**Request to Share Care and Agreement Form**

**Guideline Number 01; V1.1; Shared Care Guidelines for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (under 18 years of age)**

**Methylphenidate, Dexamfetamine, Atomoxetine, Lisdexamfetamine and Guanfacine**

**This Request to Share Care provides Key Primary Care Information on responsibilities and monitoring. The aim is to support the GP to agree to share care arrangements. Refer to Full Shared Care Protocol for further information (page 4 onwards).**

**GP to review and must respond to provider Trust request to share care within 2 weeks using form provided on page 2/3.**

**For Completion by Specialist**

Addressograph label

**Patient name…**Click here to enter text.

**DOB…**Click here to enter text. **OR**

**NHS number…**Click here to enter text.

**Drug(s) Dose and Route: …**Click here to enter text.

**Indication: ..**Click here to enter text.

**Date of first prescription by specialist:** Click here to enter text. **Patient weight (kg):** Click here to enter text.

**Estimated date for prescribing to be continued by the GP: …**Click here to enter text.

**Specialist additional comments/advice: …**Click here to enter text.

**Key Primary Care Information (refer to Full Shared Care Protocol for further information)**

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| --- |
| **GP RESPONSIBILITIES** Click here to enter text. |
| **MONITORING AND ACTIONS TO BE TAKEN****Monitoring Table**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test** | **Indication** | **Specialist** **pre-treatment baseline** | **Specialist during treatment initiation** | **GP ongoing monitoring** | **Specialist ongoing monitoring** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Action to be taken if Abnormal Result**

|  |  |
| --- | --- |
| **Abnormal Result**  | **Action to be taken by GP** |
| Click here to enter text. | Click here to enter text. |

 |

* The expectation is that this information along with the full protocol provides sufficient information to enable GPs to be confident to take on the clinical & legal responsibility for prescribing and monitoring.
* Prescribing and monitoring responsibility will only be transferred under this shared care protocol when:
* Specialist has initiated treatment and prescribed/monitored treatment for initial stabilisation period.
* Specialist has provided pre-treatment counselling and discussed patient / carer responsibilities, preferences and obtained consent to shared care arrangements.
* Specialist and patient / carer have completed and signed the shared care agreement form (page 2/3).

**Shared Care Agreement Form**

**This form is used to agree shared care between the specialist, patient / carer and GP.**

**Specialist and patient / carer agreement**

**By signing below, we accept:**

* the [Shared Care Principles](https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf) and
* the requirements and responsibilities defined in this drug specific shared care protocol

|  |  |
| --- | --- |
| **Specialist name:**Click here to enter text. | **Patient name or addressograph label:** |
| **Designation:**Click here to enter text. |
| **Provider Trust:**Click here to enter text. |
| **Direct telephone number:**Click here to enter text. |
| **Email:**Click here to enter text. |
| **Date:**Click here to enter text. | **Specialist Signature:**Click here to enter text. |
| **Date:****Click here to enter text.** | **Patient / Carer Signature or specialist confirmation of patient agreement to shared care arrangement :****Click here to enter text.** |

**GP response to shared care**

**Please return to specialist within two weeks of receipt of request to share care.**

***This form is to be completed by the GP who is requested to share care.***

I agree to accept shared care for this patient as set out in this shared care protocol and [shared care principles](https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf) [ ]

I do not accept shared care for this patient [ ]

My reason(s) for not prescribing are given below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that GP agreement is voluntary, with the right to decline to share care if for any reason you do not feel confident in accepting clinical responsibility. Refusal should not be for financial reasons.

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| --- | --- |
| **GP name:**Click here to enter text. | **Practice address /stamp:** |
| **Direct telephone number:**Click here to enter text. |
| **Email:**Click here to enter text. |
| **Date:**Click here to enter text. | **GP Signature:**Click here to enter text. |

**Please return a copy of the completed form to the requesting specialist within two weeks of receipt of request to share care (preferably by email).**

1. Specialist to retain copy in patient’s hospital records.
2. Copy to be given to patient / carer.
3. GP to retain copy in patient’s notes.

**Full Shared Care Protocol**

**Guideline Number 01; Version 1; Shared Care Protocol for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (under 18 years of age) with**

**Methylphenidate, Dexamfetamine, Lisdexamfetamine, Atomoxetine, and Guanfacine**

**This full protocol provides prescribing and monitoring guidance. It should be read in conjunction with** [**Shared Care Principles**](https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf)**,** [**Summary of Product Characteristics (SPC)**](https://www.medicines.org.uk/emc) **and the** [**BNF**](http://www.bnf.org/bnf/index.htm)**.**

