

Psychopharmacology Issues During COVID-19

Introduction

The COVID-19 pandemic has had a profound impact on nearly every aspect of life for children and families across the globe, and many of our patients may be experiencing worsened psychiatric distress as a result. The sources of emotional stress during the pandemic are diverse and range widely from cancellation of anticipated summer programs or events, having to leave school and transition to less structured settings, fear of becoming ill, financial stress, more time spent among families and less time with peers, uncertainty about the future, and increased anxiety as communities begin to relax social distancing standards. The loss of structure, direct peer support, and limited special education services related to school closures can also worsen or unmask underlying behavioral conditions in children and adolescents with mental illness or developmental disabilities. Additionally, therapy alone may not be enough to treat patients with new or worsened psychiatric symptoms due to the many changes and stressors caused by the current pandemic. Given the high levels of stress for children and families coupled with decreased services, there is an unprecedented need for outpatient child and adolescent psychopharmacology, much of which is now being delivered virtually. Over the past two months, child and adolescent psychiatrists have had to make a rapid transition to virtual care. During this time, we have learned that it is possible to provide psychopharmacologic care to children and families through virtual care. However, as a field we still have much to learn about best practices for virtual psychopharmacology, some of which may shift as the pandemic evolves. Based on the AACAP Psychopharmacology and Neurotherapeutics Committee members' experiences, we present guidelines and considerations for child and adolescent psychopharmacology during the COVID-19 pandemic.

Initiating treatment and new evaluations

The AACAP Psychopharmacology and Neurotherapeutics Committee recommends that new evaluations not be deferred until the COVID-19 pandemic resolves. Rather, virtual outpatient child and adolescent psychiatry services should be expanded to increase capacity to provide rapid evaluation and treatment for children with behavioral health concerns, as delayed care can have extremely negative consequences including increased risk of COVID-19 exposure through the emergency room. During the initial evaluation, child and adolescent psychiatrists should conduct a comprehensive diagnostic and medication evaluation, ideally by video call, but audio calls may be used when video is not possible. The goals of the initial evaluation should include formulating a preliminary diagnosis, developing a medication plan, and assessing the level of care that is needed. While most children will do well in standard outpatient settings, some children and families may benefit from the structure, support, and more intensive care that a day program can provide – either virtually or in-person. If the child is appropriate for outpatient care and treatment with medications is indicated, medications can and should be initiated during the first virtual visit. Print and online psychoeducation materials, including information about medications, can be shared with parents virtually during a video call. More frequent virtual visits should be offered to assess the child's response to and tolerability of the medication.

Medications Are No Longer The “Last Resort”

While patients may be experiencing worsened psychiatric distress during COVID-19, parents quarantining with their children are gaining a deeper understanding and experience of their child’s behaviors or mental health symptoms. They are not having to wait for reports from teachers about how children behave during the day. Whether internalizing or externalizing in nature, families have more exposure to their child’s needs as a product of greater proximity to one another. As a result of the significant social changes, their psychological consequences, and families’ proximity to their children, our patients and families are finding that medications are no longer the “last resort” in care. While therapy and behavioral interventions remain a mainstay of child and adolescent psychiatry, the various changes brought about due to COVID-19 have resulted in medications being a more immediate addition to the treatment plan.

Medical licensing regulations

Prior to COVID-19, psychiatrists needed to be licensed in the state in which the patient resided to provide virtual care. However, during the COVID-19 pandemic, several states have issued licensing reciprocity agreements. These reciprocities remain in flux and psychiatrists should obtain updates about this from their state board of registration of medicine.

Prescription of controlled substances

During the State of Emergency due to COVID-19, the Drug Enforcement Agency (DEA) is allowing DEA-registered practitioners to “begin issuing prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation.”¹ The DEA stipulates that the prescription must be issued for a legitimate medical purpose; the virtual visit must be conducted “using an audio-visual, real-time, two-way interactive communication system”; and that the practitioner must act “in accordance with applicable Federal and State law.” DEA-registered practitioners are permitted to continue prescribing controlled substances through telemedicine for as long as this designation is in effect.

Laboratory management

The AACAP Psychopharmacology and Neurotherapeutics Committee recommends that medications be started when clinically appropriate, even if it may not be possible to follow typical laboratory and medical monitoring guidelines. Child and adolescent psychiatrists should inform parents when laboratory and medical monitoring deviates from the recommended guidelines during COVID-19 and use their best clinical judgment for each patient based on the risks and benefits of obtaining laboratory values. Currently, the national standard of care is generally to be less rigorous with laboratory monitoring than we would be during pre-COVID-19 times, including starting second generation antipsychotics and mood stabilizers without obtaining baseline labs. If the clinician and family decide to forego standard baseline laboratory measures during the COVID-19 pandemic, the psychiatrist should instruct the child’s parents to measure and report the child’s height, weight, waist circumference, and pulse. They should be advised of signs and symptoms related to medication adverse effects and toxicity, including those related to diabetes. During follow-up visits, the child and adolescent psychiatrist should also obtain a more in-depth medical review of systems to clinically evaluate for medication-

