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Principles of prescribing practice in childhood and adolescence

The Maudsley® Prescribing Guidelines in Psychiatry, Fifteenth Edition. David M. Taylor, Thomas R. E. Barnes and Allan H. Young. © 2025 David M. Taylor. Published 2025 by John Wiley & Sons Ltd. Chapter 5 Principles of prescribing practice in childhood and adolescence Diagnosis can be difficult in children and comorbidity is very common. Treatment should generally target key symptoms rather than specific conditions. While a working diagnosis is beneficial to frame expectations and help communication with patients and parents, it should be kept in mind that it could take some time for the illness to evolve.1 Differences in pharmacokinetics and pharmacodynamics compared with adults can explain the more pronounced or unforeseen adverse reactions to medication in the young, as well as the differences in dose–effect relationships compared with those in adults.2 ■ ■Start low, go slow and monitor Depending on the age, dose starts lower than in adults or may be calculated in mg/kg per day terms.1,2 Titration of dose should proceed slowly, aiming for the minimum dose that adequately controls symptoms and has minimum adverse reactions. Regular reviewing of efficacy and tolerability should guide if treatment is necessary and requires continuation. ■ ■Polypharmacy in the severely ill Monotherapy is ideal. However, childhood-onset illness can be severe and may require treatment with psychosocial approaches in combination with more than one medication.1 Co-prescribing of medication for different disorders or symptoms is common. This complicates the interpretation of efficacy of each medicine1 and requires care with drug interactions and dose adjustments. ■ ■Adequate treatment duration Children are generally relatively more ill than their adult counterparts and will often require longer periods of treatment before responding. An adequate trial of treatment for those who are admitted for in-patient care may well be 8 weeks or more for depression or schizophrenia. Prescribing in children
and adolescents

562 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 ■ ■Change one drug at a time Ideally changes should be made to one drug at a time and, if possible, remove a drug when adding a new one. ■ ■Monitor outcome in more than one setting For symptomatic treatments (such as stimulants for attention deficit hyperactivity or ADHD), bear in mind that the expression of problems may be different in different settings (e.g. home and school). For example, a dose titrated against parent reports may be too high for the daytime at school. ■ ■Educate the child and parents on the treatment For some, the need for medication will be life-long. The first experiences with medications are crucial to long-term outcomes and adherence. Education regarding the target symptoms of the medication, likely adverse reactions and medication adherence should be addressed. Provide information on the monitoring required and how to identify adverse reactions. Patients and their guardians should be encouraged to ask for changes to their treatment regimen where they consider them ineffective or poorly tolerated. ■ ■Review long-term treatment As children develop and grow through adolescence, dose changes may be required and adverse reactions may emerge or wane. ■ ■Transition from paediatric to adult services It is essential that continuity of care is not lost when moving from paediatric to adult services as this can be distressing and increase the risk of relapse. Planning and co-ordination should start at an early stage to achieve a smooth transition.3 ■ ■Technical aspects of paediatric prescribing Most psychotropic drugs used in adults are not licensed for use in children or -adolescents.4 The Medicines Act 1968 and European legislation make provision for doctors to use medicines in an off-label or out-of-licence capacity or to use unlicensed medicines. Where possible a licensed preparation should be prescribed (Table 5.1), however it is recognised that the informed use of unlicensed medicines, or of licensed medicines in an 'off-label' way, is often necessary in paediatric practice. Individual prescribers are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before prescribing it.5 When writing a prescription in most countries, inclusion of age is a legal requirement in the case of prescription-only medicines for children under 12 years of age, but it is preferable to state the age for all prescriptions for children.

Prescribing in children and adolescents CHAPTER 5 Table 5.1 Psychotropic medications approved by the UK Medicines and Healthcare products Regulatory Agency (MHRA), European Medicines Agency and the US Food and Drug Administration for children and adolescents (January 2024).6–9 Condition UK MHRA approval only; age (years) European Medicine Agency;* age (years) US Food and Drug Administration; age (years) ADHD Amfetamine–dexamfetamine mixed salts – – 3+ -Amfetamine–dexamfetamine mixed salts extended release – – 6+ Atomoxetine 6+ 6+ 6+ Clonidine extended release – – 6–17 Dexamfetamine 6–17 6–17 3–16 Dexamfetamine sustained release – – -6–16 Dexmethylphenidate – – 6+ Guanfacine extended release 6–17 6–17 6–17 Lisdexamfetamine 6+ 6+ 6–17 Methamfetamine – – 6–17 Methylphenidate 6+ 6–18 6+ Viloxazine – – 6+ Anxiety disorders Duloxetine – – GAD 7+ Escitalopram – – GAD 7+ Autism spectrum disorder (irritability) Aripiprazole – – 6–17 Risperidone – – 5–17 Bipolar disorder (depressive episodes) Lurasidone – – 10+ Olanzapine–fluoxetine combination – – 10+ Bipolar disorder (manic or mixed episodes) Aripiprazole Manic episodes 13+ Manic episodes 13+ Manic or mixed episodes 10+ Asenapine – – 10+ Lithium – – 7+ Lithium extended release – – 12+ Olanzapine – – 13+ Quetiapine extended release – – 10+ (Continued)

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Depressive disorder Amitriptyline – – 12+ Escitalopram – – 12+ Fluoxetine 8+ 8+ 8+ Enuresis Amitriptyline 6–17 6–17 – Imipramine 6–17 5–18 6–17 Insomnia (in autism spectrum disorder or Smith Magenis syndrome) Melatonin extended release 6–17 2–18 – Insomnia (in ADHD) Melatonin immediate release 6–17 – – Insomnia (short term) Promethazine 5+ – – Obsessive compulsive disorder Clomipramine – – 10+ Fluoxetine – – 7+ Fluvoxamine 8+ 8+ 8+ Sertraline 6+ 6+ 6+ Schizophrenia Aripiprazole 15+ 15+ 13+ Brexpiprazole – – 13+ Lurasidone 13+ – 13+ Olanzapine – – 13+ Paliperidone 15+ 15+ 12+ Quetiapine – – 13+ Risperidone – – 13+ Sulpiride 14+ 6+ – Tourette's disorder Aripiprazole – – 6–18 *Approvals may differ in individual countries. GAD, generalised anxiety disorder. Table 5.1 (Continued)

Revision #1
Created 2026-01-04 20:16:29 UTC by Omar Ayman
Updated 2026-01-04 20:16:29 UTC by Omar Ayman