the columns

correspondence

Antipsychotics preferred by mental health professionals

Bleakley *et al* (*Psychiatric Bulletin*, March 2007, **31**, 94–96) reported a survey of professional opinion (including 65 doctors) from the Maudsley NHS Foundation Trust on antipsychotic medication. They found that aripiprazole, olanzapine and risperidone were popular.

We undertook a similar survey (Taylor & Brown, 2007) of all College members and fellows in Scotland some 18 months earlier. Coincidentally our paper was with the editorial staff of the *Bulletin* shortly before Bleakley *et al* commenced their survey. In our survey 544 psychiatrists from all specialties replied, representing 59% of the total in Scotland. Risperidone was clearly the preferred antipsychotic (29% of the total 'vote'), and it may be worth noting that risperidone is due to come off patent soon. Our study also was undertaken only 6 months after the UK launch of aripiprazole, possibly confounding views on that medication. We also collected opinions on electroconvulsive therapy and treatment preferences for depression, with some surprising results.

Collective expert opinion can be an interesting form of evidence, complementing experimental data. However, it is time sensitive and dependent on the population surveyed.

TAYLOR, M. & BROWN, T. (2007) "Do unto others as . . ." Which treatments do psychiatrists prefer? Results from a national survey. *Scottish Medical Journal*, **52**, 17–19.

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I was surprised by the results of the recent study about which antipsychotics mental health professionals would take themselves (*Psychiatric Bulletin*, **31**, 94–96). I was particularly surprised about the popularity of aripiprazole (18.6%) and quetiapine (11.2%), because this is in sharp contrast to recent results suggesting that these are likely to be less effective than olanzapine, risperidone and amisulpride when outcome measures other than Positive and Negative Syndrome Scales (PANSS) scores are applied. This is true for in-patient (McCue *et al*, 2006) and outpatient settings (Lieberman *et al*, 2005; El-Sayeh *et al*, 2006; Haddad & Dursun, 2006; Jones *et al*, 2006).

Despite this emerging evidence, amisulpride was only preferred by 1.1% and clozapine by 6.9%. It was particularly disconcerting that aripiprazole was preferred by 18.6%, although most people admitted that they had hardly any experience with this drug. It is possible that aripiprazole is seen as being relatively free of side-effects because professionals have not accumulated any experience with the drug and that they are responding to undue influence from pharmaceutical representatives. The study certainly throws up the question why major research results either do not filter through or are not being considered, despite very little evidence with certain drugs. Results from independently funded studies should be disseminated to all colleagues. This may have to be facilitated locally by academic psychiatrists or postgraduate education programmes.

EL-SAYEH, H. G., MORGANTI, C. & ADAMS, C. E. (2006) Aripiprazole for schizophrenia: systematic review. *British Journal of Psychiatry*, **189**, 102–108.

HADDAD, P. & DURSUN, S. M. (2006) Selecting antipsychotics in schizophrenia: lessons from CATIE. *Journal of Psychopharmacology*, **20**, 332–334.

JONES, P. B., BARNES, T. R., DAVIES, L., *et al* (2006) Randomised control trial of the effect of quality of life of second versus first generation antipsychotic drugs in schizophrenia: cost utility of the latest antipsychotic drugs in schizophrenia study. *Archives of General Psychiatry*, **63**, 1079–1087.

LIEBERMAN, J., STROUP, T. S., McEVOY, J. P., *et al* (2005) Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine*, **353**, 1209–1223.

McCUE, R. E., WAHEED, R., URCUYO, L., *et al* (2006) Comparative effectiveness of second-generation antipsychotics and haloperidol in acute schizophrenia. *British Journal of Psychiatry*, **189**, 433–440.

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Transitional services for neurodevelopmental disorders

As Verity & Coates (*Psychiatric Bulletin*, March 2007, **31**, 99–100), our service also recognised that there was little specialised provision for young people with attention-deficit hyperactivity disorder (ADHD) beyond the upper age limit of child and adolescent mental health services (CAMHS), but also recognised a need for young people with autistic-spectrum disorders.

A neurodevelopmental disorders clinic has been funded to extend the upper age limit of the local CAMHS by a year, giving the young person an additional year to consider a trial without medication. The young person and their family are helped to access voluntary and statutory agencies for support, educational, vocational and leisure opportunities, and housing and financial aid.

Our service also has limitations, with no additional nursing, social work or psychology input. The greatest limitation is the lack of adult services. Of the seven young people seen in 2006, only one met the criteria for referral to adult services. One young person was able to reduce and stop medication successfully. For one young person, the general practitioner agreed to take over prescribing and monitoring. For the others, there are no appropriate adult services except in the private sector. There is currently no tertiary service for adults with ADHD locally and those with autistic-spectrum disorders are considered too able for learning disability services.

Although it has been recognised that adolescents with mental health problems have been poorly served (Singh *et al*, 2005), and there has been development in services for early psychosis and transitional arrangements between CAMHS and adult services, the group of young people with neurodevelopmental disorders has been forgotten.

SINGH, S. P., EVANS, N., SIRELING, L., *et al* (2005) Mind the gap: the interface between child and adult mental health services. *Psychiatric Bulletin*, **29**, 292–294.

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