related side effects and toxicity, including the presence of diabetes (polydipsia, polyuria, fatigue, extreme hunger, unexplained weight loss, and blurred vision), when laboratory monitoring is not possible. Finally, it is advisable to initiate reasonably safe starting doses of medication, while closely observing for therapeutic response, using the lowest effective dose to decrease the risk of toxicity and side effects. For example, when wanting to start an atypical antipsychotic, the AACAP Psychopharmacology and Neurotherapeutics Committee believes it would be reasonable for an outpatient provider to prescribe a standard starting dose without baseline laboratory measures. These include starting Risperidone 0.25 mg at night, or Aripiprazole 2 mg daily, or Quetiapine 25 mg at night, or Olanzapine 2.5 mg at night. Providers should maintain close follow up to monitor for side effects and response. When starting Lithium, the AACAP Psychopharmacology and Neurotherapeutics Committee recommends the continued use of weight-based dosing guidelines. These include starting patients on 300 mg twice daily, or 450 mg twice daily among patients over 30 kilograms, without subsequent titration until necessary laboratory measures can be obtained and the current Lithium level reviewed.

Family Communication Before and After Appointments

As we convert our sessions to telepsychiatry, families have found a number of differences in the way they approach visits and consider treatment. Instead of spending time driving or riding to the appointment and sitting in the waiting room, they now gather for the session at a device. As a result, some families have been spending less time discussing updates, the patient's response or adherence to treatment, reflect on stressors or changes, and generally "prepare" for the appointment. The same is true at the end of the appointment. Prior to COVID-19, families were able to reflect on the session and recommendations together on their way home from the appointment. Since rolling out widespread telepsychiatry sessions, families do not have the same opportunity to check in together on their way home. There is an opportunity for providers to acknowledge this change in the process of attending and leaving appointments, anticipate a greater difference between patients' and guardians' response to treatment, and prompt further discussions and reflection among families at the end of the appointment.

Addressing Adherence During COVID-19

We know how important it is for patients and families to attend their treatment sessions and take their medications as prescribed. Prior to the COVID-19 pandemic, we know that in some clinical settings the no show rate made up a significant proportion of their scheduled visits. As we have had to convert our clinical visits to virtual encounters, anecdotal evidence from several different academic groups suggests that no-show rates may be lower during the pandemic and that families are engaging in more frequent care. Additionally, families have reported that virtual visits are easier to schedule and less time intensive to attend than in-person visits. As a result, families' ability to access care sooner with fewer no shows may be improved.

Regarding medication adherence, there are new challenges and opportunities that patients face. In some cases, patients may have been taking their medications at school. Since we are no longer able to rely on school administration of medications, it is important to identify a strategy for enhancing that adherence at home. This is particularly important when prescribing controlled

substances or when addressing suicidality and wanting to adhere to a safety plan that restricts patients' ability to access their medication without supervision. It is also important to be aware of the patient's current sleep pattern and when during the day to administer the patient's medications. If a patient with ADHD on a stimulant has a shifted sleep cycle and is now waking up late in the morning or early afternoon, it is important to be mindful of the dose, timing, and formulation of the stimulant that is being taken later in the day. In many circumstances this may be contributing to ongoing sleep cycle disruption and may require an adjustment of the prescribed stimulant. At the very least, it is important to discuss where the medication is stored, when it is administered, who administers it, and who monitors adherence. This can be adapted to each developmental stage from early childhood in which a parent is managing and administering the medications to early adulthood in which the young adult patient is the primary stakeholder and may be the sole manager of their medications.

Silver Linings to Virtual Care During COVID-19

There are some notable silver linings to seeing patients virtually. These visits allow us to see into the lives and homes of our patients, and it adds to our understanding and formulation of patients' needs. This is particularly useful when considering medication selection or adjustments as well as helping to inform which additional resources and therapy types to recommend amidst the pandemic. For instance, observing a household in which there is a great amount of chaos in the background or a high level of expressed emotion during the appointment informs our treatment considerations. Perhaps a patient in this type of household could benefit more from family-based interventions or having other family members engage in mental health treatment. Furthermore, this view into the home environment of our patients may help to better inform the coping skills and the factors relating to how well or poorly a patient has responded to a recent medication change.

It also bears mentioning that patients and their families are now able to see into our own spaces during virtual sessions. For those of us working remotely, it is incredibly important to be mindful of the space you are using during virtual visits, the view that patients and families will have of that space, and how best to reduce distractions during sessions. It may be developmentally appropriate for patients to ask a variety of questions about your new workspace, yet it can be a significant distraction from your ability to complete your assessment. Limiting the number and frequency of background cues or interruptions may help reduce distractions and improve your ability to provide excellent patient care.

Virtual visits have also allowed for the engagement of additional caregivers and family members who otherwise would not attend an in-person clinic visit. Now we can engage with and hear from siblings who might normally have to stay home or be in school during the day, any of the parents who may now be working from home and would otherwise not be attending in-person visits, and additional generations of caregivers such as grandparents and extended family members who have their own unique perspectives to contribute. These opportunities have helped to include more perspectives and reduce the risk of guardians not feeling included in treatment decisions.

References

- 1 DEA's response to COVID-19. Available at <https://www.dea.gov/press-releases/2020/03/20/deas-response-covid-19>. Accessed May 27, 2020.