**BACKGROUND AND INDICATION(S) FOR USE**

1. Attention Deficit Hyperactivity Disorder (ADHD) is a behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. Two main diagnostic criteria are in current use – the International Classification of Mental and Behavioural Disorders 10th revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5). ICD-10 uses a narrower diagnostic category, which includes those with more severe symptoms and impairment. DSM-5 has a broader, more inclusive definition, which includes a number of different ADHD subtypes. Severe ADHD corresponds approximately to the ICD-10 diagnosis of hyperkinetic disorder. ADHD (as defined in DSM‑5 or ICD‑10) is a common disorder. In the UK, it is estimated that amongst children between the ages of 5 and 18 years, 3.62% of boys and 0.85% of girls had ADHD, though not all of these children and adolescents would require treatment. Approximately 1% of the school aged children and adolescents would meet the diagnostic criteria for hyperkinetic disorder.
2. NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management advises that for a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
	1. meet the diagnostic criteria in DSM-5 or ICD-10 (hyperkinetic disorder) **and**
	2. cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, **and**
	3. be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
3. As part of the diagnostic process, there should be 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.
4. Children and adolescents referred for assessment for ADHD should receive a specialist clinical assessment by a psychiatrist or paediatrician, with the aim of ruling out undiagnosed disorders with symptoms that in rare instances may mimic or cause some aspects of ADHD, such as hearing impairment, epilepsy, thyroid disorder and iron deficiency anaemia.
5. Drug treatment is not indicated as the first-line treatment for all school-age children and young people with ADHD. It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have refused non-drug interventions, or whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment.
6. All children with ADHD will benefit from behavioural, educational and psychological input. Information about ADHD and additional support should be offered to parents and carers of all children aged 5 years and over and young people with ADHD. The support should be ADHD focused, can be group based and as few as 1 or 2 sessions.
7. Medication for ADHD for any child less than 5 years of age should only be prescribed after obtaining a second specialist opinion from an ADHD service with expertise in managing ADHD in young children (ideally a tertiary service). Children aged less than 5 years are outside of the scope of this Shared Care Guideline and prescribing for this age-group will be specialist-only.
8. Medications should only be initiated by an appropriately qualified healthcare professional with training and expertise in ADHD after a comprehensive assessment. Medication should be offered to children and young people only if their ADHD symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed, they and their parents and carers have discussed information about ADHD, and a baseline assessment has been carried out (see point 9 below).
9. Before starting medication for ADHD, children and young people with ADHD should have a full pre-treatment assessment, which should include:
	1. A review to confirm that they continue to meet the criteria for ADHD and need treatment
	2. full mental health and social assessment which should include:
		* presence of coexisting mental health and neurodevelopmental disorders
		* current educational or employment circumstances
		* risk assessment for substance misuse and drug diversion
	3. Review of Physical Health, including:
		* Medical history, with consideration of any conditions that may be contraindications for specific medicines
		* Current medication
		* Baseline pulse and blood pressure (plotted on a centile chart)
		* height and weight (plotted on a growth chart)
		* Cardiovascular assessment including:
			+ family history of cardiac disease or previous cardiac surgery
			+ history of sudden death in 1st degree relative under 40 suggestive of cardiac disease
			+ history of shortness of breath on exertion compared to peers
			+ Fainting on exertion or in response to fright or noise
			+ palpitations that are rapid, regular and start and stop suddenly
			+ chest pain suggesting cardiac origin
			+ murmur on examination
		* Referral for a cardiology opinion before starting medication for ADHD if any of the above apply.
		* An electrocardiogram (ECG) if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination or the person has a co-existing condition or treatment with a medicine that may pose an increased cardiac risk.

NB. In addition to the above, before initiating Guanfacine, a baseline evaluation is required to identify patients at increased risk of somnolence and sedation, hypotension and bradycardia.

1. NICE guidelines (2018, updated 2019) makes the following recommendations for pharmacological intervention in children and young people diagnosed with ADHD:
	1. Offer methylphenidate (either short or long acting) as the first line pharmacological treatment for children aged 5 years and over and young people with ADHD
	2. 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
	3. Consider dexamfetamine for children aged 5 years and over and young people whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile
	4. Offer atomoxetine or guanfacine to children aged 5 years and over and young people if:

i) They cannot tolerate methylphenidate or lisdexamfetamine or

ii) Their symptoms have not responded to separate 6-week trials of lisdexamfetamine, methylphenidate, having considered alternative preparations and adequate doses

1. If there is a choice of more than one appropriate drug, the product with the lowest cost should be used in situations where equivalent effectiveness can be demonstrated. (See Table 1). Generic prescribing of MR Methylphenidate is not recommended as different modified release preparations have varying release profiles and generic prescribing can lead to the supply of an inappropriate MR formulation product which does not meet the clinical needs of the young person or the intentions of the prescriber. This could also have an impact on the monitoring ofthe response to treatment due to variability in the product supplied each time the prescription is dispensed.

