertainties lie that demand investigation and should these be explored by randomised controlled trials (RCT) or naturalistic trials? This point of equipoise has moved over the years. Clozapine was hailed as a wonder drug completely free of neurological side-effects in 1990 and each successive new drug was also fanfared. However, a wider examination of the pivotal trials makes it clear that new drug efficacy is equal to older drugs and whereas the traditional side-effect profile is superior, a differing side-effect profile may pose equal difficulties in tolerability for new drugs. So the points of clinical uncertainty are a moving feast. In addition, with the eschewing of high dose antipsychotics we are learning more about how to use low dose strategies for conventional antipsychotics. There are several difficulties in untangling these dilemmas as I see them. There is an argument for more naturalistic studies using hard end-points. This is technically correct but the size of the sample needed is enormous. In addition, we can't do without the smaller RCT as it would be wasteful to embark on natural studies without first ascertaining baseline efficacy under controlled conditions. No prudent drug company would be expected to do this. Furthermore, if the RCT data are good, should patients be made to wait further years before the naturalistic data come in? What happens if further new generations of superior drugs come in and leapfrog the atypicals before the naturalistic data are known? From a clinical and patient point of view this seems a recipe for stagnation. I strongly believe that all these arguments will be worthless unless we consider this debate to be aimed at our incident cohort of patients rather than our prevalent cohort. Multi-episode patients currently under treatment are in the main partially treated or difficult to switch, therefore undermining any rigid guidelines. First-episode patients are more treatment responsive and more side-effect sensitive (Lieberman *et al*, 1993). Therefore, whatever the pros and cons of different drug classes, they are more likely to be amplified at first episode and in turn such patients are more likely to achieve a better prognosis with the right choice. There are other factors too. What about the duration of untreated psychosis? If it really is related to prognosis (Haas *et al*, 1998) does the current incident cohort have time to wait for the outcome of naturalistic trials or the deliberations of the National Institute for Clinical Excellence (NICE)? What is NICE going to do? I can't see it settling any arguments, because there are few head to head studies comparing new drugs and in essence no clinical effectiveness data because there are no naturalistic trials. Cost-effectiveness will have to be modelled and that will rely on RCTs. I think NICE will only be able to pronounce on these drugs as a class. In which case why not go for the cheapest, e.g. zotepine, a drug with virtually no marketing muscle behind it?

It will not be long before we have a third wave of neuroleptics, with novel mechanisms of action such as partial dopamine agonists, selective D3 blockers and more. How can we have progress with the use of these drugs unless we get a move on with deciding about what, after all, are now established treatments in schizophrenia. Hopefully the debate in this issue will help to facilitate this important discussion.

†See pp. 284–286, pp. 287–288, pp. 289–290, pp. 290–291, pp. 291–292 this issue.

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Dangerous severe personality disorder: from notion to law†

The Government's legislative proposals on dangerous severe personality disorder (DSPD) are set out in its comprehensive White Paper on mental health law reform, published last year (Department of Health & Home Office, 2000). It includes ambitious plans for the piloting of an entirely new service for the assessment and treatment of DSPD. Whether there will be any positive effect on public safety that is either measurable or confidently attributable to the proposed law may never be known.

Under the unashamed banner of public protection, Part II of the White Paper sets out the arrangements for those who are said to be DSPD (a term now used as both noun and adjective). In the Government's brave new world any citizen with, or suspected of being, DSPD will be liable to indefinite incarceration through a care and treatment order imposed by a mental health review tribunal (MHRT) or a court. Suspected cases can be self-referred or recommended for preliminary examination by a carer, general practitioner, criminal justice agency (police, probation, courts or prison service) or under a special power of the Home Secretary.

The arrangements will be a modification of those for the compulsory assessment and treatment of patients with other types of mental disorder. Preliminary examination will be followed by a 'DSPD screening assessment' carried out by a small specialist team in a 'suitable regional NHS secure facility'. If there is sufficient evidence of DSPD the patient will be transferred to a designated specialist centre for 'intensive assessment' carried out over 3 months. A MHRT will then authorise detention for specialist care and treatment, again in a specialist facility. Confirmed cases of DSPD must be detained for treatment but discharge from detention depends on a test of public safety rather than responsiveness to treatment.

Cutting through all the White Paper's promises of resources, service developments, training, standard setting and evaluation, psychiatrists will identify three consequences of this legislation. First, the law will permit lifelong detention in hospital of people facing no criminal charges but whose alleged type of personality disorder places them at risk of dangerous offending in the future. Second, the only means of extending the incarceration of a dangerous prisoner with alleged personality disorder beyond the maximum imposed by the sentencing judge will be by detention in a hospital under mental health law. Third, psychiatrists, particularly forensic psychiatrists, will have crucial roles in carrying out the assessments; advising the new MHRTs; and contributing to treatment. It may be possible for them to sidestep the new role of clinical supervisor but that role, at least for DSPD patients, will essentially be titular: crucial decisions will be taken elsewhere.

The reforms will not apply in the two parts of the UK with the highest homicide rates, Scotland and Northern Ireland. Indeed, the Scottish Executive, which has sole legislative power on this matter north of the border, has recently published its White Paper (Scottish Executive, 2001) on serious violent and sexual offenders. Legislation will be based on the findings of the MacLean Committee (Scottish Executive, 2000) and include special sentencing procedures for all serious offenders, including those with any type of mental disorder, based on a comprehensive assessment of risk rather than on possession of any particular type, or putative type, of psychiatric condition. DSPD legislation has no power whatsoever over those who are dangerous, for example as a consequence of alcohol or other substance misuse, but who do not have personality disorders.

Will forensic psychiatrists cooperate in sufficient numbers to make it all work? Haddock *et al* (2001, this issue) surveyed consultants and senior trainees in forensic psychiatry after publication of the DSPD consultation paper (Home Office & Department of Health, 1999), but before that of the White Paper. Only one in three doctors think that severe personality disorder is an identifiably distinct condition, and 82% of respondents consider that current risk assessment procedures are unsatisfactory for diagnostic purposes. Less than one in five respondents

†See pp. 293–296, this issue.

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