NOTTINGHAMSHIRE AREA PRESCRIBING COMMITTEE
SHARED CARE PROTOCOL AGREEMENT

TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN AND YOUNG PEOPLE (METHYLPHENIDATE, LISDEXAMFETAMINE, DEXAMFETAMINE AND ATOMOXETINE)

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, lisdexamfetamine, dexamfetamine and atomoxetine for attention deficit hyperactivity disorder (ADHD) in children and young people (age 6-17 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-V 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, medication treatment should be offered as the first-line treatment. Parents should also be offered a group-based parent-training/ education programme.[1]

Medication 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 for both the patient and families/carers. The patient should be reassured that they can revisit decisions about treatments.[1]

When a decision has been made to treat children or young people with ADHD with medications, healthcare professionals should consider[1]:

- Methylphenidate (either short or long acting) as the first line pharmacological treatment for children aged 6 years and over and young people with ADHD.
- Consider switching to lisdexamfetamine for children aged 5 years and over and young people who have had a 6-week trial of methylphenidate at an adequate dose and not derived enough benefit in terms of reduced ADHD symptoms and associated impairment
- Consider dexamfetamine for children aged 6 years and over and young people whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.
- Offer atomoxetine to children aged 6 years and over and young people if;
  -they cannot tolerate methylphenidate or lisdexamfetamine **or**
  -their symptoms have not responded to separate 6 week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.
- Atomoxetine may be used in combination with methylphenidate or lisdexamfetamine in children who have not adequately responded to one medication alone.

NATIONAL GUIDANCE

NICE Clinical Guidance 87: Attention deficit hyperactivity disorder: Diagnosis and Management, recommends methylphenidate, lisdexamfetamine, dexamfetamine, guanfacine and atomoxetine as treatment options for children, young people and adults with ADHD[1]. This shared care protocol does not cover treatment of children under 6 years of age or the use of other medications in ADHD for this group.

CLINCAL INFORMATION ON MEDICATIONS

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 provide relevant, age-appropriate written information to people with ADHD and their families and carers about diagnosis, assessment, support groups, self-help, psychological treatment, medication treatment and possible side-effects.
4. 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.
5. If shared care is considered appropriate for the patient, and the patient's treatment and condition are stable, the specialist will contact the GP. 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.
   - If the child/young person fails to attend for physical monitoring, despite attempts to re-appoint, further prescriptions will not be issued – the patient/carer will be contacted and the specialist will be informed.

   * Including reasons for choice of treatment, medication or medication 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.
   - discuss how the patient and their families/carers want to be involved in treatment planning and decisions to take account of changes in circumstances and developmental level.
7. The specialist team will be able to provide training for primary care prescribers if necessary to support the shared care agreement.
8. The specialist service will provide urgent advice and support around medication to patients, their families and colleagues in Primary Care.
9. The specialist will provide the patient with details of their treatment, follow up appointments, monitoring requirements and nurse specialist contact details (nurse details included where staffing available).
10. In line with NICE Guidance[1] the specialist would be expected to review the patient at least annually 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 GP medication

information sheet(s), making any subsequent changes to the medication 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. Regularly discuss treatment planning and decisions with the patient at intervals to take account of changes in circumstances and developmental level.
8. Reporting any adverse effect in the treatment of the patient to the specialist.
9. Ensuring the patient is monitored as outlined in the medication information sheet(s) and takes the advice of the referring specialist if there are any amendments to the suggested monitoring schedule.
10. 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.
11. Ensuring that all prescriptions for methylphenidate, dexamfetamine and lisdexamfetamine 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 fulfil 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.
8. The patient / carer should be told explicitly that if they fail to attend for physical monitoring, further prescriptions will not be supplied and the specialist will be informed for further review of treatment.

REFERENCES

1. Attention deficit hyperactivity disorder: diagnosis and management. NICE Clinical Guideline 87. Available: http://www.nice.org.uk/ . March 2018.(link)
2. Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: Update on recommendations from the British Association for Psychopharmacology. *Bolea-Almanac et al,* 2014, Journal of Psychopharmacology (link)

ACCESS AND CONTACT POINTS

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

Community Paediatrics (Queens Medical Centre) 0115-8831181

Pharmacy Medicines Information
Wells Road Centre 01159-555357
Queens Medical Centre (QMC) 01159-709200

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

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

Pharmacy Medicines Information
Kings Mill Hospital 01623-672213

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.

Version Control- **Children and Young People - ADHD Shared Care Protocol**			
Version	Author(s)	Date	Changes
1.1	Hannah Godden, Mental Health Interface and Efficiencies Pharmacist, NHS Nottingham and Nottinghamshire CCGs/ Nottinghamshire Healthcare NHS Foundation Trust	April 2021 (interim update)	-Added standard header & version control
1.0	Nottinghamshire Healthcare NHS Foundation Trust: Professor Chris Hollis (CAMHS South), John Lawton (Clinical Pharmacy Services Manager), Dr Val Yeung (CAMHS North) Nottingham University Hospitals Community Paediatrcis: Dr Jane Williams, Dr Rosemary Gradwell, Dr Katherine Martin and Dr Amy Taylor Sherwood Forest Hospitals Community Paediatrics: Dr Esther Corker and Dr Mike Farrall Nick Sherwood, Mental Health Interface and Efficiencies Pharmacist, Nottinghamshire CCGs/Nottinghamshire Healthcare NHS Foundation Trust	December 2019	