1. Rarely, under specialist supervision, methylphenidate and atomoxetine may be combined. If this occurs, then prescribing will remain wholly with specialist services.
2. If treatment is adopted and the patient is stabilised after dose titration, consideration can be given to shared care arrangements for prescribing. The specialist should write to the GP requesting that they continue prescribing in line with this protocol. It is the responsibility of the GP to contact the specialist if they do not agree or there is a problem. (See Shared Care Agreement Forms, pg 1 & 2 of this document).
3. The shared care arrangements should be agreed by the patients (if appropriate) and/or their parents and supported with patient information leaflets and their GP**.**
4. **Review of medication and discontinuation:** Successful treatment reduces the risk of development of secondary complications such as conduct disorder or academic failure. The specialist should carry out a comprehensive review of ADHD medication at least once a year and discuss with the person with ADHD (and their families and carers as appropriate) whether medication should be continued. Trial periods of stopping medication or reducing the dose should be considered when assessment of the overall balance of benefits and harms suggests this may be appropriate. Medication should be discontinued if review shows it to be of no benefit. Methylphenidate, Dexamfetamine, Lisdexamfetamine and Guanfacine should be withdrawn carefully with tapered dosing as per SPC. Atomoxetine **can** be discontinued without tapering the dose.
5. **Transition of young people aged > 17 years to Adult Psychiatric Services**:

Appropriate transition arrangements must be in place for young people who require treatment to continue into adulthood. Decisions to continue treatment in adults should be considered by adult psychiatrists after an assessment of symptoms and as part of a wider programme of care. Only adolescents who show clear improvement with ADHD medication should be considered for on-going treatment as adults. The need for continuing treatment beyond the age of 17 years should be reviewed by the Community Paediatrician/Specialist Team before the patient reaches the age of 18. In most cases, treatment should have been discontinued by the age of 18, but if treatment beyond this age is considered necessary, the following transitioning arrangements should be undertaken by the Community Paediatric team:

* Inform Adult Psychiatric Services of the details and history of the patient who is approaching his/her 18th birthday and who has been identified as someone who may require on-going support with ADHD.
* Inform the GP of any decision to stop or alter the treatment plan prior to transition to adult services.
* Review the young person prior to their 18th birthday with the aim of deciding whether treatment should be discontinued (a clear de-prescribing plan); referral to adult psychiatric services is required for continuation of treatment or whether, in exceptional cases, a referral to a tertiary centre is required. (NICE guidance states that guanfacine should only be prescribed to adults on the advice of a tertiary centre).

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| **Drug and Place in Therapy** | **Indication** | **Dose and Route of Administration** |
| **Preparation** | **Dose** | **Notes** |
| **METHYLPHENIDATE****First line** | Treatment of ADHD | **Immediate Release tablets\***Available in the following strengths: **5mg, 10mg, 20mg (**Brands available: Ritalin® Medikinet®)**NB should be prescribed generically** | Age 4- 5 years: 2.5 mg twice daily increased if necessary, at weekly intervals by 2.5 mg daily to max. 1.4 mg/kg daily in 2–3 divided dosesAge 6-17 years: Initially 5 mg 1–2 times a day, increased in steps of 5–10 mg daily if required, at weekly intervals, increased if necessary up to 2.1 mg/kg daily in 2–3 divided doses, max. licensed dose is 60 mg daily in 2–3 doses, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks | * Children under 5 years of age are excluded from this Shared Care Guideline and prescribing for this age group remains specialist-only
* In some children rebound hyperactivity may occur if the effect of the drug wears off in the evening. An additional dose later in the day may eliminate this difficulty but may disturb sleep.
* MR formulations may be preferred over IR formulations for the following reasons: convenience, improving adherence, reducing stigma (no need to take medication at school or in the workplace),reducing problems of storing and administering CDs at school, the risk of stimulant misuse and diversion with immediate release preparations, pharmacokinetic profiles
 |
| **Sustained/modified release tablets** Available in the following strengths **18mg, 27mg, 36mg, 54mg** Concerta® XL, Matoride, Xenidate, Delmosart, Xaggitin***The prescriber must specify the brand*** | Initially 18 mg once daily in the morning, increased in steps of 18 mg daily at weekly intervals, increased if necessary up to 2.1 mg/kg daily, max. licensed dose is 54 mg daily, (maximum of 108 mg daily under the direction of a specialist) discontinue if no response after 6 weeks. Concerta XL® tablets consist of an immediate release component (22%) of the dose and a modified release component (78% of the dose). | * Total daily dose of 15mg of immediate-release tablet is considered equivalent to 18mg once daily of sustained release tablets. 60mg of Ritalin is the maximum licensed dose. The equivalent dose of Concerta**®** XL is 72mg, which is above the maximum licensed dose.
* The different types of products are not interchangeable and the BNF recommends prescribing by brand name to avoid the risk of de-stabilisation from different release characteristics of the MR products dispensed generically
 |
| **Sustained/modified release capsules** Available in the following strengths **5mg, 10mg, 20mg, 30mg, 40mg, 50mg,60mg**Equasym® XL Medikinet® XL ***The prescriber must specify the brand*** | Initially 10mg once daily (in the morning before breakfast), increasing if necessary, by weekly increments of 10mg to a max. licensed dose of 60 mg daily, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks.Medikinet XL® capsules consist of an immediate release component (50% of the dose) and a modified release component (50% of the dose).Equasym XL® capsules consist of immediate release component (30% of the dose) and a modified release component (70% of the dose). | * 40mg XL strength not available in Equasym® XL brand
* The different types of products are not interchangeable and the BNF recommends prescribing by brand name to avoid the risk of de-stabilisation from different release characteristics of the MR products dispensed
 |
| **LISDEXAMFETAMINE****2ND LINE**To be considered if methylphenidate has not been successful or is not tolerated | Licensed for ADHD for children over 6 years of age. | **Elvanse® 20mg. 30mg, 40mg, 50mg 60mg and 70mg Capsules** | Starting dose 30mg taken once in the morning (with or without food)The dose may be increased by10-20mg increments at approximately weekly intervals. Maximum recommended dose = 70mg/day. Discontinue if insufficient response after 1 month | * Lower starting dose of 20mg once daily may be needed in some patients
* Lisdexamfetamine may be swallowed whole, or the capsules opened, and the entire contents emptied and mixed with a soft food such as yogurt or in a glass of water or orange juice
 |

