**Psychiatric and physical assessment**

**Antipsychotic free initial assessment (aim for 7 days from onset of psychosis symptoms) with baseline investigations.**

 Delay antipsychotic medication until the diagnosis of psychosis is confirmed in collaboration with the EI Team.

Exclude organic causes.

Benzodiazepines (e.g. Diazepam 5mg TDS) can be used for sedation and behavioural control during this period and beyond this time as required.

**Disturbed behaviour**

Avoid use of antipsychotics.

Use benzodiazepines e.g. Lorazepam 0.5-1mg oral.

If rapid tranquilisation is needed refer to Trust Procedure

**After 7 days**

Choose antipsychotics following discussion of benefits and side effect profile with patient and family where possible.

If patient is an inpatient or with Intensive Service discuss prescribing decision with prescriber in EI Team prior to initiating antipsychotic.

Choose a second generation antipsychotic with low side effect profile. Start with a low dose and increase slowly.

**First line: Aripiprazole 5mg 0D (increasing to 10mg OD)** with benzodiazepines as above if needed. Note that response to Aripiprazole can be slower than with other antipsychotics.

**Assess response within 2-3 weeks**

Sooner if the patient is experiencing adverse effects. Consider use of GASS rating scale to monitor side effects.

If some response continue treatment. If no response after 2-3 weeks, increase dose or consider choosing an alternative antipsychotic with patient involved in choice.

Start with low dose and increase slowly – **Second line options** are:

Quetiapine 50mg daily increasing to 300mg daily

Risperidone 0.5mg daily increasing to 2mg OD

Amisulpride 25mg BD increasing to 200mg BD

Olanzapine 2.5 mg nocte increasing to 10mg nocte

Prescribe Olanzapine with caution.

Monitor weight at baseline and at least three-monthly, promoting exercise and healthy diet, and checking lipids and glucose at baseline and 3-monthly.

Provide information and practical help to promote and monitor concordance.

**Re-assess after further 2-3 weeks**

Continue with effective dose; slowly increase/adjust depending on individual response.

Aim to allow sufficient time at a tolerated therapeutic dose of 4-6 weeks before switching if needed as above.

Choice of depot to be offered.

Ensure patient is receiving NICE psychosocial interventions alongside medication eg CBTp, Family Interventions.

Ensure ongoing physical health checks.

Combinations of antipsychotics should not be routinely prescribed.

**When to cease medication**

Please consider on a case-by-case basis with advice from EI Team.

After a single episode aim to gradually reduce medication after 12- 18 months of symptom remission (slowly taper over at least 3 months with close follow-up).

Multiple episodes: advise continued treatment.

Ensure appropriate monitoring in place.

**Non-adherence**

Discuss with patient and carers, analyse reason and optimise treatment. Compliance therapy.

If side effects, try alterative medication as above.

Consider trial of atypical depot medication.

Improved adherence: continue with treatment, or switch to another antipsychotic if no response.

**Clozapine**

Following inadequate response to two antipsychotics consider Clozapine in discussion with service user and family.

A multidisciplinary discussion should be held to review formulation prior to initiation.

Community initiation to be considered whenever possible.

Refer to AWP Clozapine Procedure, Med 20.