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CLEAR
CLOZAPINE IN EARLY PSYCHOSIS

CLOZAPINE IN EARLY PSYCHOSIS (CLEAR): A MULTI-CENTRE, OBSERVATIONAL STUDY OF CLOZAPINE FOR YOUNG PEOPLE WITH TREATMENT RESISTANT PSYCHOSIS IN REAL WORLD SETTINGS

Protocol (Version 10.0 05/12/25)

Study Identifiers

EudraCT Number:	2021-006248-28
IRAS Number:	1004947
REC Number	22/LO/0723

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1. Study Synopsis

Title	CLOZAPINE IN EARLY PSYCHOSIS (CLEAR): A MULTI-CENTRE, OBSERVATIONAL STUDY OF CLOZAPINE FOR YOUNG PEOPLE WITH TREATMENT RESISTANT PSYCHOSIS IN REAL WORLD SETTINGS
Protocol Short Title/Acronym	CLEAR
Trial Phase	Phase IV
Co-Sponsors name	King's College London South London and Maudsley NHS Foundation Trust
Chief Investigator	Professor James MacCabe
EudraCT number	2021-006248-28
IRAS number	1004947
Medical condition or disease under investigation	Treatment-resistant psychosis
Purpose of study	The study will assess whether clozapine is more effective than treatment as usual (TAU, i.e. standard antipsychotics) in people < 25 years old, at the level of clinical symptoms, patient rated outcomes, quality of life and cost effectiveness.
Primary objective	To compare the change in total PANSS score at 12 weeks relative to baseline between patients treated with clozapine and TAU.
Secondary objectives	a) To compare clozapine treatment to TAU to test the following hypotheses: i. Clozapine is associated with greater functional improvement, greater self-assessed improvement, better quality of life, better medication adherence and reduced service use. ii. Clozapine is associated with more severe adverse effects. iii. Clozapine is associated with better patient rated outcomes.

	iv. Clozapine is cost-effective compared with TAU when clinical effectiveness, quality of life, and costs of service use are combined. b) To evaluate the effectiveness of a decision support intervention for personal legal representatives through a randomised Study Within a Trial (SWAT). c) To evaluate patient attitudes to clozapine. d) To understand the treatment decisions of patients with respect to clozapine versus treatment as usual.
Study design	Multi-centre, rater-blinded, observational study.
Endpoints	Change in total PANSS score after 12 weeks, relative to baseline.
Sample size	50 patients with treatment-resistant psychosis < 25 years old.
Summary of eligibility criteria	<u>Inclusion Criteria:</u> i. Age ≥12 and <25 years at baseline. ii. Meets criteria for schizophrenia or related disorder, in the range in the range ICD-10v2016 F20.x, F22.x-F29.x iii. Meets NICE criteria for treatment resistance, defined as: a. Previous trials of at least two different antipsychotic drugs with adequate adherence (estimated <20% missed doses) – both treatment trials to exceed 4 weeks at adequate doses (within the dose range given in the British National Formulary and the British National Formulary for children) b. At least 1 of these trials must be with a second-generation drug. iv. Positive and Negative Syndrome Scale (PANSS) total ≥70, at least 2 items >4 v. Clinician Rating Scale [24] (CRS) ≥3 vi. Capacity to give informed consent OR has a legal representative able to give consent to the study.

	<u>Exclusion Criteria:</u> i. Psychosis predominantly caused by substance misuse. ii. Pregnancy. iii. Breastfeeding. iv. Women of child-bearing potential (WOCBP*) not using at least acceptable methods of contraception** during the study (see 6.1 for definitions) v. Previous adequate trial of clozapine. vi. CNS disorders (ICD-10 G00-26; G40-41, G45-46; G80-94, G97). vii. Concurrent medications with documented interactions with antipsychotics. viii. Participation in a clinical trial involving any unlicensed investigational medical product within the last 3 months. ix. Positive test for COVID-19 within the past 10 days. x. Current Electroconvulsive Therapy (ECT)
IMP, dosage and route of administration	Clozapine, as per BNF guidance, oral.
Active comparator product(s)	Treatment as usual is any other antipsychotic, oral.
Duration of treatment of a participant	12 weeks (treatment can be continued after end of study upon clinical teams' choice)
Version and date of protocol amendments	2.0 01/12/2022 3.0 01/03/2023 4.0 01/08/2023 5.0 19/02/2024 6.0 27/08/2024 7.0 12/03/2025 8.0 19/05/2025 9.0 14/07/2025 10.0 05/12/2025

2. Glossary of Terms

AE	Adverse Event
AR	Adverse Reaction
CA	Competent Authority
CGI-S	Clinical Global Impression – Severity
CGI-I	Clinical Global Impression – Improvement
CI	Chief Investigator
CRF	Case Report Form
CRS	Clinician Rating Scale
CRO	Contract Research Organisation
CTA	Clinical Trial Authorisation
CTIMP	Clinical Trial of Investigational Medicinal Product
CTU	Clinical Trials Unit
DAI-10	Drug Attitude Inventory – 10 items
DMC	Data Monitoring Committee
DSUR	Development Safety Update Report
EC	European Commission
EI-AD-SUS	Early Intervention Adult Service Use Schedule
EMEA	European Medicines Agency
EQ-5D-Y	Youth version of the EQ-5D-3L
EU	European Union
EUCTD	European Clinical Trials Directive
EudraCT	European Clinical Trials Database
GASS-C	Glasgow Antipsychotic Side-effects Scale for Clozapine
GCP	Good Clinical Practice
GMP	Good Manufacturing Practice
GSH	Glutathione
IB	Investigator Brochure
ICF	Informed Consent Form
IL	Interleukin
IMP	Investigational Medicinal Product
IMPD	Investigational Medicinal Product Dossier
ISF	Investigator Site File (This forms part of the TMF)
ISRCTN	International Standard Randomised Controlled Trials Number
MA	Marketing Authorisation
MHRA	Medicines and Healthcare products Regulatory Agency
NIMP	Non-Investigational Medicinal Product
PI	Principal Investigator
PIC	Participant Identification Centre
PIS	Participant Information Sheet
QA	Quality Assurance
QC	Quality Control
QP	Qualified Person
PANSS	Positive and Negative Syndrome Scale
RA	Research Assistant
rCBF	Regional Cerebral Blood Flow
REC	Research Ethics Committee
ReQoL-10	Recovering Quality of Life Questionnaire

SAE	Serious Adverse Event
SAR	Serious Adverse Reaction
SDV	Source Data Verification
SOP	Standard Operating Procedure
SmPC	Summary of Product Characteristics
SUSAR	Suspected Unexpected Serious Adverse Reaction
SWAT	Study Within a Trial
TAU	Treatment as usual
SMF	Study Master File
SMG	Study Management Group
SSC	Study Steering Committee

3. Background & Rationale

3.1. Background

Clozapine is an antipsychotic drug with unique efficacy. It is the only recommended treatment for treatment-resistant schizophrenia (TRS: failure to respond to at least two different antipsychotic drugs). In addition, it is the most effective of all antipsychotics in reducing hospital use, suicide, aggressive behaviour, violent crime, and substance misuse. However, it is also associated with a range of adverse effects which restrict its use, including blood dyscrasias, for which patients require haematological monitoring. As treatment resistance is increasingly recognised earlier during the course of the illness, the question of whether clozapine should be prescribed in children and young people is increasingly important. However, most research to date has been in older, chronic patients, and both the NICE Guideline Development Group and James Lind Alliance have highlighted the lack of evidence about the efficacy and safety of clozapine in people under age 25. At present, most young patients with schizophrenia who meet criteria for treatment resistance are treated with standard antipsychotics, rather than the clozapine that is recommended by NICE. The study will assess whether clozapine is more effective than treatment as usual (TAU: standard antipsychotics), at the level of clinical symptoms, patient rated outcomes, quality of life and cost effectiveness. This is a multi-centre, open label, blind-rated, observational effectiveness study of clozapine vs TAU (i.e. compared with other antipsychotics), for 12 weeks in 50 children and young people with TRS (12-24 years old). We will recruit from NHS-funded secondary care, both inpatient and community settings. The primary outcome is the change in total blind-rated PANSS scores at 12 weeks from baseline. Secondary outcomes include blind-rated clinical global impression score (CGI-S), patient-rated outcomes, quality of life, adverse effects and treatment adherence. In addition, we will use questionnaires, surveys and interviews to explore patient and clinician attitudes to clozapine versus other antipsychotics, and the process of decision making between these two options.