**DOSAGE, ROUTE OF ADMINISTRATION AND DURATION OF TREATMENT**

**TABLE 1** NB: The information in this table is not exhaustive and is intended for guidance only. For full information on doses, cautions, contra-indications and interactions please refer to the current British National Formulary and Summary of Product Characteristics. (www.medicines.org.uk)this table is for guidance only. Refer to BNF and SPC for full information before prescribing.

|  |  |  |
| --- | --- | --- |
| **Drug & Place in therapy** | **Indication** | **Dose and Route of Administration** |
| **Preparation** | **Dose** | **Notes** |
| **DEXAMFETAMINE**To be considered if methylphenidate not successful or tolerated and have responded to lisdexamfetamine but cannot tolerate the longer effect profile | Licensed for ADHD for children over 6 years of age. | **Amfexa® tablets 5mg, 10mg 20mg**Oral solution is 1mg/ml | Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required, increased if necessary up to 1 mg/kg daily, maintenance dose to be given in 2–4 divided doses, up to 20 mg daily (40 mg daily has been required in some children). | Doses after 5pm are more likely to worsen sleep but occasionally may help settling if given less than three hours before bedtime. Specialist prescribing only (refer to West Essex Paediatric Formulary) |
| **ATOMOXETINE****3RD LINE**To be considered if methylphenidate or lisdexamfetamine has not been successful or tolerated | Licensed for ADHD for children over 6 years of age. | **Strattera® Capsules 10mg, 18mg, 25mg, 40mg, 60mg, oral solution 4mg/ml****Child over 6 years (body weight****<70kg)** | Initially 500 micrograms/kg daily for 7 days, increased according to response; usual maintenance dose 1.2mg/kg daily, but may be increased to 1.8mg/kg daily (max. 120mg daily) under the direction of a specialist | Total daily dose may be given either as a single dose in the morning or in 2 divided doses with last dose no later than early evening. |
| **Child over 6 years (body weight****>70kg)** | Initially 40mg daily for 7 days, increased according to response; usual maintenance dose 80mg daily, but may be increased to 120mg daily under the direction of a specialist. |
| **GUANFACINE****3rd LINE**To be considered if methylphenidate or lisdexamfetaminehas not been successful or tolerated | Licensed for ADHD for children over 6 years of age | **Intuniv ® tablets 1mg, 2mg, 3mg, 4mg****Child 6-17years (body weight 25kg – 41.4kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 4mg once daily | Somnolence and sedation may occur, predominantly during the first 2-3 weeks of treatment and with dose increases; manufacturer advises to consider dose reduction or discontinuation of treatment if symptoms are clinically significant or persistent |
| **Child 13 - 17years (body weight 41.5kg – 49.4kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 5mg once daily |
| **Child 13 - 17years (body weight 49.5kg – 58.4.kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 6mg once daily |
| **Child 13 - 17years (body weight****>58.4.kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 7mg once daily | Dose can be titrated to a 7 mg/day dose after the subject has completed a minimum of 1 week of therapy on a 6 mg/day dose and the physician has performed a thorough review of the subject's tolerability and efficacy. |

Swallowing difficulties

Please refer to the [‘specials’ alternative guidance](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hweclinicalguidance.nhs.uk%2Fall-clinical-areas-documents%2Fdownload%3Fcid%3D2274%26checksum%3D95f8d9901ca8878e291552f001f67692&data=05%7C02%7Cheernamehta%40nhs.net%7Ccba67ac584344a90298108dcafcc3bcd%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638578538908037976%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=drWPIVzT4RkMn0VJJa96%2F2dIm19xPNtqcc0yghL%2FsEA%3D&reserved=0) for a list of commonly prescribed medicines and alternative methods of administration for patients with swallowing difficulties, feeding tubes or for patients prescribed unlicensed ‘specials’ medication. Each entry takes into account alternative medicines, formulations, cost and licensing. This list is not exhaustive. As not all medicines are listed, please contact the initiating specialist if required for individual patient advice if a patient has a swallowing difficulty.

