

conflict and lead to greater knowledge, adherence and satisfaction, whatever the chosen treatment option may be.

Decision-making tools called decision aids (usually online or paper-based tools) can facilitate shared decision-making. A systematic review of decision aids across all health areas found that they: increase patients' knowledge of treatment options; give patients more realistic expectations about the potential risks and benefits of these treatment options; help patients to make a decision that is more in line with their personal values and to be more involved in the decision-making process.<sup>3</sup>

There has been a growing interest in shared decision-making for mental disorders.<sup>4</sup> Shared decision-making interventions, usually involving decision aids, for treatment decision-making in areas of mental health have shown promising preliminary results and include one study for adult in-patients diagnosed with schizophrenia faced with a decision about treatment with anti-psychotic medication.<sup>5</sup> The shared decision-making intervention was feasible for this population and significantly increased patients' knowledge about schizophrenia, uptake of psychoeducation and feelings of involvement in consultations, without increasing consultation time.

In areas where there is uncertainty or ambiguity in the available evidence for treatment options, it is imperative to inform patients of the potential risks and benefits and support them to explore their preferences and values around these outcomes. Shared decision-making is one way in which to do this and is well suited to the provision of antipsychotic medication for psychotic (and other) disorders.

- 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 Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Soc Sci Med* 1999; **49**: 651–61.
- 3 Stacey D, Bennett CL, Barry MJ, Col NF, Eden KB, Holmes-Rovner M, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2011; **10**: CD001431.
- 4 Simmons M, Hetrick S, Jorm A. Shared decision-making: benefits, barriers and current opportunities for application. *Australas Psychiatry* 2010; **18**: 394–7.
- 5 Hamann J, Langer B, Winkler V, Busch R, Cohen R, Leucht S, et al. Shared decision making for in-patients with schizophrenia. *Acta Psychiatr Scand* 2006; **114**: 265–73.

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doi: 10.1192/bjp.201.6.492b

In any other branch of medicine today, the question 'Is it time to introduce patient choice?' would sound absurd: the only appropriate answer would be an incredulous, 'Has this not happened already?' For a significant number of readers of the *British Journal of Psychiatry*, this question in relation to the matter of antipsychotics is likely, in contrast, to be provocative and controversial. That this is the case shows just how far there is to travel before discrimination on the grounds of mental ill health can be said to have been extinguished.

I welcome the publication of the important editorial by Morrison *et al*,<sup>1</sup> which makes clear the extensive levels of coercion surrounding antipsychotic medication for people with diagnoses of psychosis. (Let us recall that the UN Convention on the Rights of Persons with Disabilities 'require[s] health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent'.)

The authors provide strong arguments and evidence with which to counter the 'prevailing opinion that all service users with psychosis require antipsychotic medication in order to recover'.

What is notable is how the editorial reprises arguments that writers from the service user and survivor movement have been making for some decades. For example, Morrison and colleagues argue in their editorial that 'some decisions to refuse or discontinue antipsychotic medication may represent a rational informed choice rather than an irrational decision due to lack of insight or symptoms of suspiciousness';<sup>1</sup> Judi Chamberlin, one of the leading American activists in the psychiatric survivors movement, reflected in 1998 on 25 years of activism in the consumer/survivor movement, and wrote, 'A patient who refuses psychiatric drugs may have very good reasons – the risk of tardive dyskinesia [...] or the experience of too many undesirable negative effects. But professionals often assume that we are expressing a symbolic rebellion of some sort when we try to give a straightforward explanation of what we want and what we do not want'.<sup>2</sup> (See also writings documented by the Survivors History Group, available at: <http://studymore.org.uk/mpu.htm>.)

The growing convergence between service user/survivor perspectives and those of parts of the mental health establishment on issues of such critical importance to many mental health service users' lives is to be celebrated. At the same time, it is important to keep in view the uneven ways in which arguments and evidence originating from different sources are treated and weighed. This will allow us better to understand why service users' writings are not as frequently referenced – even as they are central to the arguments being made – in mainstream mental health publications.

- 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 Chamberlin J. Confessions of a noncompliant patient. *J Psychosoc Nurs Mental Health Serv* 1998; **36**: 49–52.

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doi: 10.1192/bjp.201.6.493

The editorial by Morrison *et al*<sup>1</sup> is timely in suggesting we should re-evaluate the way in which antipsychotic medication is used in the treatment of psychosis, particularly for those very early in the course of illness. Since the beginning of the early psychosis reform period, we have consistently advocated for low-dose anti-psychotic treatment of first-episode psychosis complemented with comprehensive psychosocial care. More recently we have argued<sup>2</sup> that the success of early detection efforts means that young people are being seen much earlier in the development of their symptoms, and this alters the risk–benefit ratio associated with treatments. As proposed by the clinical staging model,<sup>3</sup> there is a strong rationale for beginning treatment with more benign, but evidence-based psychological approaches and reserving pharmacological agents, which despite their efficacy, can have significant adverse effects for (psychological) treatment-resistant cases. Treatment should be proportional to severity and need. Factors that support the call for change in the use of antipsychotic medications include the well-documented metabolic side-effects of most antipsychotic medications, the possibility that some of the structural brain changes seen in psychosis may actually be produced by antipsychotic medications (although the significance of these changes in relation to course and outcome is still unclear), and the widespread non-adherence to prescribed antipsychotic