Treatment resistant schizophrenia (TRS), defined by NICE and most other treatment guidelines as non-response to at least two different antipsychotic drugs and a course of psychological treatment [1], affects around one third of people diagnosed with schizophrenia [2]. TRS is associated with severe long-term consequences on social, educational and occupational functioning, with total treatment costs between three and eleven times that of schizophrenia that is responsive to standard treatment [3]. Treatment resistance in schizophrenia is strongly associated with age at illness onset, with onset before age 25 predicting higher risk of subsequent treatment resistance [4]. Clozapine is the only antipsychotic to have superior efficacy in TRS and is the treatment of choice in adults with TRS. This is supported by evidence from randomised controlled trials [5, 6] although some doubt has been cast

on the strength of this evidence [7]. Pharmacoepidemiological studies have demonstrated the superiority of clozapine over other antipsychotics in reducing readmission [8], violent offending [9], self-harm [10] and all cause mortality [11]. Most of the evidence for the superiority of clozapine over other antipsychotics derives from studies in chronic patients; a recent meta-analysis found the median age in trials of clozapine to be 39 years with a median length of illness of 16 years [7]. The evidence for the efficacy of clozapine in younger patients is sparse, although it suggests that clozapine is superior to other antipsychotics in people under 18 with TRS. A recent retrospective study showed that the vast majority of paediatric patients (95%) admitted with or started on clozapine during an acute psychiatric hospitalization remained on clozapine at discharge, suggesting that it was clinically effective [12]. Furthermore, a Danish cohort study on early onset schizophrenia showed that the majority of patients (88.8%) prescribed clozapine had a favourable clinical response [13]. An unpublished secondary analysis from a recent meta analysis of RCTs comparing clozapine versus other antipsychotics [6] showed an effect size of -0.61 [95%CI -1.05 to -0.17] in children versus -0.36 [95%CI -0.60 to -0.11] in adults (Dan Siskind personal communication). However this is based on a meta-analysis of data from only 85 patients in 3 small non-UK RCTs [14–16]. There is thus a clear need for larger scale studies in younger patients. Clozapine is reserved as a third line treatment because of its associated adverse effects, which are more numerous and severe than those of most other antipsychotics [17]. The most problematic is the rare but potentially fatal adverse effect of agranulocytosis [18]. In order to reduce the risk of agranulocytosis, in the UK and most other developed countries, monitoring of the patient's full blood count is mandatory in clozapine-treated patients. There is evidence that psychiatrists unfamiliar with clozapine are reluctant to prescribe it, and that blood testing in particular acts as a barrier [19]. This may particularly apply to child and adolescent psychiatrists, who rarely encounter treatment resistant psychosis. Less than 0.5% of prescriptions for clozapine are in children and adolescents, and a survey of UK psychiatrists showed that only 40% of psychiatrists working in UK CAMHS services have ever prescribed clozapine [20]. The probable superior efficacy of clozapine in younger patients has to be balanced against its potentially inferior tolerability [21]. A recent literature review concludes that the risk-benefit ratio for clozapine use in young TRS patients is unclear, and that the question can only be resolved by conducting well powered studies that simultaneously measure safety and effectiveness [22]. The NICE guidance for schizophrenia and psychosis in adults (CG-178) and children (CG-155) recommend clozapine in patients whose illness has not responded to trials of at least two antipsychotics of adequate dose and duration. Nevertheless, the NICE Guideline Development Group and the James Lind Alliance have both identified the lack of evidence surrounding this recommendation, particularly with regard to overall cost-effectiveness.

CLEAR will also contribute to the evidence-base to improve the design and conduct of future studies through embedding a Study Within A Trial (or SWAT). A SWAT is a self-contained research study that is embedded within a host trial or observational study with the aim of evaluating alternative ways of delivering or organising a particular study process [56].

Recruiting adults (over 16 years) who lack capacity into clinical research can be challenging [57]. This is due in part to the psychological stress and uncertainty that family members or close friends may experience when asked to make what can be complex and challenging decisions, with some experiencing decisional and emotional burden as a result [58]. A decision aid (DA) has been developed to help personal legal representatives of participants over the age of 16 who lack capacity to consent for themselves, to make informed decisions about participation and to reduce the decisional burden they experience [59]. The aim of the CONSULT SWAT is to evaluate the effectiveness and cost-effectiveness of the DA in approx. 5 host studies, including CLEAR [60].

Personal legal representatives involved in CONSULT will be invited to take part in an optional interview to talk about their experience, alongside interviews with members of the research teams who provided the study information and DA. Consent will be obtained by the CONSULT study team at Cardiff University prior to participation in an optional interview. Interviews and all data-analysis will be undertaken by the CONSULT study team. SWAT processes will be aligned with CLEAR to minimise any additional burden for participants, families, or researchers.

3.2. Rationale for study design

Although the gold standard in most studies is considered the randomised controlled trial, there are some patient groups in which randomisation is not practical. Having initially conceived this study as a randomised clinical trial, we found that most potential participants, who met the inclusion criteria, were not willing to be randomised as they or their prescribers had clear preference for one or other arm. Continuing to insist on randomisation would have resulted in the trial not recruiting on time and would have led to high dropout rates where participants were randomised to their non-favoured arm. Another problem we have faced is that some centres, due to operational constraints and limited bed availability, have been unable to participate in the trial as they cannot guarantee that, following randomisation, clozapine could be commenced within 2 weeks as per protocol. Following a

comprehensive review of the options with the study funder (NIHR-HTA board) we have concluded that a switch to a non-randomised design will enable the study to recruit and improve the external validity of the trial by bringing it closer to real world practice and by reducing sample selection bias. Therefore as of Version 8.0 of this protocol, we are removing the randomisation, thus switching to a non-randomised observational study, where the treatment arms will be as before, but the participants and/or their clinicians can choose between the treatment arms. This may result in unequally sized treatment groups, but our experience with recruitment thus far suggests that participants will be approximately equally split in their preferences for the two arms, and our statistical modelling shows that the power to detect a statistically significant effect is robust to substantial departures from a 1:1 ratio. We will retain the blinded ratings and are collecting the same data as previously, meaning that those already enrolled in the study can continue in the study, and their data will be included in the final analysis.

Please note as of Version 8.0 of this Protocol, the 6 and 12 month follow ups have been removed to ensure timely completion of the study within budget.

3.3. Risk and benefit evaluation

The CLEAR study will contribute to knowledge about the efficacy and safety of clozapine in young people with TRS, providing strong evidence to reinforce clinical guidance.

People with severe mental illness, especially TRS, are often not included in research studies due to the impact of their symptoms on capacity, and there is evidence of systemic exclusion from research leading to lack of strong generalisable results in TRS research. This is even more true in young people, especially <16s, whose consent to participate needs additional consideration. The CLEAR study will allow young people with TRS to participate in research and contribute to more generalisable knowledge on the best management of TRS in this population. Furthermore, the CLEAR study is designed to be as close to real-world settings as possible to reflect everyday clinical practice. This will allow to further improve the generalisability of the results and hopefully facilitate clinicians for the duration of the study. Additionally, such design will add as little burden as possible to the participants, who will be likely to be already struggling due to their illness.

