CAMHS prescribing guidance during the COVID-19 pandemic

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Contents

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Background

Changes to the way we deliver care during the COVID-19 pandemic have resulted in the swift implementation of remote consultation methods as the norm. Engaging patients and families in telephone or video consultations can bring challenges for clinical practice. Prescribing has been subject to discussion in terms of achieving adequate monitoring for adverse effects and response to treatment.

This document aims to outline locally agreed guidance on commonly prescribed medications within the CAMHS population. We hope the level of detail allows for useful examples of consensus practice, without being overly prescriptive. This guidance is not aimed to address all eventualities encountered by prescribers, and clinical judgement will still be required. This guidance should be utilised in conjunction with local guidelines on lockdown measures, social distancing and the use of personal protective equipment (PPE).

1. Principles relating to use of remote consultations and prescribing during the COVID-19 pandemic

1.1 Best practice for remote consultations

There are many useful resources outlining principles of best practice relating to the use of remote consultations[1-6].

Deciding on the need for face to face consultations will require clinical judgement on a case by case basis[6]. This will also take into account the child or adolescent's care setting, level of supervision and engagement with their care plan. If face to face contact is deemed necessary, then local guidelines on social distancing and the use of PPE should be followed.

1.2 General principles for prescribing remotely for children and adolescents during the COVID-19 pandemic

The RCPsych Faculty of Child and Adolescent Psychiatry have published guidance on prescribing practice during the COVID-19 pandemic, detailing 'what to consider when starting and/or continuing psychotropic medication in children and adolescents whilst working remotely during the COVID-19 pandemic'[7]. We anticipate this document will complement this guidance.

1.3 General prescribing practice for children and adolescents

During this global pandemic, changes to the lives of the children and adolescents we treat may directly influence emotional regulation, behaviour and functioning. It is therefore imperative that this is considered and discussed with the family when initiating or changing medications during this time. This may extend to considering the impact on validity of assessments, which is not discussed here. The use of objective tools to measure symptom severity and impact on functioning may be more pertinent when recording baseline presentation and response to treatment.

Regardless of method of consultation, clinicians should consider established principles for obtaining informed consent, documenting collaborative decision making and initiating medication in this age group. In line with principles relating to informed consent, material risk is considered of most importance here and adverse effects and their monitoring should be discussed in the context of risk of exposure to COVID-19[8].

In terms of prescribing practice, this should include usual recommended practice, documenting:

- Rationale for choice of medication.
- Discussion around benefits of treatment and risks of adverse effects, with written information provided (which may be in digital form).
- Explanation of commonly prescribed unlicensed medications in this age group.

Additional consideration during the COVID-19 pandemic may include:

- Documenting rationale for initiation of medication at this time.
- Documenting rationale for dose increase or discontinuation.
- Discussion around limitations to monitoring and investigations indicated, including highlighting the need for parents/carers to seek medical review if they are concerned about a deterioration in the child/adolescent's physical health.
- It may be particularly pertinent during this time to follow the 'start low, go slow' principle when initiating and titrating medication for children and adolescents.
- The use of mental state assessment tools and/or side effect rating scales may provide an additional objective measure to aid remote assessment e.g. GASS (Glasgow Antipsychotic Side effect Scale).

2. Using available resources

It is accepted that there will be variations in local resources available during the COVID-19 crisis. Therefore the methods used by clinicians to achieve medical monitoring may feature the following (which is not exhaustive):

- Devising a central clinic for face to face medical monitoring with careful use of PPE, social distancing and available deep cleaning facilities.
- Services may provide patients with home monitoring equipment or families/carers may be able to purchase these to measure blood pressure, pulse, height and weight.
- Primary care services may be able to accommodate requests for bloods, ECGs, blood pressure etc.
- Nursing staff may be available to conduct face to face physical examinations using PPE e.g. within local paediatrics services, adult services or the patient's care setting/accommodation.