**SPECIALIST RESPONSIBILITIES INCLUDING PRE-TREATMENT ASSESSMENT**

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| --- |
| 1. Confirm a diagnosis of ADHD as described in sections 2, 3 and 4 of this Protocol. Decide on the most appropriate drug treatment and discuss benefits and side-effects with the patient and/or parent(s)/carer(s) and provide written information where appropriate. Provide pre-treatment counselling to the patient (and parent(s)/carers). This should include both written and verbal information on the rationale for treatment, benefits, time to response, potential side-effects and precautions, and obtain agreement to initiate treatment. Document discussion in electronic patient record
 |
| 1. Undertake pre-treatment assessment and physical screen, as specified in section 9 of this protocol and advise the GP of the outcome of the assessment.
 |
| 1. Confirm that any new ADHD therapy is not contra-indicated because of concurrent therapy for other conditions the patient may be suffering from e.g. check drug-drug and drug-disease interactions
 |
| 1. Initially prescribe, titrate dose and stabilise the patient on the chosen medication. Monitor height, weight and blood pressure and other parameters as specified (See under Monitoring and Actions to be Taken). Monitor behavioural response to treatment and side effects and adjust medication accordingly
 |
| 1. When appropriate, ask GP if they are willing to participate in shared care by completing and sending the Request to Share Care and Agreement Forms (see page 1 & 2) ensuring that monitoring requirements are clearly stated.
 |
| 1. Advise GP of information provided to the patient/carer about the treatment and/or about the proposed shared care arrangement e.g. what and to whom the patient should report potential side effects.
 |
| 1. Continue to prescribe for the patient after initiation of treatment until such time as the patient’s GP agrees to the shared care arrangement. The GP should complete the Shared Care Agreement Form and return it to the Specialist. Care must not be transferred until this form is received AND the GP has indicated on it that they agree to shared care.
 |
| 1. Once a patient is moved over to a shared care agreement, supply a final 28-day prescription of ADHD medications to allow GP time to issue the next supply.
 |
| 1. Communicate promptly with the GP about any changes in treatment and any dose change following clinic review.
 |
| 1. Once stabilised, monitor the efficacy of the treatment and any side effects at least 6 monthly, taking into account specific monitoring requirement of individual drugs (see Monitoring and Actions to be Taken) considering whether continuation is necessary.
 |
| 1. Agree how the outcome of monitoring will be communicated between specialist, GP and patient.
 |
| 1. Ensure clear arrangements are in place for back up, advice and support e.g. out of hours and/or when the consultant initiating therapy is not available.
 |
| 1. Ensure that patient/carers understand their treatment regimen and any monitoring or follow up that is required (using advocacy if appropriate). Educate about the drug therapy to maximise compliance and be aware of when to seek medical advice.
 |
| 1. Liaise with the school if necessary.
 |
| 1. Provide the parent/carer and where appropriate, the patient with verbal and written medication information and to inform the GP that if they wish to opt out of the shared care agreement, they should notify the specialist team
 |
| 1. Evaluate any adverse effects reported by the GP (Any adverse effects which are suspected to relate to the drug should be reported to the MHRA via the Yellow Card Scheme <https://yellowcard.mhra.gov.uk/> ).
 |
| 1. Refer for additional behavioural therapy (social skills, anger management or parents

group/parenting skills) if appropriate. |
| 1. Send Clinic Letter to the GP after each clinic attendance ensuring current dose is stated. The Specialist will specify the brand of medication, if appropriate, in their communication to GP.
 |