Participants in both arms will be patients who are already taking antipsychotics and participation in the study will be determined by the clinical decision to switch antipsychotics due to non-response. All

antipsychotics are associated with potentially severe adverse events (SAEs). All participants will be closely monitored for adverse events, and managed by the treating clinicians. SAEs will be promptly reported to the KHP-CTO and CI. As no previous study has focused on clozapine-related adverse events in young adults, this study will be of unique importance to add evidence-based data on the safety of clozapine in young people. Participating in the CLEAR study will allow young people with TRS on antipsychotic medications to have a closer and more structured monitoring of the potential adverse events.

4. Study Objectives and Design

4.1. Study Objectives

The purpose of the study is to assess whether clozapine is more effective than treatment as usual (TAU: standard antipsychotics) in real-world settings, over a 12-week period. The primary objective is to compare the treatments on the change in total PANSS score from baseline to 12 weeks. The secondary objectives are to compare the treatments on function, side effects, quality of life, subjective improvement and cost effectiveness.

4.2. Primary endpoints

The primary endpoint of the study is the change in total PANSS score assessed after a treatment period of 12 weeks. Participants will be assessed by a centralized blinded experienced rater.

4.3. Secondary endpoints

Secondary endpoints include change in overall clinical impression (CGI) [32] by a centralised blinded rater, clinician rated level of adherence (CRS) [33], side effects (GASS-C) [34], quality of life (EQ-5D-Y) [35], and subjective experience (DAI-10) [36], psychotropic treatment, service use and readmission rate, (EI-AD-SUS) [37], and change in PANSS sub scale (positive, negative and general) [38]. We will also combine these outcomes (EQ-5D-Y and total PANSS score) with service use data (EI-AD-SUS) to compare treatments on cost effectiveness.

For the CONSULT SWAT, endpoints include the quality of decision-making by personal legal representatives, CONCORD [61], alongside qualitative data exploring family/close friends' and researchers' experiences, and the costs involved (resource use data).

4.4. Study Design

4.4.1. Treatment

Intervention: Clozapine, oral, flexible dose within dose range defined by British National Formulary (BNF); (Maximum dose = 900 mg per day), at the discretion of the prescriber, for 12 weeks. Following this, if clozapine is continued, it will no longer be classified as an investigational medicinal product.

Control: Any oralantipsychotic in TAU group ATC code – N05A (other than clozapine ATC code – N05AH02 and Lithium – N05AN), within licensed dose range defined by BNF, for 12 weeks. The choice of antipsychotic will be agreed by the clinical team in collaboration with the participant, and the dose titrated to achieve the best balance between response and adverse effects.

4.4.2. Target population

Children and young people under age 25 with treatment resistant schizophrenia as defined by NICE (CG178, Section 1.5.7.2) as having failed to respond to at least two antipsychotic treatments in adequate doses. The inclusion and exclusion criteria are specified in greater detail in 6.1.

4.4.3. Design

Multi-centre, open label, blind-rated (primary outcome), observational effectiveness study of clozapine versus treatment as usual in children and young people (<25) with treatment resistant schizophrenia.

4.5. Study Flowchart

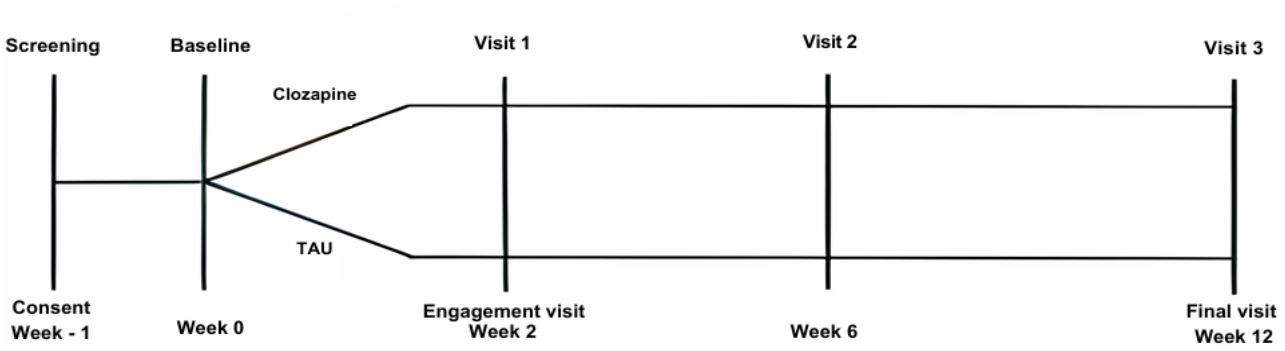


Figure 1. Study design treatment period (n=50)

	Screening visit	**Baseline visit**	***Treatment with new study drug starts***	**Visit 1**	**Visit 2**	**Visit 3** (1^ outcome)
			Day 1	week 2 (+/- 3 days)	week 6 (+/- 3 days)	week 12 (+/- 7 days)
Informed consent	x					
Inclusion/exclusion criteria review	x	x				
Sociodemographic data	x					
Medical/psychiatric history	x					
Medication use	x	x		x	x	x
Smoking status	x	x		x	x	x
Pregnancy Test		x				
Decision-making Questionnaire		x				
Interview (optional)		x				
Clozapine plasma levels (in clozapine arm only, clinicans to request)				x	x	x
Lipid, and prolactin, HbA1c and LFTs (clinicians to request)		x				x

Adverse events (spontaneous)	x	x		x	x	x
Height		x				
Weight		x		x	x	x
Primary outcome						
PANSS		x			x	x
Secondary outcomes						
CGI-S		x				
CGI-I					x	x
GASS-C		x			x	x
CRS	x	x			x	x
DAI-10		x			x	x
Switch, continue or end antipsychotic (clinical decision)						x
Economic Measures						
EQ-5D-Y		x			x	x
ReQoL-10		x			x	x
EI-AD-SUS		x			x	x
Blood sample		x				x
CONSULT SWAT*						
Randomisation	x					
CONCORD scale	x					

Table 1: Schedule of assessments
**Personal legal representatives will be approached by CLEAR Research Assistants to take part in CONSULT SWAT; randomised 1:1 ratio to receive the decision aid in addition to standard legal representative CLEAR information sheet and both groups will complete the CONCORD scale.*

5. Study Medication

5.1. Investigational Medicinal Product

All the drugs being evaluated in the study are licenced in the UK for the treatment of schizophrenia and other psychoses, so they will be prescribed and dispensed using routine NHS systems.

Both Clozapine and all medicines in the TAU comparator control arm are considered IMPs for the purposes of the study. Clozapine is a licenced treatment for treatment-resistant schizophrenia in the UK. It is recommended by NICE guidelines at all ages, including in the NICE guideline CG155 [Psychosis and schizophrenia in children and young people: recognition and management]. It is licenced for age 16 and above, and it is clinically used from 12 years old [39-44]. It is distributed by Britannia Pharmaceuticals Limited (Denzapine), Mylan (Clozaril) and Leyden Delta B.V. (Zaponex).

As this is a Type A study, with no higher risk to the participant than standard of care, and the study will use commercially available IMP with no modifications and which will be used in accordance with the SmPC, no additional labelling is required.

5.2. Dosing Regimen

Intervention: Clozapine, oral, flexible dose within dose range defined by BNF, at the discretion of the prescriber, for a minimum of 12 weeks. Clozapine has unpredictable pharmacokinetics with high heterogeneity in plasma concentration, depending on age, sex, smoking status and genetics of the liver enzymes that metabolise clozapine, especially CYP-1A2 and -2D6. It also requires titration over the first 2 weeks up to therapeutic doses to minimise postural hypotension, and the optimal balance between efficacy and adverse effects can only be achieved on an individual basis. Enforcing a fixed dose would reduce the acceptability of the study to patients and clinicians and affect recruitment.

The previously prescribed antipsychotic can be titrated down during the first 2 weeks of clozapine treatment but must be stopped within the first two weeks.