3. Prescribing for Attention Deficit Hyperactivity Disorder (ADHD)[9]

The inability to do face to face visits should not be viewed as an absolute contraindication to starting and continuing medication. Instead, the risks and benefits of initiating or maintaining medication under the COVID-19 restrictions should be carefully considered.

If use of medication is clinically indicated and recommended as per local and national guidelines, the opportunity to start treatment should be offered as long as an initial assessment is completed. Being prevented from accessing medication after an initial assessment or failure to continue ongoing medication could increase health risks related to COVID-19 due to behaviour related to ADHD becoming more disorganised and poorly controlled, thus adversely impacting the patient's ability to comply with social distancing requirements.

Non-pharmacological treatments (e.g. psychoeducation) are also integral to ADHD management, however, they are not discussed in this guidance.

3.1 Initial assessments and follow-up assessments for ADHD

Given the requirement of social distancing, all relevant assessments should continue to take place using telephone or appropriate online video technology, in line with current recommendations for the use of telepsychiatry as per guidance from the Royal College of Psychiatrists[4]. Detailed history taking will assume greater importance if physical assessment is not completed. If face to face assessment is judged to be necessary this should be conducted following local guidance on social distancing and the use of PPE.

3.2 Pharmacological treatment for ADHD

3.2.1 General considerations[9]

Individuals with ADHD should still be offered the opportunity to start on a pharmacological treatment (if clinically indicated and as recommended in standard national guidelines) after completion of the initial assessment. If already on medication, this should be continued as usual and dosing optimised in response to clinical presentation.

Ensure parents/carers of children and adolescents with ADHD are aware to request new prescriptions before medications run too low to ensure they get medication on time and don't run out. They should not ask for extra prescriptions 'just in case'. Risk of diversion should be assessed on an individual basis.

Parents/carers of children and adolescents with ADHD should avoid increasing doses or adding doses (beyond those prescribed) to manage a crisis or stress related to current restrictions. Similarly, the use of antipsychotic medications to manage disruptive behaviour or the use of sedatives when not clinically indicated should be avoided. Parents/carers should continue to implement behavioural strategies recommended for disruptive/challenging behaviours in children and adolescents with ADHD.

The variety of available formulations of stimulants (i.e. short, intermediate and long-acting durations) allows clinicians and parents/carers to tailor treatment to the specific needs of the child/adolescent during the day. Considering the change in routine during the COVID-19 pandemic, clinicians may want to discuss possible changes in the type of formulation with each child/adolescent and their representatives.

3.2.2 Initiating medication for ADHD remotely

The European ADHD Guidelines Group (EAGG) have produced guidance on starting ADHD medications during the COVID-19 pandemic[10].

The EAGG deems it appropriate, in terms of the risk–benefit ratio, to remotely start a pharmacological treatment if the three following conditions are satisfied:

1. Absence of a personal history of:
    - shortness of breath on exertion compared with peers;
    - fainting on exertion or in response to fright or noise;
    - excessive palpitations, breathlessness or syncope (at rest or after exercise) or palpitations that are rapid, regular, and start and stop suddenly (fleeting occasional bumps are usually ectopic and do not need investigation);
    - chest pain suggesting cardiac origin;

- any previously documented hypertension, congenital heart abnormality, previous cardiac surgery, or underlying condition that increases the risk of having a structural cardiac disorder (e.g. genetic conditions or multisystemic disorders).

2. Absence of family history of early (<40 years) sudden death in a first-degree relative suggesting cardiac disease.

3. Baseline monitoring completed before initiation.
   - Blood pressure and pulse can be measured by a family member or another person remotely (with telephonic assistance, if needed) on three separate occasions, following the guidance in Appendix 1[9].

If the first or second conditions are not satisfied, a referral to a cardiologist should be made before starting the pharmacological treatment.

