NOTTINGHAMSHIRE AREA PRESCRIBING COMMITTEE
SHARED CARE PROTOCOL AGREEMENT

METHYLPHENIDATE AND ATOMOXETINE TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN AND YOUNG PEOPLE

OBJECTIVES
- To outline the referral criteria for shared-care, define the responsibilities of the Specialist (e.g. Child & Adolescent Psychiatrist, Paediatrician) and GP.
- To provide an information summary on the prescribing and monitoring of methylphenidate and atomoxetine for attention deficit hyperactivity disorder (ADHD) in children and adolescents (age 6-18 years).

REFERRAL CRITERIA
- Prescribing responsibility will only be transferred when it is agreed by the specialist and the patient's primary care prescriber that the patient’s condition is stable.

PROCESS FOR TRANSFERRING PRESCRIBING TO PRIMARY CARE
- The request for shared care should include individual patient information, outlining all relevant aspects of the patients care and which includes direction to the information sheets at www.nottsapc.nhs.uk.
- If the GP does not agree to share care for the patient then he/she will inform the specialist of his/her decision in writing within 14 days.
- In cases where shared care arrangements are not in place, or where problems have arisen within the agreement and patient care may be affected, the responsibility for the patients’ management including prescribing reverts back to the specialist.

CONDITION TO BE TREATED
ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of inattention, hyperactivity and impulsivity. Not every person with ADHD has all of these symptoms – some people are predominantly hyperactive and impulsive; others are mainly inattentive. Symptoms of ADHD are distributed throughout the population and vary in severity; only those people with at least a moderate degree of psychological, social and/or educational or occupational impairment in multiple settings should be diagnosed with ADHD.

Determining the severity of ADHD is a matter for clinical judgement, taking into account severity of impairment, pervasiveness, individual factors and familial and social context. Symptoms of ADHD can overlap with those of other disorders therefore care in differential diagnosis is needed. ADHD is also persistent and many young people with ADHD will go on to have significant difficulties in adult life.¹

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
- meet the diagnostic criteria in DSM-IV or ICD-10 (hyperkinetic disorder) and
- be associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
As part of the diagnostic process, include an assessment of the person’s needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people there should also be an assessment of their parents’ or carers’ mental health.¹

In school-age children and young people with severe ADHD, drug treatment should be offered as the first-line treatment. Parents should also be offered a group-based parent-training/ education programme.¹

Drug treatment for children and young people with ADHD should always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions.¹

When a decision has been made to treat children or young people with ADHD with drugs, healthcare professionals should consider:
– methylphenidate for ADHD without significant co-morbidity.
– methylphenidate for ADHD with co-morbid oppositional defiant disorder or conduct disorder.
– methylphenidate or atomoxetine when tics, Tourette's syndrome, anxiety disorder, stimulant misuse or risk of stimulant diversion are present.
– atomoxetine if methylphenidate has been tried and has been ineffective at the maximum tolerated dose, or the child or young person is intolerant to low or moderate doses of methylphenidate.¹

NATIONAL GUIDANCE
NICE Clinical Guidance 72: Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults, recommends methylphenidate and atomoxetine as treatment options for children, young people and adults with ADHD¹. This shared care protocol does not cover treatment of children under 6 years of age or the use of lisdexamfetamine and dexamfetamine in ADHD.

CLINICAL INFORMATION ON METHYLPHENIDATE AND ATOMOXETINE
See Information Sheets for Primary Care Prescribers.

AREAS OF RESPONSIBILITY

Specialists Roles and Responsibilities
1. The specialist will confirm the working diagnosis.
2. The specialist will recommend and initiate the treatment.
3. The specialist will ensure that the patient has an adequate supply of medication (usually 28 days) until shared care arrangements are in place. Further prescriptions will be issued if, for unseen reasons, arrangements for shared care are not in place at the end of 28 days. Patients should not be put in a position where they are unsure where to obtain supplies of their medication.
4. If shared care is considered appropriate for the patient, and the patient’s treatment and condition are stable, the specialist will contact the GP.
5. The specialist will provide the patient’s GP with the following information:
   • diagnosis of the patient’s condition with the relevant clinical details.
   • details of the patient’s treatment to date.
   • details of treatments to be undertaken by GP*, including dose regimen (stating brand and formulation if it is a modified-release methylphenidate preparation) and date for GP to start prescribing from.
   • details of monitoring arrangements.

Part of the Shared Care Protocol for ADHD in Children and Adolescents Fourth Edition.
Update approved by the APC: March 2015  Review Date: January 2016.
Part of the Shared Care Protocol for ADHD in Children and Adolescents Fourth Edition.
Update approved by the APC: March 2015  Review Date: January 2016.

* Including reasons for choice of treatment, drug or drug combination, frequency of treatment, number of months of treatment to be given before review by the specialist.