Control: Any oral antipsychotic other than clozapine, (ATC code = N05A) within licensed dose range defined by BNF, for a minimum of 12 weeks. The choice of antipsychotic will be agreed by the clinical team in collaboration with the participant, and the dose titrated to achieve the best balance between response and adverse effects. The full list of drugs available to be prescribed in the comparator arm is listed below:

- AMISULPRIDE
- ARIPIPRAZOLE
- ASENAPINE
- BENPERIDOL
- CARIPRAZINE
- CHLORPROMAZINE
- FLUPENTIXOL
- HALOPERIDOL
- LEVOMEPROMAZINE
- LOXAPINE
- LURASIDONE
- OLANZAPINE
- PALIPERIDONE
- PENFLURIDOL
- PERICYAZINE

- PIMOZIDE
- PROCHLORPERAZINE
- PROMAZINE
- QUETIAPINE
- RISPERIDONE
- TRIFLUOPERAZINE
- ZUCLOPENTHIXOL

The previously prescribed antipsychotic can be titrated down over the first 2 weeks of the study antipsychotic treatment but must be stopped within the first 2 weeks.

5.3. IMP Risks

Risks, special precautions and contra-indications to clozapine (ATC code – N05AH02) and TAU (ATC code N05A, except clozapine (N05AH02) and Lithium (N05AN) are listed in the applicable SmPCs for each drug product.

5.4. Drug Accountability

As this is a Type A study, drug accountability will be according to local pharmacy protocols. Treatments will be prescribed by the participants' psychiatrist using local prescriptions and dispensed by their local pharmacies as it is per standard care.

5.5. Storage of IMP

IMP and TAU to be stored according to the applicable SmPCs and under local pharmacy protocols.

5.6. Participant Compliance

Medication adherence will be determined by clozapine plasma level as in standard care, and via the Clinician Rating Scale (CRS) and the Drug Attitude Inventory-10 (DAI-10).

5.7. Concomitant Medication

Any concurrent medication will be permitted except where documented interaction with antipsychotics exists. A complete listing of all concomitant medication received during the treatment phase will be recorded in the eCRF and source data documents.

6. Selection and Withdrawal of Participants

6.1. Inclusion and Exclusion Criteria

Inclusion Criteria:

i. Age ≥12 and <25 years at baseline.

ii. Meets criteria for schizophrenia or related disorder, in the range ICD-10v2016 F20.x, F22.x-F29.x

iii. Meets NICE criteria for treatment resistance, defined as:

a. Previous trials of at least two different antipsychotic drugs with adequate adherence (estimated <20% missed doses) – both treatment trials to exceed 4 weeks at adequate doses (within the dose range given in the British National Formulary and the British National Formulary for children).

b. At least 1 of these trials must be with a second-generation drug.

iv. Positive and Negative Syndrome Scale (PANSS) total ≥70, at least 2 items >4

v. Clinician Rating Scale [24] (CRS) ≥3.

vi. Capacity to give informed consent OR has a legal representative able to give consent to the study.

Exclusion Criteria:

i. Psychosis predominantly caused by substance misuse.

ii. Pregnancy.

iii. Breastfeeding.

iv. Women of child-bearing potential (WOCBP*) not using at least acceptable methods of contraception** during the study

v. Previous adequate trial of clozapine.

vi. CNS disorders (ICD-10 G00-26; G40-41, G45-46; G80-94, G97).

vii. Concurrent medications with documented interactions with antipsychotics.

viii. Participation in a clinical trial involving any unlicensed investigational medical product within the last 3 months.

ix. Positive test for COVID-19 within the past 10 days.

x. Current Electroconvulsive Therapy (ECT)

** WOCBP defined as: fertile, following menarche and until becoming post-menopausal unless permanently sterile. Permanent sterilisation methods include hysterectomy, bilateral salpingectomy and bilateral oophorectomy. A postmenopausal state is defined as no menses for 12 months without an alternative medical cause.*

*** acceptable methods of contraception include:*

- *progestogen-only oral hormonal contraception, where inhibition of ovulation is not the primary mode of action*
- *male or female condom with or without spermicide ****
- *cap, diaphragm or sponge with spermicide ****

*** *A combination of male condom with either cap, diaphragm or sponge with spermicide (double barrier methods) are also considered acceptable, but not highly effective, birth control methods*

Acceptable methods are the minimum requirement. It should be noted that the requirement for 'at least acceptable methods of contraception' would include the above methods but also include all 'highly effective' methods listed below:

- *combined (estrogen and progestogen containing) hormonal*
- *contraception associated with inhibition of ovulation 1:*
    - *oral*
    - *intravaginal*
    - *transdermal*
- *progestogen-only hormonal contraception associated with inhibition of ovulation 1:*
    - *oral*
    - *injectable*
    - *implantable*
- *intrauterine device (IUD)*
- *intrauterine hormone-releasing system (IUS)*
- *bilateral tubal occlusion*
- *vasectomised partner*
- *sexual abstinence (if defined as refraining from heterosexual intercourse during the entire period of risk associated with the study treatments).*

6.2. Selection of Participants

Recruitment will focus on those recruitment sites that came under the original London hub, including London Trusts, Oxford, Cambridgeshire, Kent, West Country and others within a reasonable distance. NIHR LCRNs are involved in the recruitment process.

6.3. Consent

If a participant or their representative (family member / friend) do not speak sufficient English a translation service will be offered.

During the screening visit, the patient's capacity to consent to the study will be assessed. Overall responsibility for the taking of informed consent under GCP guidelines will rest with the local PI. They will ensure that any person delegated responsibility to participate in the informed consent process is duly authorised, trained and competent to participate according to the ethically approved protocol, principles of Good Clinical Practice (GCP) and Declaration of Helsinki. Moreover, given the particular sensitivities of assessing capacity in minors, capacity to consent will be assessed by the local psychiatrist or via video link by the study psychiatrist following GCP guidelines. If the patient lacks capacity, a legal representative will be sought. During a joint visit with the RA and the clinician, after checking understanding of the participant and clarifying any concerns, the clinician will obtain informed consent, informing the participant of their rights according to GCP.

There are three ethical aspects to this study that require further consideration:

a) Some of the participants may lack capacity to give informed consent to the study.
b) Some of the participants may be detained in hospital under the Mental Health Act, which will usually entail a requirement to stay in hospital and may also include a requirement to take treatment. It should be noted that many patients detained patients under the Mental Health Act retain the capacity to consent to research.
c) Some participants will be under 16 and thus prohibited under the Medicines for Human Use (Clinical Trials) Regulations from giving consent to participate in a CTIMP (note that despite the removal of the randomisation component, the study still meets the MHRA regulatory definition of a CTIMP and will therefore remain under the Medicines for Human Use (Clinical Trials) Regulations).

All three of these issues can be addressed by the appointment of a legal representative where potential participants lack capacity to consent to the study. Under the UK Clinical Trials Regulation No 536/2014, a relative or friend may act as personal legal representative The personal legal representative must decide whether the person lacking capacity should participate in the study on the basis of what they would have wanted had they the capacity to choose for themselves, their 'presumed will'. The legal representative will be given the opportunity to understand the objectives, risks, and inconveniences. If a participant is deemed to gain capacity during their time in the study, consent should be re-sought.

If no personal legal representative can be identified, a professional legal representative should be consulted. This may include the doctor responsible for the participant's care or a person nominated by the healthcare provider (e.g., an acute NHS trust medical consultant). Importantly, the professional legal representative must have no connection to the research being conducted.

For children under 16, a legal representative will consent on their behalf. Young adults over the age of 16 are able to consent for themselves if deemed to have capacity to understand the research and their involvement. If participants reach the age of 16 (with a legal representative e.g. parent or guardian initially signing on their behalf) whilst in the study and deemed to have capacity, consent should be re-sought. For further information please visit https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/research-involving-children/

Family members or close friends approached to act as a personal legal representative (for CLEAR participants 16 years old and over) will be given the opportunity to take part in CONSULT SWAT and randomised 1:1 ratio to receive the receive the DA in addition to the standard information sheet containing information about CLEAR compared with those who receive the standard information sheet alone. Both groups will be provided with brief information about CONSULT and asked to complete a questionnaire about their experience of making a decision. Responses from those who received the booklet and those who did not will be compared to see if it increased their knowledge and decision-making. Return of the questionnaire will indicate consent to participate in the CONSULT SWAT and for their anonymised data to be shared with the CONSULT study team at Cardiff University. Participants (i.e. CLEAR's personal legal representatives) will be given the option of providing their contact details if they are willing to be contacted about participating in an interview with the CONSULT team.