If only the third condition (baseline monitoring) is not satisfied, the prescriber will need to evaluate the risks and benefits of a face to face assessment in the context of the severity of ADHD symptoms and the impact on the patient and the family.

3.3 Monitoring of possible adverse events from pharmacological treatment of ADHD during the COVID-19 pandemic[9]

The clinician should explain that routine monitoring for adverse events may be delayed due to the COVID-19 pandemic. The option of home monitoring should be discussed if the family are able to achieve this.

The following paragraph suggests how clinicians may wish to document these discussions (to be adapted as required):

"*We discussed the current limitations on face to face reviews, physical health monitoring and on checking of physical observations (weight / height / blood pressure and pulse) due to the current COVID-19 emergency. The family understand these limitations and on the balance of risks and benefits have decided to continue with medication at present. We discussed the need for the family to closely monitor for any physical health concerns or problems and, should these develop, to report these immediately to medical staff. "*

3.3.1 Cardiovascular monitoring

- Routine cardiovascular clinical examination and face to face monitoring for individuals with ADHD without any cardiovascular risk factors could be postponed until routine face to face visits are reinstated. At present, the risks of conducting face to face assessments in this patient group outweigh the benefits of cardiac monitoring.
- If possible, monitoring of blood pressure and pulse using home blood pressure machines is recommended[9], following the guidance in Appendix 1.
  - There is a risk that measurements provided by parents/carers may not be accurate[7] and clinicians will need to consider this when reviewing the readings.
  - Clinicians could request parents perform blood pressure monitoring during remote video consultations.
  - The clinician should average the readings sent to them and assess this value against expected age adjusted norms.

    - This is particularly pertinent for children and adolescents who have previously been recorded as having increased blood pressure readings and/or pulse, as modest changes in blood pressure are found in patients prescribed medication for ADHD. However, findings have revealed only 2% of patients have ADHD medication discontinued for any cardiac event.
- If the child/adolescent experiences any emerging cardiovascular symptoms (e.g. chest pain, prolonged palpitations, breathing difficulties) or any other concerning symptoms, their parent/carer should contact the clinician, NHS 24 or 999 depending on the severity of symptoms.

The decision to start or continue medication for ADHD in patients with cardiovascular conditions should be discussed on an individual basis with the prescriber and a specialist in cardiology.

3.3.2 Weight and height

Given the current restrictions, weight and height measurements may need to be performed at home rather than in the clinic. Whilst ADHD medication can impact on weight, it should be considered that weight may also be affected by factors related to self-isolation (e.g. reduced physical activity and increased caloric intake). Local guidance on weighing at home is included in Appendix 2.

3.3.3 Sleep

Although sleep disruption is a possible side effect of stimulants, it can also be caused by other factors associated with the current restrictions e.g. stress, late-morning waking and disruption of daily routines. Appropriate sleep hygiene should be implemented and/or reinforced in preference to increasing doses of melatonin beyond the therapeutic range[11].

3.3.4 Headaches

The Commission of Human Medicines (CHM) Expert Working Group on COVID-19 has concluded that there is currently insufficient evidence to establish a link between use of ibuprofen nor other non-steroidal anti-inflammatory drugs (NSAIDs), and susceptibility to contracting COVID-19 or the worsening of its symptoms[12].

Patients can therefore take paracetamol or ibuprofen when self-medicating for symptoms of COVID-19, such as fever and headache, and should follow NHS advice if they have any questions or if symptoms get worse[12].

4. Prescribing antidepressants, anxiolytics and antipsychotics

For most patients, advice should be given to continue on regular medication at the current dosage until this can be reviewed in a face to face setting and the child/adolescent and/or parent/carer can be involved in shared decision making with their usual prescriber. This should take account of the fact that anxiety and depressive and psychotic symptoms are all likely to worsen during extreme stress and social disruption[7].

Careful consideration should be given to whether it is appropriate to withdraw or change patients from antidepressant, anxiolytic or antipsychotic medication during the current restrictions. In some circumstances this may be unavoidable due to clinical need but the clinical rationale should be clearly documented and arrangements for monitoring put in place[7].

