

MEDICATION GUIDELINES

1. A neuroleptic-free observation period

- If possible employ a neuroleptic-free observation period during which the diagnosis of psychosis can be confirmed and organic causes can be excluded (NEPP, 1998).
- During this time benzodiazepines (e.g. diazepam 10 to 30mg daily for agitation or lorazepam 1 mg to 2mg stat IM for behavioural control) should be used as an alternative to antipsychotic medication.

2. A preference for novel antipsychotic medication

- Currently there is no methodologically sound evidence to suggest that novel antipsychotics (excluding Clozapine) are more effective than conventional neuroleptics in treating positive and negative symptoms of psychosis in unselected first-episode psychosis populations. However, they have repeatedly been found to cause fewer side effects and thus, their use as first choice treatment is recommended to encourage compliance (Emsley et al, 1999; Ahmed et al 1996; Robinson et al 1996; Sanger et. al 1999).
- If conventional neuroleptics are used, prophylactic antiparkinson medication has been recommended to avoid adverse initial experiences with medication (NEPP, 1998). It can be ceased if not necessary. A low threshold for change to a novel neuroleptic in the presence of extrapyramidal side effects is recommended.

3. Low dose medication

- If commencing clients on conventional neuroleptics, most clients with first-episode psychosis will respond to 2-3 mg haloperidol equivalents although they may take 2 to 4 weeks to do so. Thus, titrate slowly to this dose depending on side effects. Ideally, the dose should be held at this for two to four weeks to observe the full response (McEvoy et. al. 1991; Wong et. al., 1996; Kapur et. al., 1996)
- If the response is inadequate, a cautious increase in dose if tolerated may be appropriate. However, there appears no response advantage in exceeding doses of 6mg haloperidol equivalents and doses above this are likely to cause unpleasant side effects and potential non-compliance (Remington et al., 1998).
- If Risperidone is chosen as first-line therapy, doses of 2mg to 4mg should be adequate in most cases (Kopala, 1997; Kopala et. al., 1997; McGorry, 1999). Recommendations suggest a slow titration from 0.5mg daily to avoid side effects (NEPP, 1998). Extrapyramidal side effects at doses over 2mg daily are common (McGorry, 1999). Thus, after doses of 2mg daily sufficient time needs to be given to observe the response. Increments at intervals of 1 mg every one to two weeks have been suggested (Kopala, 1997; NEPP, 1998).
- When using other novel neuroleptics, at the moment there is insufficient data to recommend other than standard doses in first episode psychosis (Sanger et. al., 1999).
- Behavioural control can be obtained by the continued use of benzodiazepines, thus avoiding potential disengagement from treatment due to extrapyramidal side effects caused by high doses antipsychotics. Polypharmacy with antipsychotic medication should also, therefore, be avoided.

4. Dealing with mood disorder

- In most cases depressed mood will resolve with the psychosis (Koreen et. al., 1993). Antidepressants can therefore be reserved for cases where depression clearly precedes the psychosis or fails to resolve in proportion to the psychotic symptoms (NEPP, 1998). A mood

stabiliser would be appropriate in the presence of a full affective syndrome (NEPPI 1998).

5. Aiming for remission

- With sufficiently assertive treatment the vast majority of clients with first episode psychosis remit (Lieberman et. al., 1993). Thus, remission of, not adjustment to, symptoms should be the aim.

6. Timely reviews of inadequate response

- Failure of symptoms to adequately respond to six weeks of initial treatment with maximum tolerated doses within the limits detailed above needs prompt action. For example, review the diagnosis (e.g. for unsuspected mania, depression or organic factors), consider lack of compliance or concurrent substance misuse. If none of these account for the lack of response, change neuroleptics, preferably to a novel antipsychotic (Bech et. al., 1998; Remington and Chong, 1999; Bebbington, 2000; Kennedy et. al., 2000).
- If positive symptoms fail to adequately respond to two adequate (i.e. six weeks) trials neuroleptics (one being atypical) review as above. Clozapine can then be considered.
- If positive symptoms fail to remit after six months of interventions with at least two classes of neuroleptic and ongoing psychosocial interventions, indications for Clozapine are strong. (Tohen et. al., 1992; Szymanski et. al., 1996; Edwards et. al., 1998).
- The presence of moderate negative symptoms at six months needs prompt action. For example, review and treat for unsuspected depression, consider a reduction in neuroleptic dose if positive symptoms are well controlled or change to a novel antipsychotic. (Szymanski et. al., 1996).

7. Maintenance medication

- Current guidelines suggest ceasing medication after 1 to 2 years of remission in those who ultimately meet criteria for schizophrenia (Working Group for the Canadian Psychiatric Association and the Canadian Alliance for Research on Schizophrenia, 1998; Kissing 1991). However, these recommendations are likely to change to lengthier treatment of 2 to 5 years (Robinson et. al., 1999; Zipursky, 2000). Some such clients may need medication for lesser periods although they are difficult to identify but are unlikely to be people with durations of untreated psychosis over one year. (Crow et. Al., 1985)