6.4.Blinding

There will be blinded members of the study team: at least two research psychiatrists, one for adult participants and the other for child participants (each with appropriate training for that age group), the Chief Investigator (Prof MacCabe) and Co-Chief Investigator (Prof Santosh). The research psychiatrists will conduct the blinded assessments where possible, but when unavailable, these will be conducted by the CI and Co-CI. All blinded raters will be blind to treatment allocation. They will not be informed which treatment the participants are taking and will not enquire about the participant's treatment or side effects. The participants will be instructed by the RA not to mention their treatment

or side effects to the research psychiatrists. The eCRF will have a blinded section containing only the participant's study ID, and the blind-rated measures which are the PANSS scores and CGI. The blinded raters will not have access to the non-blinded sections of the eCRF.

Levels of blinding are clarified in the below table:

Group or individual blinded	Information withheld	Method of blinding
Chief investigators	Treatment group	Not told of treatment group
Outcome assessors	Treatment group	Not told of treatment group
Study manager	Data split by group	No knowledge of accumulating study data split by group
Research Assistants	Data split by group	No knowledge of accumulating study data split by group
Site PIs and clinicians	Data split by group	No knowledge of accumulating study data split by group
Study statistician / Health Economist (undertaking analyses)	Group identities	Groups given numerical identifiers (e.g. A/B)
	Participant identities	Participants given numerical identifiers
Senior statistician(s) / Senior Health Economist	Treatment group assignment	Not told of treatment group
	Participant identities	Participants given numerical identifiers

6.5. Withdrawal of Participants

Participants have the right to withdraw from the study at any time for any reason. Any patient who withdraws consent will be withdrawn from the study. The investigator also has the right to withdraw participants from the study drug in the event of inter-current illness, AEs, SAEs, SUSARs, protocol violations, cure, administrative reasons or other reasons. It is understood by all concerned that an excessive rate of withdrawals can render the study un-interpretable; therefore, unnecessary withdrawal of participants should be avoided. Should a participant decide to withdraw from the study, all efforts will be made to report the reason for withdrawal as thoroughly as possible. Should a participant withdraw from study drug only, efforts will be made to continue to obtain follow-up data, with the permission of the participant. Where a participant withdraws due to a serious adverse event, the study team will conduct appropriate safety follow-up in collaboration with the clinical team.

6.6. Expected Duration of Study

The end of study will be at the point of the database lock.

6.7. End of Study Treatment Period

After the 12-week treatment period, the treatment period will end and the participant and treating team will decide what treatment, if any, the participant takes thereafter.

7. Study Procedures

7.1. By Visit

The location of the visits will be determined locally. Visits can be conducted remotely when deemed appropriate. All data will be collected via an electronic case report form (eCRF).

1) Screening visit
    - Inclusion/exclusion criteria review: The RA will visit the potential participant with a member of the clinical team. The clinician will confirm that the participant meets the eligibility criteria. The inclusion/exclusion criteria will be reviewed and eligibility confirmed after PANSS has been completed at Baseline visit.
    - Informed consent: The participant will be given information about the study and encouraged to ask any questions and consult widely with family, friends, clinicians and other advisors. The patient's capacity to consent to the study will be assessed, usually by the treating psychiatrist. If he/she lacks capacity, a legal representative will be sought (see Ethics for more details). Any queries that cannot be addressed by the RA will be escalated to the research psychiatrist or the local PI. No study-specific procedures will be conducted prior to taking consent. Potential participants will be given a written information sheet about the study and be given sufficient time to read and consider the study information prior to deciding whether to take part. A second joint visit with the RA and a clinician may be required. After checking understanding and clarifying any concerns, the clinician will obtain informed consent, informing the participant of their rights according to GCP.
    - If a personal legal representative is involved, CLEAR RAs will provide the additional CONSULT SWAT envelope with the CONCORD scale for completion and either a DA booklet (if randomised to receive) or a blank notebook.
    - Adverse events (on current medication/treatment)
    - Data collection at this visit will include, sociodemographic data including ethnicity, smoking status, medical/psychiatric history, medication use past/current and the clinician rating scale (CRS).

2) Baseline
    - Inclusion/exclusion criteria review.
    - Medication use past/current.
    - Smoking status.
    - Decision-making questionnaire (preferably at baseline/prior to medication start but can be administered up to visit 1).
    - Interview (optional) to discuss experiences of medication changes and challenges, around 30-60 minutes, conducted in person or by phone. The interview will be audio recorded and uploaded onto the secure network hosted by Kings College London. Interviews will be transcribed and pseudonymized, and audio-recordings will be deleted.
    - A routine clinical blood sample will be taken to measure Lipid, and prolactin, HbA1c and LFTs (this can be up to 28 days before treatment start)
    - Adverse events (on current medication/treatment)
    - Height and weight.
    - Assessments conducted will be PANSS, CGI-S, GASS-C, EQ-5D-Y, CRS, DAI-10, ReQoL-10, EI-AD-SUS.
    - PANSS and CGI-S assessment will take place via a 4G-enabled laptop over an encrypted video link by the blinded centralised physician rater. The blinded rater will be the research psychiatrist, or if he/she is unavailable, the Chief Investigator (Adults) or co-CI (under age 18).
    - Urine pregnancy test for females of child bearing potential
    - Additional blood sample for peripheral biomarkers.

3) Treatment with clozapine or another antipsychotic will commence (within 2 weeks of the baseline visit) **and the day treatment starts will be defined as day 1**.

4) Visit 1 at 2 weeks after start of treatment (+/- 3 days).
    - The 2-week visit is an engagement visit to ensure the patient is participating in the study, record any adverse effects and to address any concerns.
    - Medication use current
    - Smoking status

- Weight
- For those participants taking clozapine a routine clinical blood sample will be taken to measure clozapine plasma levels.
- Treatment with study drug continues.

5) Visit 2 at 6 weeks (+/- 3 days).
   - Medication use current
   - Smoking status
   - Weight
   - For those participants taking clozapine a routine clinical blood sample will be taken to measure clozapine plasma levels.
   - Adverse events
   - Assessments conducted by the RA will include GASS-C, EQ-5D-Y, CRS, DAI-10, ReQoL-10, EI-AD-SUS.
   - PANSS and CGI-I assessment will take place via a 4G-enabled laptop over an encrypted video link by the blinded centralised physician rater. The blinded rater will be the research psychiatrist, or, if he or she is unavailable, the Chief Investigator (Adults) or co-CI (under age 18)
   - Treatment with study drug continues.

6) Visit 3 at 12 weeks (+/- 7 days)
   - Medication use current
   - For those participants taking clozapine a routine clinical blood sample will be taken to measure clozapine plasma levels.
   - All participants will have a routine clinical blood sample to measure Lipid, and prolactin, HbA1c and LFTs
   - Adverse events
   - Smoking status
   - Weight
   - Assessments conducted by the RA will include GASS-C, EQ-5D-Y, CRS, DAI-10, ReQoL-10, EI-AD-SUS.
   - PANSS and CGI-I assessment will take place via a 4G-enabled laptop over an encrypted video link by the blinded centralised physician rater. The blinded rater will

be the research psychiatrist, or, if he or she is unavailable, the Chief Investigator (Adults) or co-CI (under age 18)

- Switch, continue or end antipsychotic (clinical decision)
- Additional blood sample for peripheral biomarkers.

7.2. Assessments

7.2.1. Centralised, remote, blind assessment by Research Psychiatrists

a) Positive and Negative Syndrome Scale (PANSS) is the primary outcome, the most well validated standardised rating scale in clinical trials of psychosis.

b) Clinical Global Impression Scale (CGI). It is simple and designed to capture the overall clinical judgement of an experienced clinician, hence it will be administered by the research psychiatrist as opposed to the RA.

