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.[3]

There has been a growing interest in shared decision-making for mental disorders.[4] 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 antipsychotic medication.[5] 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.

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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*,[1] 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';[1] 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'.[2] (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.

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The editorial by Morrison *et al*[1] 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 antipsychotic treatment of first-episode psychosis complemented with comprehensive psychosocial care. More recently we have argued[2] 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,[3] 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

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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.

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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.

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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