the columns

correspondence

Dominance of second-generation antipsychotics – time for reflection?

Bleakley *et al* (*Psychiatric Bulletin*, March 2007, **31**, 94–96) address an interesting and relevant question regarding which antipsychotics healthcare professionals would choose for themselves. It is reassuring that their choices are broadly in keeping with the medications that they give their patients.

What is striking is the overwhelming preference for second-generation antipsychotics. The authors cite this preference as support for the widespread use of these drugs and state that risperidone and olanzapine have advantages in effectiveness over conventional antipsychotics. The evidence base for this is not as clear as it once appeared. Three recent, large, independent trials have not found superior effectiveness for second-generation antipsychotics (although they did not consider aripiprazole) and have failed to show an advantage in terms of quality of life or patient preference compared with conventional antipsychotics (Rosenheck *et al*, 2003; Lieberman *et al*, 2005; Jones *et al*, 2006).

How then do we explain the enthusiasm for these medicines among healthcare professionals? It is perhaps worth considering that although some of the side-effects of typical antipsychotics are rapid (e.g. extrapyramidal symptoms), the side-effects of the second-generation atypical antipsychotics (e.g. metabolic syndrome) may be delayed, and this may reduce their impact on health professionals. Other possible explanations include clinical optimism for new treatments, greater familiarity with second-generation antipsychotics, delayed dissemination of new evidence and effective marketing of these drugs.

It is no longer the case that the literature overwhelmingly supports the use of atypical over conventional antipsychotics. Perhaps it is time to revisit the evidence and debate current practice.

Declaration of interest. B.U. has received hospitality from all major drug companies involved in the manufacture of antipsychotics.

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Bed numbers and acute in-patient care

I am pleased that Mat Kinton has given some views on bed numbers as a limitation to acute in-patient care (*Psychiatric Bulletin*, February 2007, **31**, 76) as it provides an opportunity to extend the debate further.

To my mind arguing that 'improvement may be reliant upon a much more fundamental question of resources: beds for the patients' is an unjustified oversimplification. Of course it is highly unsatisfactory when over-occupancy does occur but as Mat himself acknowledges this is not a universal experience. The 2004 survey of acute care (Sainsbury Centre for Mental Health, 2004) found a range of regional average bed occupancy rates of 91–109%. Furthermore, overall rates of admission are falling (Glover *et al*, 2006) and figures from the Department of Health (http://www.performance.doh.gov.uk/hospitalactivity) suggest that this is reflected in falling national bed occupancy rates (from 91.4% in 2002–2003 to 85.6% in 2005–2006).

As the situation is not homogenous, there will be places where bed numbers are unsatisfactory, and there, local action might be needed to correct shortcomings, but arguing simply for more resources for more beds detracts from the need to look in detail at what the shortcomings might be. Mat acknowledges that improvement of patient services requires a multi-agency approach; surely that includes close attention to reasons for delayed discharge, the background to admissions of uncertain purpose, process delays and cumbersome interprofessional practices and power relationships.

Glover *et al* (2006) highlight the influence that home treatment/crisis resolution teams can have upon bed use, and that as this is a delayed effect, the mechanism is likely to be complex. Besides (or perhaps instead of) complaining once again about inadequate resources, perhaps we should also continue to question whether those resources we have are being used as well as they might. In the case of acute psychiatric in-patient beds this might include critical reappraisal of how clearly the purpose of an admission is articulated, how readily discharge can happen when it is due, how successfully communications between in-patient and community teams support care planning, and so on. Merely highlighting bed shortages oversimplifies and detracts from more relevant but possibly more complex and challenging aspects of the very necessary agenda to improve acute in-patient care.

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Sexual dysfunction among patients of south-east Asian origin

As psychiatrists, we do not ask often enough about sexual symptoms, for fear of embarrassment, a perceived lack of importance or sensitivity (Abbasian, 2002). Among patients from a south-east Asian background who are unable to speak English, eliciting symptoms can be