7.2.2. Data collected by RA

a) Medical history: Full history of antipsychotic use, doses and response. From Version 8.0, additional data will be collected in order to evaluate treatment pathways prior to study enrolment, with the following variables added to the medical history schedule: Date of first psychotic symptom; date of first presentation to mental health services; date at first psychosis diagnosis and the ICD-10 diagnosis/ code; date of transition from CAMHS to adult mental health services and service use data, including outpatient visits, inpatient admissions, and crisis team engagements.

b) Patient-rated outcome measure (PROM): Drug Attitude Inventory (DAI-10).

c) Adverse events: Glasgow Antipsychotic Side-effect Scale for Clozapine. It is a modification of the GASS, a well validated side effect scale, with additional questions pertaining to common adverse effects of clozapine.

d) Adverse events: Spontaneous report. The RAs will prompt for any other suspected adverse reactions and record these.

e) Adherence: Clinician Rating Scale (CRS).

f) Health-related quality of Life: EQ-5D-Y, a generic patient-reported outcome measure recommended by NICE, which can be used to generate quality adjusted life years (QALYs).

g) Health-related quality of life: Recovering Quality of Life for users of mental health services-10 items measure (ReQoL-10), a patient-reported outcome measure specifically designed for severe mental health populations.

h) Service use to support costing for the economic evaluation: Early Intervention Adult Service Use Schedule (EI-AD-SUS). A measure specifically designed for use in children, adolescents and young adults with psychosis.

7.3. Laboratory Tests

Laboratory measurements will be collected at baseline (the sample can be taken up to 28 days before treatment start) and at 12 weeks. Blood tests include HbA1c, lipids, prolactin and LFTs. As per standard care, the clozapine arm will undergo weekly blood monitoring to check FBC and clozapine plasma levels as per standard care. As the blood tests required for the study would be performed in standard care at treatment initiation and 12-week follow-up, the local clinical team will perform venepunctures and local labs will conduct the analyses.

7.4. Blood sampling for biomarkers and sample storage

For participants recruited at London Trusts or close by, an additional blood sample will be acquired at baseline and at 12 weeks. Blood samples will be collected via venous puncture according to the study blood sampling manual. Where practical, these blood samples for biomarkers can be collected at the same time as the blood samples for laboratory tests, to reduce the number of venepunctures (providing they are +/- 7 days from the baseline and visit 3 date). The blood samples can be collected either at the participant's clinical team base / ward or at the relevant University research facility. The participant will give up to 110 mL (about 6 tablespoons) of blood in total during the study (up to 55 ml at baseline and at week 12); this is in line with sampling guidelines. The blood samples will be used to measure levels of: pro- and anti-inflammatory markers (cytokines, immunoglobulins, lymphocytes); oxidative defence (GSH), proteomics, genetics and epigenetics.

While study data collection is ongoing, samples will be stored within -80 freezers owned by King's College London.

We are planning for samples to be subsequently transferred by courier for analysis as follows:

- Pro- and anti-inflammatory markers: University of Birmingham and King's College London.
- Proteomics: Stoller Biomarker Discovery Centre, University of Manchester and Royal College of Surgeons of Ireland, Dublin.
- Genetics: MRC Centre for Neuropsychiatric Genetics and Genomics, Cardiff University and King's College London.

- Epigenetics: MRC Centre for Neuropsychiatric Genetics and Genomics, Cardiff University.

We will store DNA from the samples and plan to keep it for 5 years for genotyping/sequencing or other analyses as part of other projects. Relevant material will not be stored beyond the end of the project.

8. Assessment of Efficacy

8.1. Efficacy Parameters

8.1.1. Primary Efficacy Parameters

The primary outcome is the change in total blind-rated PANSS scores at 12 weeks from baseline.

8.1.2. Secondary Efficacy Parameters

Secondary outcomes include blind-rated clinical global impression (CGI), patient-rated outcomes (DAI-10, ReQoL-10), quality of life (EQ-5D-Y), adverse effects (GASS-C, HbA1C, lipids, LFTs, prolactin), treatment adherence (CRS) and service use (EI-AD-SUS).

Secondary outcome	**Range of possible scores**	**Indication**	**Analysis – change or absolute level**
CGI-I	*1-7*	Higher score indicates worsening of symptoms. A score of 4 indicates no change.	The score represents the change from baseline.
DAI-10	-10 - +10	A positive total score indicates a positive subjective response and a negative total score indicates a negative subjective response	Change
ReQoL-10	Range of score for each question: 0-4 (if the answer is missing, we can use 999) Range of total score: 0-40	The higher score relates to higher quality of life	Absolute
EQ-5D-Y	Range of each question: 1-3. Total 15.	The higher the score the higher quality of life.	Absolute

	(if the answer is missing, we can use 999) Range of visual analogue scale: 0-100		
GASS-C	0-48	Higher number indicates worse side effects	Absolute
CRS	1-7	Higher number indicates greater compliance	Absolute
EI-AD-SUS	The plausible range would differ for each question. 0-999 would cover the whole ranges for all questions.		Absolute
HbA1C	Individual site reference ranges applied	Higher value indicates greater pathology	Change
Lipids	Individual site reference ranges applied	Higher value indicates greater pathology	Change
LFTs	Individual site reference ranges applied	Higher value indicates greater pathology	Change
Prolactin	Individual site reference ranges applied	Higher value indicates greater pathology	Change

8.2. Procedures for Assessing Efficacy Parameters

Research assistants will administer questionnaires and record patient-rated outcomes according to the schedule, and coordinate PANSS and CGI assessment via a 4G-enabled laptop computer over an encrypted video link by the blinded centralised physician rater.

9. Assessment of Safety

9.1. Specification, Timing and Recording of Safety Parameters

Participants will be asked at each visit from consent onwards to report any suspected adverse reactions. Any suspected adverse events will be recorded from consent visit to end of study. Any suspected adverse events recorded will be explored again at each visit thereafter. Blood tests will be performed at baseline and end of study, by the treating team, and the results recorded in the eCRF in order to investigate glucose and lipid profile and prolactin level. BMI will be calculated at baseline and

end of the study, and recorded in the eCRF, in order to investigate the treatment effect on weight. Participants from the clozapine arm will also undergo to regular weekly blood monitoring (FBC) as per standard practice, but the results will not be recorded in the eCRF.

9.2. Procedures for Recording and Reporting Adverse Events

The Medicines for Human Use (Clinical Trials) Regulations 2004 and Amended Regulations 2006 gives the following definitions:

- **Adverse Event (AE)**: Any untoward medical occurrence in a participant to whom a medicinal product has been administered, including occurrences which are not necessarily caused by or related to that product.
- **Adverse Reaction (AR):** Any untoward and unintended response in a participant to an investigational medicinal product which is related to any dose administered to that participant.
- **Unexpected Adverse Reaction (UAR)**: An adverse reaction the nature and severity of which is not consistent with the information about the medicinal product in question set out in the summary of product characteristics (SmPC) for clozapine (clozapine arm) and other antipsychotics (TAU).
- **Serious adverse Event (SAE), Serious Adverse Reaction (SAR) or Suspected Unexpected Serious Adverse Reaction (SUSAR):** Any adverse event, adverse reaction or unexpected adverse reaction, respectively, that**:**
    - results in death;
    - is life-threatening;
    - required hospitalisation or prolongation of existing hospitalisation;
    - results in persistent or significant disability or incapacity;
    - consists of a congenital anomaly or birth defect.
- **Important Medical Events (IME) & Pregnancy:** Events that may not be immediately life-threatening or result in death or hospitalisation but may jeopardise the participant or may require intervention to prevent one of the other outcomes listed in the definition above should also be considered serious. Although not a serious adverse event, any unplanned pregnancy will also be reported via the SAE reporting system.

