**Journal of Prescribing Practice**

**A-Z of Prescribing for children**

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**C - Concordance**

It has been more accepted in recent years that the inclusion of patients in the therapeutic prescribing processis more beneficial to the patient, and concordance considers the wishes and expectations of both the prescriber and the patient (Atal, Sadasivam et al. 2019), and that also includes children. This is a shift in approach to patient care, but also terminology, where ‘compliance’ and ‘adherence’ have been used. The term compliance is now outdated, as it had a focus on patient obedience to instructions (Rae 2021), which is not applicable to children not adhering to medication regimes. ‘Adherence’ is less autocratic than compliance, and there is a view that the prescriber is given more information to the patient before they agree to take the medication.

Even twenty years ago, consideration was given to children’s roles in concordance (Sanz 2003), as the prescribing process is not just a two way process, but a three way one: the prescriber, the child, and the parents. It is imperative to consider all beliefs, thought processes, and expectations from *all* involved in order to negotiate a successful plan of care. Factors that potentially influence a child’s ability to take their medication need to be explored. These can include family relationships and influences, actual medicine formulations, or beliefs about the medication effectiveness or side effects: all these factors can all play a part (Chappell 2015).

At the start of the prescribing process, it is clear that the prescriber needs to identify potential barriers to adherence. Exploration and incorporation of a psychological model which can categorise these factors can be utilized (Jackson, Eliasson et al. 2014), namely considering the *Capability*, the *Opportunity* and the *Motivation* patients have in order to take their medications: ultimately hoping to change their *Behaviour*, which is the desired outcome (ie, taking the medications). This is known as the COM-B model. These different factors can be explored in more detail, and then subsequently discussed, and then potentially modified, in order to improve adherence (see Table 1).

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| **Capability** | **Opportunity** | **Motivation** |
| **The patient’s physical and psychological capacity to engage in the behaviour** | **Factors lying outside the patient that make the behaviour possible** | **All brain processes that direct behaviour** |
| - Comprehension of disease and treatment  - Cognitive functioning (eg memory, thinking)  - Capacity to plan | - Cost  - Availability of medication  - Packaging  - Physical characteristics of medicine (eg, formulation, taste)  - Complexity of regiment  - Social support  - Communication between patient and prescriber | - Perception of illness  - Beliefs about treatment  - Outcome expectancies  - Self efficacy |

Table 1: Factors to consider in relation to adherence

Adapted from (Jackson, Eliasson et al. 2014)

This has been studied in detail in children with growth hormone (GH) deficiency: GH therapy involves regular injections. In interviews with children and their parents, modifiable factorsn were identified that affect attitudes towards treatment, such as difficulties with the pen device (other ones can be tried), or incorrect beliefs surrounding the treatment (where further information from the team on the particular condition and treatment can help) (Graham, Auyeung et al. 2020).

Similar modifiable factors have also been identified in children with asthma, where, for example, a parent could not access the pharmacy easily in order to collect medications, or where correct follow up had not been arranged properly (Chan, Stewart et al. 2016). Unawareness of disease management and control, with reference to the importance of medicines has also been identified in children with rheumatic disease (Manatpreeprem, Lerkvaleekul et al. 2023).

Involving not just the parents in the prescribing process, but also the child, can promote concordance. Considering an appropriate consultation model can be of use, such as the Me First Communication Model (Martin, Morton et al. 2019), which ensures the child is listened to, and that they are at the centre of decisions about their healthcare and treatment. Involving children and their parents has been shown to enhance medicines optimization: it has been shown that more than a third of parents do not feel involved in decisions regarding their child’s treatment (Trivedi 2017), so communication is key. Parental factors, however, have also been shown to have an influence, such as parents’ perceptions and attitudes towards the importance of taking medicine (Kalaman, Ibrahim et al. 2023), so it is clear the prescriber needs to consider all potential influences.

The prevalence of non-adherence to medications in children is underestimated by prescribers (Kardas, Dabrowa et al. 2021), and a review of old fashioned, paternalistic approaches to the patient-prescriber relationship needs to be undertaken. Introducing the concept of concordance, and identifying modifiable factors from all avenues, will enhance adherence to medications, alongside not just increased education and enhanced communication, but also introducing behavioural approaches to demonstrate beneficial effects (Dean, Walters et al. 2010).

*The next article in the series is D: Distribution*

*Word count: 795 words*

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