

14 - Psychosis in children and adolescents

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580 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 Psychosis in children and adolescents Schizophrenia is rare in children, but the incidence increases rapidly in adolescence. A detailed developmental and physical assessment is always needed before the diagnosis is made.^{1,2} Early-onset schizophrenia spectrum (EOSS) disorder is often chronic and in the majority of cases requires long-term treatment with antipsychotic medication.³ However, there is very limited RCT evidence for maintenance treatment with antipsychotics beyond 8 weeks,⁴ although there are supportive open-label studies.⁵ There have been several RCTs of first-generation antipsychotics, many of them using very high doses and all of them showing high rates of extrapyramidal side effects (EPSEs) and significant sedation.⁵ Treatment-emergent dyskinesias can also be problematic⁶ even when smaller doses are used.⁷ First-generation antipsychotics should be avoided in children and adolescents. There have also been a number of RCTs of SGAs in EOSS disorder. Olanzapine,⁸⁻¹⁰ risperidone,^{8,9,11,12} aripiprazole,^{13,14} quetiapine,^{14,15} paliperidone¹⁶ and lurasidone¹⁷ have all been shown to be effective in the treatment of psychosis in younger people. There is meta-analytical evidence suggesting broadly comparable efficacy of individual SGAs, with the exception of ziprasidone and asenapine which are relatively less effective.^{18,19} Importantly, neither aripiprazole nor lurasidone seems to have an effect on QT in adolescents.^{20,21} At the time of writing there is no RCT evidence supporting any additional benefit for long-acting antipsychotic injections in younger people, although advantages observed in adults might be assumed to be relevant in younger people. Indeed, a 2023 review of 119 reported adolescent cases suggested good outcomes.²² Children and adolescents are at greater risk than adults for adverse effects such as extrapyramidal symptoms, raised prolactin, sedation (even with aripiprazole¹⁴), weight gain and metabolic effects.²³ Metformin has RCT evidence for the reduction of antipsychotic-related overweight/obesity in children and adolescents with EOSS - disorder, while healthy lifestyle education alone does not.²⁴ There is evidence that clozapine is effective in treatment-resistant psychosis in adolescents, although this population may be somewhat more prone to neutropenia and seizures than adults.²⁵⁻²⁹ Based on data obtained from the treatment of younger adults, olanzapine should probably be tried before moving to clozapine³⁰ because there is a palpable chance that it will be effective, although clozapine is clearly more effective than olanzapine in adolescents.^{26,27} Overall, algorithms for treating psychosis in children

and adolescents are the same as those for adult patients. In the UK, NICE³¹ recommends oral antipsychotics in conjunction with family interventions, individual CBT and art therapy. Starting doses should be at the lower end of, or below, the adult range. Antipsychotics should not be offered with the aim of decreasing the risk of developing psychosis;^{31–33} they are indicated only in the treatment of psychosis. When prescribing antipsychotics in children and adolescents always measure baseline parameters and monitor as outlined in the guidance in the chapter on schizophrenia (see Chapter 1). For children and adolescents also include waist and hip circumference, assessment of any movement disorders and assessment of nutritional status, diet and level of physical activity.³¹

Revision #1

Created 2026-01-04 20:16:34 UTC by Omar Ayman

Updated 2026-01-04 20:16:34 UTC by Omar Ayman