Reporting Responsibilities

KCL / SLaM have delegated the delivery of the Sponsor's responsibility for Pharmacovigilance (as defined in Regulation 5 of the Medicines for Human Use (Clinical Trials) Regulations 2004 to the King's Health Partners Clinical Trials Office (KHP-CTO).

All SAEs, SARs and SUSARs (excepting those specified in this protocol as not requiring reporting) will be reported immediately (and certainly no later than 24hrs) by the Investigator to the KHP-CTO and CI for review in accordance with the current Pharmacovigilance Policy. The KHP-CTO will report SUSARs to the regulatory authorities (MHRA) and to the relevant ethics committee. Reporting timelines are as follows:

- SUSARs which are fatal or life-threatening must be reported not later than 7 days after the sponsor is first aware of the reaction. Any additional relevant information must be reported within a further 8 days;
- SUSARs that are not fatal or life-threatening must be reported within 15 days of the sponsor first becoming aware of the reaction.

The Chief Investigator and KHP-CTO (on behalf of the co-sponsors), will submit a Development Safety Update Report (DSUR) relating to this study IMP, to the MHRA and REC annually.

9.3. Adverse events that do not require reporting

Events or reactions listed in the Summary of Product Characteristics (SmPC) do not need to be reported unless they fulfil seriousness criteria.

9.4. Premature Termination of the Study

The study may be prematurely discontinued by the Sponsor, Chief Investigator or Regulatory Authority on the basis of new safety information or for other reasons given by the Data Monitoring & Ethics Committee / Study Steering Committee regulatory authority or ethics committee concerned.

If the study is prematurely discontinued, active participants will be informed and no further participant data will be collected. The Competent Authority and Research Ethics Committee will be informed within 15 days of the early termination of the study.

10. Statistics

A detailed statistical analysis plan for the primary and secondary objectives will be prepared by the study statisticians and approved by the DMC and SSC. The statistical analysis plan will be drafted

before recruitment starts and will be approved before the trial statistician sees any outcome data split by arm. The senior statistician will remain fully blind throughout the study and any future amendments to the SAP will be made by them.

We will report data in line with the TREND statement [45] showing attrition rates and loss to follow-up. All primary and secondary analyses will be carried out following the intention to treat principle, incorporating data from all participants including those who do not complete treatment. Every effort will be made to follow up all participants in both arms for research assessments. The study will be blind-rated to minimise observer bias.

The primary analysis will be conducted after the final 12-week follow-up assessment is completed for the final patient recruited into the study. The study team including CI and study statisticians will be aware of the results of the primary analysis from this point.

10.1. Sample Size

The standardised mean difference for clozapine versus other antipsychotics is based on the network meta-analysis by Krause *et al* of RCTs in children and young people under age 18 [46]. Krause *et al* gives 12 separate estimates of the standardised mean differences between clozapine and other antipsychotics, all of which significantly favour clozapine, with SMDs ranging from 0.83 to 2.53. In order to derive the most accurate overall effect size comparing clozapine with other antipsychotics, we calculated a weighed mean of the individual SMDs, weighted by the prescribed prevalence of antipsychotics in people under 18 in England, taken from a recent publication in Lancet Psychiatry [47], giving a weighted mean effect size of 1.026.

Under these assumptions, a sample size of 40 in the analysis will have 95% power to detect a standardized effect size of 1.026 with a type 1 error rate of 0.05. It should be noted that 95% power is based on the two groups being of equal sizes. However, if the allocation ratio alters to 2:1 or 1:2 it would reduce the power to 91% which is within an acceptable range.

Assuming 20% attrition, a recruited sample of 50 will be required.

10.2. Statistical Analysis

Analyses will be conducted in Stata version 17 or later. Descriptive statistics within each treatment group will be presented for baseline values. These will include counts and percentages for binary and categorical variables, and means and standard deviations, or medians with lower and upper quartiles,

for continuous variables, along with minimum and maximum values and counts of missing values. We will test for differences between treatment groups on key demographic and clinical baseline variable.

For the primary analysis, the treatment effects on primary and secondary outcomes will be estimated using linear mixed models fitted to all outcome variables up to and including the 12-week assessment. To control for confounding, the following covariates will be added into the model: age, age of disease onset, sex, bmi, severity of illness (baseline CG-1), site, attitude to medication (DA1-10 total score), compliance with antipsychotics (CRS total score). Fixed effects will be sex, age (±18) and duration of previous treatment (±3 years), baseline assessment for the outcome under investigation, treatment, time and time*treatment interactions. Participant will be included as a random intercept to account for repeated measures. Marginal treatment effects will be estimated for primary outcome (PANSS score at 12 weeks), and for PANSS scores at each other time point (2w, 6w), and reported separately as adjusted mean differences in scores between the groups with 95% confidence intervals and 2-sided p-values. For secondary outcomes the same approach will be followed using linear mixed models to estimate and report the treatment effect at each time point. Cohen's D effect sizes will be calculated as the adjusted mean difference of the outcome divided by the sample standard deviation of the outcome at baseline. These will be displayed in a forest plot showing the treatment effects on the primary and the secondary outcomes at 12 weeks.

Missing data on individual measures will be pro-rated if more than 80-90% (depending on questionnaire) of the items are completed; otherwise the measure will be considered as missing. We will check for differential predictors of missing outcomes by comparing responders to non-responders on key baseline variables. Any significant predictors will be included in the analysis models in a sensitivity analysis. This accounts for missing outcome data under a missing at random assumption, conditional on the covariates included in the model. A pre-specified subgroup analysis will test the treatment effect in children (age<18 years) by estimating the effect in each group separately.

There are no planned interim analyses.

11. Economic evaluation

A detailed health economic analysis plan (HEAP) will be prepared by the health economists and approved by the DMC and SSC. The HEAP will be drafted before recruitment ends and will be approved before the junior health economist sees any outcome data split by arm. The senior health economist will remain fully blind throughout the study and any future amendments to the HEAP will be made by them.

A within-study cost-effectiveness analysis will be carried out, taking the NHS and social services perspective preferred by NICE [48], including relevant education-based health and social care services, given the age group. Service use will be collected in interview at baseline (covering the previous 3 months) and at the 6,12-week follow-up assessments using the Early Intervention Adult Service Use Schedule (EI-AD-SUS). The EI-AD-SUS was originally designed and successfully applied in populations of young people and young adults at risk of or with psychosis [37]. Nationally applicable unit costs will be applied to all services (for example, NHS Reference Costs for hospital contacts, British National Formulary for medications, PSSRU Unit Costs of Health & Social Care for community-based services etc.).

The primary economic evaluation will be a cost-utility analysis carried out at the 12-week follow-up, in line with the primary clinical analysis, with outcomes expressed in terms of quality adjusted life years (QALYs) calculated from the EQ-5D-Y [35], as preferred by NICE [48]. Secondary analyses will explore cost-effectiveness using the primary clinical measure of outcome (PANSS total score) at 12-weeks.

QALYs will be calculated using the recommended area under the curve approach [49]. However, given evidence to suggest the EQ-5D may not be particularly sensitive in psychosis populations [50], we will additionally include the Recovering Quality of Life-10 items measure (ReQoL-10), a new generic self-reported outcome measure for use with people experiencing mental health difficulties [51], which may be more sensitive to change than the EQ-5D. The ReQoL is not appropriate as the main measure of effectiveness for the economic evaluation because it is not yet associated with preference weights to generate QALYs for use in cost effectiveness analyses and it is currently considered suitable for people aged 16 and over. However, the inclusion of this brief measure will support exploration of the sensitivity of the EQ-5D in comparison to the ReQoL and the validity of the measure in young people under the age of 16.