**GP RESPONSIBILITIES**

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| --- |
| 1. To opportunistically reinforce patients’ understanding of their treatment regime and any monitoring and follow up that is required on an ongoing basis.
 |
| 1. Complete the Shared Care Agreement Form within 2 weeks of receipt from the Specialist, indicating whether shared care is agreed or declined.
 |
| 1. If care is agreed to be shared, prescribe Methylphenidate/ Lisdexamfetamine/ Dexamfetamine/ Atomoxetine/Guanfacine at the dose recommended by the Specialist once the patient is stabilised on treatment and side effects have been excluded as far as possible by the specialist team.
 |
| 1. To discuss with the specialist if suicidal behaviour, self-harm or hostility develop
 |
| 1. Report and discuss with Specialist any adverse effects of medication, possible drug interactions, changes to the patient’s medication regimen, deteriorating behaviour, suspected diversion/ misuse and/ or relevant medical information including any test results If patient reports changes in parameters monitored by the specialist, including loss of efficacy or worsening of condition related symptoms, urgent referral back to the specialist should be considered. (See Monitoring and Actions to be Taken)
 |
|

|  |
| --- |
| 1. Check for possible drug interactions when newly prescribing or stopping concurrent medication.
 |

 |
|  8. Arrange appropriate investigation if the patient shows signs of liver problems and discontinue the medication if the person has jaundice or has laboratory evidence of hepatic injury. Contact the specialist team immediately. |
| 1. Report adverse events to the MHRA via the Yellow Card Scheme <https://yellowcard.mhra.gov.uk/> ; If the drug has black triangle status or is unlicensed, all adverse events should be reported even if causal relationship is not known or if the adverse event is already known about.
 |
| 1. Only ask the Specialist to take back the prescribing should unmanageable problems arise and/or patient not engaging with GP
 |
| 1. Continuation of ADHD medicine without specialist review is not recommended.
 |

**PATIENT/PARENT/CARER RESPONSIBILITIES**

|  |
| --- |
| 1. Discuss potential benefits and side effects of treatment with the specialist and GP, to identify whether they have a clear picture of these from the specialist and to raise any outstanding queries
 |
| 1. Check that where possible the specialists have provided a patient-held record or information sheet for monitoring and/or to alert other clinical staff to the treatment they are receiving
 |
| 1. Share any concerns they have in relation to treatment with their drug(s)
 |
| 1. Report any adverse effects to their specialist or GP whilst taking drug(s)
 |
| 1. Report to the specialist or GP if they do not have a clear understanding of their treatment
 |
| 1. Participate in the monitoring of therapy and the assessment of outcomes, to assist health professionals to provide safe, appropriate treatment
 |
| 1. Ensure that all current medication is taken to consultations with the specialist or provide an up-to-date list
 |

**ICB RESPONSIBILITIES**

1. To provide feedback to Provider Organisations via HWE Area Prescribing Committee
2. To support GPs to make the decision whether or not to accept clinical responsibility for prescribing.
3. To support Provider Organisations in resolving issues that may arise as a result of shared care.

**MONITORING AND ACTIONS TO BE TAKEN**

For people taking methylphenidate, lisdexamfetamine, dexamfetamine and atomoxetine, routine blood tests and ECGs are not recommended unless there is a clinical indication.

Prior to prescribing, it is necessary to conduct a baseline evaluation of a patient's cardiovascular status including blood pressure and heart rate (see section 9)

Liver damage is a rare and idiosyncratic adverse effect of atomoxetine, but routine liver function tests are not recommended

 **Table 1: Monitoring Requirements for ADHD medicines excluding Guanfacine**

|  |  |  |  |
| --- | --- | --- | --- |
| PARAMETER | FREQUENCY OF MONITORING | ACTION | BY WHOM |
| Efficacy | At each appointment and when doses are changed. | * Rating scales may be used.
 | **Specialist** |
| Weight and height | * measure height at baseline and every 6 months in children and young people
* measure weight at baseline and every 3 months in children 10 years and under
* measure weight at 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise
 | * Plot Weight and Height on published Growth Charts and ensure review.
* If weight loss is a clinical concern, consider the following strategies:
* taking medication either with or after food, rather than before meals
* taking additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off
* obtaining dietary advice
* consuming high-calorie foods of good nutritional value
* taking a planned break from treatment
* changing medication.
* If a child or young person's height over time is significantly affected by medication (that is, they
* have not met the height expected for their age), consider a planned break in treatment over
* school holidays to allow 'catch-up' growth
 | **Specialist** |
| Cardiovascular risk assessment | * Baseline (Pre-treatment)
 | * Refer for cardiology assessment/opinion before prescribing medication if any of the following apply:
* Cardiovascular assessment including:
* family history of cardiac disease or previous cardiac surgery
* history of sudden death in 1st degree relative under 40 suggestive of cardiac disease
* history of shortness of breath on exertion compared to peers
* Fainting on exertion or in response to fright or noise
* palpitations that are rapid, regular and start and stop suddenly
* chest pain suggesting cardiac origin
* murmur on examination
 | **Specialist** |
| Blood pressure and heart rate | * At Baseline
* compare with the normal range for age before and after each dose change and every 6 months.
 | If sustained resting tachycardia (more than 120 beatsper minute), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinicallysignificant increase) measured on 2 occasions, reduce the dose and refer to a Paediatric hypertension specialist.  | **Specialist**  |
| TICs | Monitor at appointments | If TICs develop during prescribing of stimulants, consider if:the tics are related to the stimulant (tics naturally wax and wane) andthe impairment associated with the tics outweighs the benefits of ADHD treatmentIf tics are stimulant related, reduce the stimulant dose, or consider changing to guanfacine (in children aged 5 years and over and young people only), atomoxetine, clonidine, or stopping medication. | **Specialist**  |
| Seizures |  Monitor at appointments | If new seizures develop or there is a worsening of existing seizures, review the ADHD medication and stop any medication that might be contributing to the seizures. Afterinvestigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of the seizures. | **Specialist** |
| Changes in sleep pattern | Monitor at appointments | Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly. | **Specialist** |
| Liver impairment (Atomoxetine) | Duration of treatment with atomoxetine | Rare side effect, however, be vigilant for signs of abdominal pain, unexplained nausea, malaise, darkening of the urine or jaundice. Patients and carers should be advised to seek prompt medical attention if these symptoms develop.Routine testing of LFTs is not required. | **Specialist/GP** |
| Non-specific side-effects | Monitor at appointments | Review and monitor adverse effects, possible drug interactions, changes to medication regime, deteriorating behaviour. Communicate any relevant medical information to Specialist /GP. | **Specialist/GP** |
| Risk assessment for substance misuse and drug diversion | Monitor at baseline and ongoing | At baseline consider/enquire about known substance use in patient or that of close family member or carer.Ongoing, requests for frequent repeat prescriptions deemed unnecessary should be communicated to the Specialist | **Specialist****GP** |
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**Table 2: Monitoring Requirements for Guanfacine**