For patients with presentations suggestive of an organic aetiology or past medical histories where caution is advised, physical investigations may be indicated and discussions around how to achieve these should be documented.

4.1 Antidepressants

- There is usually no requirement for initial physical assessment and medical monitoring when prescribing antidepressant medications for children and adolescents.
    - Physical investigations may be indicated depending on the patient's current presentation, past medical history and experience of side effects.
- Remote monitoring for adverse effects on initiation of antidepressant therapy may be once a week or fortnightly on initiation, reducing in frequency thereafter and adjusted according to clinical need.
- Significant adverse effects such as the emergence of elevated mood or suicidal ideation should be explicitly discussed with patients and carers along with more commonly experienced side effects.
- Remote assessment of response to treatment can be done within usual time scales for antidepressant medication i.e. 6-8 week trial from established therapeutic dose.

4.2 Anxiolytics

- There are no requirements for initial physical assessment and medical monitoring when prescribing anxiolytic medications for children and adolescents.
- Remote monitoring for adverse effects on initiation and assessment of response to treatment can be done within usual time scales on a week to week basis depending on clinical presentation.

4.3 Antipsychotics

- Collaborative decision making with the patient and family around side effect profiles and efficacy of antipsychotics should be documented as usual.
    - These discussions may be particularly pertinent during this time where some side effects may be less tolerable than others and influence first-line choice of antipsychotic medication.
- Clinical need may require the urgent initiation of antipsychotic medication, before achieving recommended physical investigations.
- It may also be the case that due to the patient's level of distress or inability to engage in such tests, recommended physical investigations can be delayed.
- In circumstances relating to remote prescribing, if clinical presentation allows for physical investigations to be completed then this should be attempted, depending on local resources available during the COVID-19 pandemic.
- If this is not possible then this can be delayed until a time when face to face consultations and local services have been resumed.

4.4 Other medications

There is available guidance on lithium and clozapine initiation and monitoring during the COVID-19 pandemic[13,14], which should be considered alongside existing local protocols.

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Appendices

Appendix 1 - Recommendation for home blood pressure monitoring

1. Use an age adapted cuff size
2. Take the blood pressure and pulse readings at least 2 hours after taking a dose of medication
3. Sit down for 10-15 minutes before taking the reading
4. Take the reading on the left arm
5. Take the lowest of 3 readings
6. Repeat the above steps at approximately the same time on three separate days and send the readings (both blood pressure and pulse values) to the prescriber

Appendix 2 - Guidelines for weighing at home

As part of the child/adolescent's treatment plan, they will need to be weighed on a regular basis. Below are guidelines to support more accurate weight monitoring:

- If you already have scales in the house and want to know if they are accurate, you can use a pre-weighed item, e.g. 1kg bag of sugar, to check if the scales are accurate.
- If you are planning to buy a new set of scales, please ensure that there is a CE marking on the label - this certifies that the product has met EU consumer safety, health or environmental requirements. The use of metric scales (units in kilograms) are preferable.

Before weighing:

- **Levelling -** ensure that the scales are on a firm, solid surface or floor – not carpet
- **Zero -** check that the scales display zero before use, re-zero if necessary
- **Timing -** it is useful if weight is taken at the same time of the day each time. Preferably this would be first thing in the morning or when the child/adolescent gets out of bed, however this is not essential
- **Documentation -** have pen and paper ready to write down the weight and the time the weight was taken
- **Child/adolescent to be weighed -** try to minimise the amount of clothing worn by the child/adolescent; remove shoes/jewellery/mobile phones from pockets, ensure hair is dry and that they have been to the toilet beforehand
- **Position -** make sure that the child/adolescent is standing upright with feet squarely and completely on the platform
- **Take the weight** - document the weight and the time the weight was taken to report to the clinician