Costs and QALYs will be presented as mean values by treatment arm with standard deviations. Mean differences in costs and 95% confidence intervals will be obtained by non-parametric bootstrap regressions to account for the non-normal distribution commonly found in economic data [52]. Cost-effectiveness will be assessed using the net benefit approach and following standard approaches [53]. A joint distribution of incremental mean costs and effects for the two groups will be generated using bootstrapping to explore the probability that clozapine is the optimal choice compared to TAU, subject to a range of possible maximum values (ceiling ratio) that a decision-maker might be willing to pay for unit improvements in outcomes. Cost-effectiveness acceptability curves will be presented by plotting these probabilities for a range of possible values of the ceiling ratio [54]. These curves are the recommended decision-making approach to dealing with the uncertainty that exists around the

estimates of expected costs and expected effects associated with the interventions under investigation and uncertainty regarding the maximum cost-effectiveness ratio that a decision-maker would consider acceptable. To provide more relevant treatment-effect estimates, all economic analyses will include adjustment for the variable(s) of interest and baseline covariates [55], which will be prespecified and in line with the clinical analyses. To control for confounding, in line with the clinical analysis, the following covariates will be added: age, age of disease onset, sex, BMI, severity of illness (baseline CG-1), site, attitude to medication (DA1-10 total score), compliance with antipsychotics (CRS total score).

Missing data will be explored in line with the approach outlined for the clinical analysis.

12. Study Steering Committee

An independent Study Steering Committee (SSC) has been established. The roles and constitution of the SSC are as set out in the NIHR Research Governance Guidelines. The SSC meets bi-annually, and is responsible for ensuring that the study is conducted in accordance with Good Clinical Practice (GCP). The SSC has the power to stop the study prematurely, on grounds of ethics, safety or efficacy.

13. Data Monitoring Committee

A Data Monitoring Committee (DMC) has been established to review accruing data and safety information, reporting to the SSC. Independent membership includes an adult psychiatrist, a CAMHS psychiatrist and a clinical study statistician.

14. Direct Access to Source Data and Documents

The Investigator(s) will permit study-related monitoring, audits, REC review, and regulatory inspections by providing the Sponsor(s), Regulators and REC direct access to source data and other documents (e.g. participants' case sheets, blood test reports, X-ray reports, histology reports etc.).

15. Ethics & Regulatory Approvals

The study will be conducted in compliance with the principles of the Declaration of Helsinki (1996), the principles of GCP and in accordance with all applicable regulatory requirements including but not limited to the Research Governance Framework and the Medicines for Human Use (Clinical Trial) Regulations 2004, as amended in 2006 and any subsequent amendments.

This protocol and related documents will be submitted for review to Health Research Authority (HRA), Research Ethics Committee (REC, details below), and to the Medicines and Healthcare products Regulatory Agency (MHRA) for Clinical Trial Authorisation.

London - Dulwich Research Ethics Committee
Health Research Authority
Skipton House
80 London Road
London, SE1 6LH

Any subsequent protocol amendments will be submitted to the REC and Regulatory Authorities for approval, and we will comply with regulations including Pharmacovigilance reporting and providing the REC & MHRA with progress reports, and a copy of the Final Study Report.

The Chief Investigator will submit a final report at conclusion of the study to the KHP-CTO (on behalf of the Sponsor) and the REC within the timelines defined in the Regulations. The KHP-CTO or delegate will inform the MHRA of the results on behalf of the Sponsor.

The CONSULT SWAT has received separate ethical approval (Leeds West ref. REC 22/YH/0121), including approved documents for participants. The SWAT has been registered on MRC SWAT/SWAR repository (https://nicola.qub.ac.uk/sites/TheNorthernIrelandNetworkforTrialsMethodologyResearch/SWATSWARInformation/Repositories/SWATStore/ CONSULT registration #159).

16. Quality Assurance

Monitoring of this study will be to ensure compliance with Good Clinical Practice and scientific integrity will be managed and oversight retained, by the KHP-CTO Quality Team.

17. Data Handling

The Chief Investigator will act as custodian for the study data. The following guidelines will be strictly adhered to:

- Participant data will be pseudo-anonymised.
- All pseudo-anonymised data will be stored on a password protected computer.
- All study data will be stored in line with the Medicines for Human Use (Clinical Trials) Amended Regulations 2006 and the Data Protection Act and archived in line with the Medicines for Human Use (Clinical Trials) Amended Regulations 2006 as defined in the Kings Health Partners Clinical Trials Office Archiving SOP.
- Source documents will include medical records for adverse events, prescription, eligibility, blood results, height and weight. The eCRF will be used as source for all primary and secondary outcome questionnaires.

- Investigator(s) and the institution(s) will permit study-related monitoring, audits, REC review, and regulatory inspections (where appropriate) by providing direct access to source data and other documents (i.e. patients' case sheets, blood test reports, etc).

18. Data Management

A web based electronic data capture (EDC) system is being used, using the InferMed Macro 4 system. The EDC was created in collaboration with the study analyst/s and the CI and maintained by the King's Clinical Trials Unit for the duration of the project. It is hosted on a dedicated server within KCL. The system is compliant with FDA 21 CFR part 11 and Good Clinical Practice (GCP). It is an appropriate system to use for medicinal studies falling under the Medicines for Human Use (Clinical Trials) Regulations 2004 and its subsequent amendments and has also been used for other complex intervention trials. The web-based system can be accessed 24 hours a day.

The CI or delegate will request usernames and passwords from the KCTU. Database access will be strictly restricted through user-specific passwords to the authorised research team members. It is a legal requirement that passwords to the EDC are not shared, and that only those authorised to access the system are allowed to do so. If new staff members join the study, a user-specific username and password must be requested via the CI or delegate (e.g Study Manager) from the KCTU team and a request for access to be revoked must be requested when staff members leave the project. Study site staff experiencing issues with system access or functionality should contact the CI or delegate (e.g Study Manager) in the first instance.

Participant initials and date of birth will be entered on the EDC. NHS number, email addresses, participant names and addresses and full postcodes will not be entered into the EDC. No data will be entered onto the EDC system unless a participant has signed a consent form to participate in the study. Source data will be entered by recruiting site staff and the central rater, directly onto the EDC via 4G enabled laptop. A full audit trail of data entry and any subsequent changes to entered data will be automatically date and time stamped, alongside information about the user making the entry/changes within the system.

The CI team will undertake appropriate reviews of the entered data, in consultation with the project analyst, for the purpose of data cleaning and will request amendments as required. No data will be amended independently of the study site responsible for entering the data.

The DMC, which is independent of the study team, may request data for safety and study monitoring when necessary.

After the last observation of the last patient, the site PI will review all the data for each participant and to verify that all the data are complete and correct. At this point, all data can be formally locked for analysis.

Upon request, KCTU will provide a copy of the final exported dataset to the CI in .csv format and the CI will onward distribute as appropriate.

19. Publication Policy

It is intended that the results of the study will be reported and disseminated at international conferences and in peer-reviewed scientific journals.

20. Insurance / Indemnity

(Co-)Sponsor(s) insurance and indemnity schemes apply.

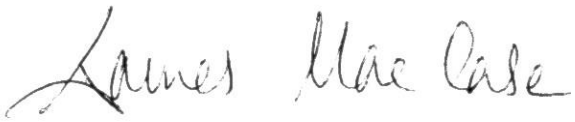
21. Financial Aspects

Funding to conduct the study is provided by NIHR Health Technology Assessment Programme (Call 19/41 Clozapine for children and young people with treatment resistant schizophrenia.

22. Archiving

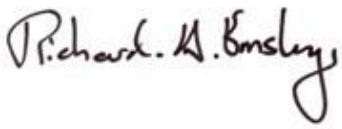
At the end of this study, all study data will be stored in line with the Medicines for Human Use (Clinical Trials) Amended Regulations 2006 and the 2018 Data Protection Act and archived in line with the Medicines for Human Use (Clinical Trials) Amended Regulations 2006 as defined in the (Co)-Sponsor(s) Archiving Standard Operating Procedure (SOP).
Participant information and research data will be archived for 25 years.

23. Signatures



Chief Investigator **Date** 05/12/25

Professor James MacCabe



Chief Statistician **Date** 05/12/25

Professor Richard Emsley

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