|  |  |  |  |
| --- | --- | --- | --- |
| PARAMETER | FREQUENCY OF MONITORING | ACTION | BY WHOM |
| Efficacy | At each appointment and when doses are changed. | * Rating scales may be used.
 | **Specialist** |
| Weight increase/obesity | * measure at baseline and every 3 months for the first 12 months
* Monitor every 6 months after the first year
 | * Plot Weight and Height on published Growth Charts and ensure review.
* Children and adolescents treated with guanfacine may show an increase in their BMI.
 | **Specialist** |
| Height | * At Baseline and Measure 6 monthly
 | * If a child or young person's height over time is significantly affected by medication (that is, they
* have not met the height expected for their age), consider a planned break in treatment over
* school holidays to allow 'catch-up' growth
 | **Specialist** |
| Cardiovascular risk assessment | * Baseline (Pre-treatment)
 | * Refer for cardiology assessment/opinion before prescribing medication if any of the following apply:

Cardiovascular assessment including:* family history of cardiac disease or previous cardiac surgery
* history of sudden death in 1st degree relative under 40 suggestive of cardiac disease
* history of shortness of breath on exertion compared to peers
* Fainting on exertion or in response to fright or noise
* palpitations that are rapid, regular and start and stop suddenly
* chest pain suggesting cardiac origin
* murmur on examination
 | **Specialist** |
| Blood pressure and heart rate | * Baseline assessment of risk of hypotension and bradycardia.
* Monitor heart rate and blood pressure weekly during dose titration then every 3 months for the first 12 months
* Monitor 6 monthly thereafter
* Monitor on dose reduction or discontinuation of treatment
 | * If sustained resting tachycardia (more than 120 beats

per minute), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinicallysignificant increase) measured on 2 occasions, reduce the dose and refer to a Paediatric Hypertension Specialist. * If sustained orthostatic hypotension or fainting episodes, reduce the dose or switch to another ADHD medication.
* Blood pressure and pulse may increase following discontinuation. Dose should be reduced gradually (see [SPC](https://www.medicines.org.uk/emc/product/5099/smpc#UNDESIRABLE_EFFECTS)) and BP and pulse monitored.
 | **Specialist**  |
| Somnolence and sedation | * baseline assessment of increased risk somnolence and sedation
* Monitor weekly during dose titration for signs and symptoms then 3 monthly for the first 12 months
* Monitor 6 monthly thereafter
 | If somnolence and sedation are judged to be clinically concerning or persistent, a dose decrease, or discontinuation should be considered. | **Specialist** |
| Appearance of suicidal behaviour,self-harm orhostility. | Ongoing basis at appointments | Patients/parents should be advised of this risk and madeaware of possible signs/symptoms to report back to theSpecialist immediately if noticed.Treatment of an underlying psychiatric condition may be necessary, and consideration should be given to a possible change in the ADHD treatment and appropriate referral | **Specialist/GP as agreed** |
| Seizures |  Monitor at appointments | If new seizures develop or there is a worsening of existing seizures, review and stop any medication that might be contributing to the seizures. After investigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of the seizures. | **Specialist** |
| Changes in sleep pattern | Monitor at appointments | Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly. | **Specialist** |
| Non-specific side-effects | Monitor at appointments | Review and monitor adverse effects, possible drug interactions, changes to medication regime, deteriorating behaviour. Communicate any relevant medical information to Specialist /GP. | **Specialist/GP** |
| Risk assessment for substance misuse and drug diversion | Monitor at baseline and ongoing | At baseline consider/enquire about known substance use in patient or that of close family member or carer.Ongoing, requests for frequent repeat prescriptions deemed unnecessary should be communicated to the Specialist | **Specialist****GP** |
|  |  |  |  |

