Relative propensity for EPS was originally the primary factor behind typical/atypical classification. Clozapine has long been known as an atypical antipsychotic on the basis of its inability to cause EPS and its failure in animal-based antipsychotic screening tests. Its re-marketing in 1990 signalled the beginning of a mass of introductions of other drugs claimed, with varying degrees of accuracy, also to be atypical. Of these, perhaps only clozapine and quetiapine are 'fully' atypical, seemingly having no propensity whatever for EPS. Others show dose-related effects, although therapeutic activity can usually be gained without EPS. This is perhaps the real distinction between typical and atypical drugs: the ease with which a dose can be chosen (within the licensed dosage range) which is effective but which does not cause EPS (compare haloperidol with olanzapine).

The typical/atypical dichotomy does not lend itself well to classification of antipsychotics in the middle ground of EPS propensity. Thioridazine was widely described as atypical in the 1980s but is a 'conventional' phenothiazine. Sulpiride was marketed as an atypical but is often classified as typical. Risperidone, at its maximum dose of 16 mg/day (10 mg in the US) is just about as 'typical' as a drug can be. Alongside these difficulties is the fact that there is nothing either pharmacologically or chemically which clearly binds these so-called atypicals together as a group, save a general, but not universal finding, of preference for D2 receptors outside the striatum. Nor are atypicals characterised by improved efficacy over older drugs (clozapine and one or two others excepted) or the absence of hyperprolactinaemia (which is probably worse with risperidone and amisulpride than with typical drugs).

In an attempt to get round some of these problems, typicals and atypicals were re-classified as first- or second-generation antipsychotics (FGA/SGA). All drugs introduced since 1990 are classified as SGAs (i.e. all atypicals) but the new nomenclature dispenses with any connotations regarding atypically, whatever that may mean. However, the FGA/SGA classification remains problematic because neither group is defined by anything other than time of introduction – hardly the most sophisticated pharmacological classification system. Perhaps more importantly, date of introduction is often wildly distant from date of first synthesis. Clozapine is one of the oldest antipsychotics (synthesised in 1959) while olanzapine is hardly in its first flush of youth having first been patented in 1971. These two drugs are of course SGAs; apparently the most modern of antipsychotics.

In this edition of *The Guidelines* we conserve the FGA/SGA distinction more because of convention than some scientific basis. Also we feel that most people know which drugs belong to each group – it thus serves as a useful shorthand. However, it is clearly more sensible to consider the properties of *individual* antipsychotics when choosing drugs to prescribe, or in discussions with patients and carers.

Choosing an antipsychotic

The NICE guideline for medicines adherence[1] recommends that patients should be as involved as possible in decisions about the choice of medicines that are prescribed for them, and that clinicians should be aware that illness beliefs, and beliefs about medicines, influence adherence. Consistent with this general advice that covers all of healthcare, the NICE guideline for schizophrenia emphasises the importance of patient