medications suggesting a lack of consumer engagement and dissatisfaction with the treatments offered. The influence of all of these factors is magnified in the case of young people early in their experience of psychotic illness. Finally, the arbitrary threshold of sustained positive symptoms may be an imperfect guide to the timing of antipsychotic medication use in every patient. Some people with subthreshold psychosis (or attenuated psychotic symptoms) may fail to respond to psychosocial treatments as first line and prove to benefit from antipsychotic medications, while a subset of patients with first-episode psychosis with short durations of illness may not require antipsychotic medication. Our research and that of other groups has indicated that antipsychotic medications are not needed as first-line therapy in subthreshold psychosis. We are also attempting to clarify the timing and need for antipsychotic medication in first-episode psychosis by conducting a randomised controlled trial investigating whether intensive psychosocial treatment is sufficient for recovery in a selected low-risk subgroup. It is possible that the results of this study will support a staged approach to the treatment of first-episode psychosis such that medications with significant side-effects are reserved for cases where safer treatments have not led to full remission and recovery. The study will also provide important information about structural brain changes in psychosis and the contribution of antipsychotic medication to these changes. The results of this randomised controlled trial will enhance available information about the risk and benefits of treatments for psychosis and thus improve the capacity of clinicians to support informed decision-making by consumers about their treatment.

1 Morrison AP, Hutton P, Shiers D, Turkington D. Antipsychotics: is it time to introduce patient choice? *Br J Psychiatry* 2012; **201**: 83–4.

2 Francey SM, Nelson B, Thompson A, Parker AG, Kerr M, Macneil C, et al. Who needs antipsychotic medication in the earliest stages of psychosis? A reconsideration of the benefits, risks, neurobiology and ethic in the era of early intervention. *Schizophr Res* 2010; **19**: 1–10.

3 McGorry PD. Issues for DSM-V: clinical staging: a heuristic pathway to valid nosology and safer, more effective treatment in psychiatry. *Am J Psychiatry* 2007; **164**: 859–60.

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The excellent editorial by Morrison *et al*[1] strongly makes the case to shift current practice away from one in which service users are told that medication works and that they really must take it, towards one in which service users are presented with an accurate representation of the costs and benefits of antipsychotic medication and supported to make informed decisions about whether or not, for them, this is a option that appeals. This raises a very important challenge. How do we translate the information from this review of meta-analyses and double randomised controlled trials into something that will change the practice of front-line healthcare staff and be of direct use to service users? I am aware that despite similar conclusions being drawn with respect to antidepressant use for mild depression over 10 years ago[2] and even changes to National Institute for Health and Clinical Excellence guidelines about prescribing,[3] this has not led to a reduction in prescriptions of these drugs and I doubt very much they are now prescribed along with an accurate summary of exactly how much clinical benefit one can expect to see as a result of taking them. This is a plea that this excellent analysis is followed up by a strategy to ensure it has a direct impact on clinical practice as soon as possible.

1 Morrison AP, Hutton P, Shiers D, Turkington D. Antipsychotics: is it time to introduce patient choice? *Br J Psychiatry* 2012; **201**: 83–4.

2 Kirsch I, Moore TJ, Scoboria A, Nicholls SS. The emperor's new drugs: an analysis of antidepressant medication data submitted to the U.S. Food and Drug Administration. *Prev Treat* 2002; **5**: Article 23.

3 National Institute for Health and Clinical Excellence. *Depression: The Treatment and Management of Depression in Adults (Update)* (Clinical Guideline CG90). NICE, 2009.

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Authors' reply: We have been pleasantly surprised by the positive tone of the responses to our editorial, as we had envisaged that it would attract criticism as well as support. However, this support has been very welcome, and we have been particularly impressed by the number of eloquent and authoritative responses from service users.

As Callard points out, the ability of service users to have a voice in academic and clinical journals is often missing, and the publication of several letters from service users in the *British Journal of Psychiatry* represents an important step in the right direction. We share her regret that the voice of service users, who have for years been making similar arguments to those in our editorial, but from a position of lived experience rather than scientific research, is often unheard or viewed as less legitimate. Jones, as one such service user voice, draws our attention to the often negative subjective effects that accompany antipsychotic medication, which is another important factor to consider in the cost–benefit profile. She shares experiences of service users being discharged from services if they choose not to take medication, which is a situation we have encountered many times, especially in recruiting for our recent clinical trial; this is clearly not to the benefit of anyone, and is only likely to result in crises that could have been avoided by a more collaborative approach to service provision. She also notes the lack of opportunities for guided discontinuation of antipsychotics; hopefully this is a situation that will change, given encouraging evidence from clinical trials that demonstrate that at least a proportion of people can be successful in their choices to discontinue medication.[1]

Campbell-Taylor provides a compelling argument in support of autonomy and the importance of the ability to make decisions about our life, regardless of whether others agree with those decisions or not; we would agree that service users should have the right to make such choices as long as there is no immediate risk of significant harm to self or others. However, even in such difficult circumstances, there may be other ways to manage risk, including alternative pharmacological approaches such as the use of benzodiazepines in order to reduce arousal, which can still accommodate peoples' wishes and respect their autonomy.

Simmons suggests shared decision-making as a way forward in the promotion of choice, and we would agree that this approach has great potential to enhance the involvement of service users in decisions about their care. However, we would also suggest a note of caution, as there may be risks if this is delivered in isolation from the system that service users have to negotiate, given that the wider cultural context within services may discourage autonomy and involve coercion; indeed, as Hamann and colleagues reported,[2] service users who received the shared

decision-making intervention 'were perceived as more "difficult" by their psychiatrists'. Thus, interventions should also aim to change the wider service context.

Francey *et al* discuss the relevance of a staging approach to the issues of choice regarding antipsychotics, which may certainly influence the relative cost–benefit profiles for service users at a particular phase of their mental health problems. However, we consider the issue of informed choice to be important regardless of whether it is an early phase or a more long-term condition. They also discuss their innovative clinical trial, which is a welcome development that will undoubtedly inform the evidence base regarding the possible costs and benefits of alternatives in comparison with antipsychotic medication, especially in first-episode psychosis, which is sorely needed.[3]

Finally, Lobban asks for a strategy for translating the emerging evidence into changes to routine practice, which we can only endorse. It can be hoped that the increasing influence of recommendations such as those contained in the National Institute for Health and Clinical Excellence guidelines,[4] in combination with an associated programme of audit and incentives to perform in accordance with them, will promote such collaborative evidence-based practice. Similarly, we would hope that widespread provision of such information for service users and carers will help them in demanding change and ushering in genuinely collaborative care that embraces patient choice.

1 Wunderink L, Nienhuis FJ, Sytema S, Slooff CJ, Knegtering R, Wiersma D. Guided discontinuation versus maintenance treatment in remitted first-episode psychosis: relapse rates and functional outcome. *J Clin Psychiatry* 2007; **68**: 654–61.

2 Hamann J, Mendel R, Meier A, Asani F, Pausch E, Leucht S, et al. How to speak to your psychiatrist: shared decision-making training for inpatients with schizophrenia. *Psychiatr Serv* 2011; **62**: 1218–21.

3 Bola JR, Kao DT, Soydan H. Antipsychotic medication for early-episode schizophrenia. *Schizophr Bull* 2012; **38**: 23–5.

4 National Institute for Health and Clinical Excellence. *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. NICE, 2009.

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