6. Whenever the specialist sees the patient, he/she will
   - send a written summary within 14 days to the patient’s GP.
   - record test results on any patient-held monitoring booklet if applicable.
   - communicate any dosage changes made to the patient.

7. The specialist team will be able to provide training for primary care prescribers if necessary to support the shared care agreement.

8. Contact details for primary care prescribers during working and non working hours will be made available.

9. Details for fast track referral back to secondary care will be supplied.

10. The specialist will provide the patient with details of their treatment, follow up appointments, monitoring requirements and nurse specialist contact details.

11. In line with NICE Guidance¹ the specialist would be expected to review the patient every 6-12 months to establish continuing need for medication.

**Primary Care Prescribers Roles and Responsibilities**

The GP will be responsible for:

1. Ensuring that he/she has the information and knowledge to understand the therapeutic issues relating to the patients clinical condition.

2. Undergoing any additional training necessary in order to carry out a practice based ADHD service.

3. Agreeing that in his/her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain with the specialist.

4. If the GP does not agree to shared care for the patient then he/she will inform the specialist of his/her decision in writing within 14 days.

5. Prescribing and monitoring maintenance therapy in accordance with the written instructions contained within the shared care referral and the methylphenidate/atomoxetine GP information sheet(s), making any subsequent changes to the drug regimen as notified by the specialist, and communicating any changes of dosage made in primary care to the patient. It is the responsibility of the prescriber that makes a dose change to communicate this to the patient.

6. Where applicable keep any patient-held monitoring booklet up to date with the results of investigations, changes in dose and alterations in management and take any actions necessary. It is the responsibility of the clinician actioning the results from monitoring, in accordance with this shared care guideline, and thereby prescribing for the patient to complete the patients record with the necessary information.

7. Reporting any adverse effect in the treatment of the patient to the specialist.

8. Ensuring the patient is monitored as outlined in the methylphenidate/atomoxetine information sheet(s) and take the advice of the referring specialist if there are any amendments to the suggested monitoring schedule.

9. Ensuring the patient is given the appropriate appointments for follow up and monitoring, and that defaulters from follow up are contacted to arrange alternative appointments. It is the GPs responsibility to decide whether to continue treatment in a patient who does not attend appointments required for follow up and monitoring. Further prescriptions should not normally be provided by the GP for patients who do not attend the appointments required for follow up and monitoring, and the specialist should be informed.

10. Ensuring that all prescriptions for methylphenidate conform to regulations relating to Schedule 2 Controlled Drugs.
Dispensing Pharmacist Roles and Responsibilities
1. The pharmacist will professionally screen prescriptions to ensure they are safe for the patient and contact the GP/specialist if necessary to clarify their intentions.
2. The pharmacist will fulfill legal prescriptions for medication for the patient unless they are considered unsafe.
3. The pharmacist will counsel the patient on the proper use of their medication.
4. The pharmacist will advise patients suspected of experiencing an adverse reaction to their medicines to contact their GP or specialist.

Patient / Carer Roles and Responsibilities
1. The patient / carer will take / give the medication as agreed, unless otherwise instructed by an appropriate healthcare professional.
2. The patient / carer will attend all follow-up appointments with GP and specialist. If they are unable to attend any appointments they should inform the relevant practitioner as soon as possible and arrange an alternative appointment.
3. The patient / carer will bring along to their appointments their patient-held monitoring booklet if applicable.
4. The patient / carer will inform all healthcare professionals of their current medication prior to receiving any new prescribed or over-the-counter medication.
5. The patient / carer will report all suspected adverse reactions to medicines to their GP or specialist.
6. The patient / carer will store their medication securely.
7. The patient / carer will read the information supplied by their GP, specialist and pharmacist and contact the relevant practitioner if they do not understand any of the information given.

REFERENCES

AUTHORS
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UPDATED John Lawton 18.3.15

ACCESS AND CONTACT POINTS

**Nottinghamshire South**
**In working hours:**
Child and Adolescent Mental Health Services (CAMHS), and
0115-9691300

**Nottinghamshire North**
**In working hours**
Child and Adolescent Mental Health Services (CAMHS)
Mansfield-Ashfield 01623-650921
Newark-Sherwood 01636-670633

Community Paediatrics
(Queens Medical Centre)
0115-8831181

Community Paediatrics
- Mansfield, Newark, Ashfield (excluding Hucknall) at Kings Mill Hospital (KMH) 01623-622515

Out of Hours
Contact on-call CAMHS Psychiatrist via Nottinghamshire Healthcare NHS Foundation Trust 01159-691300.
Community Paediatricians - Nottinghamshire South 0115-8831181 (QMC), Nottinghamshire North (KMH)
01623-622515.