**SIDE EFFECTS AND ACTIONS TO BE TAKEN**

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| --- | --- |
| **Side Effect** | **Action to be taken by GP** |
| Seizures (development or worsening) | Notify Specialist Immediately |
| Emergence of suicidal ideation, self-harm, hostility | Notify specialist immediately |
| Abdominal pain, unexplained nausea, malaise, darkening of the urine or jaundice | Notify specialist immediately and refer to acute services if necessary; order tests for liver function |

**CONTRAINDICATIONS AND PRECAUTIONS**

Please refer to the current Summary of Product Characteristics and current BNF for full information.

* (SPC) with up to date revisions available at: <https://www.medicines.org.uk/emc/>

 Information on the contraindications, notable drug interactions, and precautions for each individual drug can also be obtained from:

* British National Formulary and British National Formulary for Children (BNF/BNFC), available at <https://www.medicinescomplete.com/#/> and <https://bnfc.nice.org.uk/>

**CONTACT DETAILS for BACK-UP INFORMATION / ADVICE**

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| --- | --- | --- |
|  | **West Essex Community Paediatric Service** | **HWE ICB PMOT** |
| **Contact Details***(provide details of different sites where applicable)* | 0300 247 0022 | hweicbhv.medicinesoptimisationteam@nhs.net  |
| **Specialist Team designated nhs.net email** | essexquality@hcrgcaregroup.com |  |
| **Out of hours contact** | Not applicable |  |
| **Pharmacy Team shared care admin nhs.net email** | essexquality@hcrgcaregroup.com |  |
| **Switchboard** | 0300 247 0122 Opt3 Opt1 (central admin team) |  |

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**GP Considerations for Shared Care**

This shared care agreement outlines suggested management for the prescribing of the specified drug(s) and indication(s) when the responsibility is shared between the specialist and general practitioner (GP). Sharing of care assumes communication between the specialist, GP and patient. It is important that patients are consulted about treatment and are in agreement with it. The intention to share care should be explained to the patient by the doctor initiating treatment and consent obtained.

Prescribing is to be initiated in secondary care by a provider Trust specialist and will usually be prescribed for 12 weeks unless otherwise stated within the agreed individual shared care protocol**. The expectation is that these shared care guidelines should provide sufficient information to enable GPs to be confident to take on the clinical and legal responsibility for the prescribing and the monitoring of this / these drug(s) in stable patients.** The questions below will help you confirm this:

* Is the patient’s condition predictable or stable?
* Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care document?
* Have you been provided with relevant clinical details including monitoring data?
* Have this document and BNF/SPC provided sufficient information for you to feel confident in accepting clinical and legal responsibility for prescribing?

**If you can answer YES to all of these questions (after reading this shared care guideline), then it is appropriate for you to accept the prescribing responsibility. GPs need to formally accept shared care by completing and returning the form provided within this protocol to the specialist within two weeks of receipt of request to share care.**

If the answer is NO to any of these questions, you should not accept prescribing responsibility. You should respond back to the consultant outlining your reasons for NOT prescribing on the agreement form within two weeks of receiving the request to share care. If you do not have the confidence to prescribe, you still have the right to decline. In such an event, the total clinical responsibility for prescribing the medication and any monitoring required remains with the specialist. Please note that medication cost is not an acceptable reason for refusal to take on shared care.

The prescribing doctor legally assumes clinical responsibility for the drug and the consequences of its useas well as responsibility of monitoring (securing and reviewing blood test results).

Prescribing and monitoring responsibility will only be transferred when the consultant and the GP agree that the patient’s condition is stable or predictable. This will usually be 12 weeks of treatment unless otherwise stated within the agreed individual shared care protocol.

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| --- | --- |
| Title of Guideline | Shared Care Protocol for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (under 18 years of age) withMethylphenidate, Dexamfetamine, Lisdexamfetamine, Atomoxetine, and Guanfacine |
| Version | 1.3 |
| Effective Date | October 2024 |
| Review Date | The recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available. |
| Original Version Produced | 1.1 |
| ***Approvals:*** | December 2020 |
| Provider Trust Drug / Formulary Group  | ECFWS Prescribing Meeting 9.11.20 |
| WEMOPB | November 2020 |
| Author/s  | Louise Crowley; Beryl Navti |
| June 2022 | Removal of EWMHS from shared care: logo and contact details |
| December 2023 v1.2 | Harmonisation of Hertfordshire Medicines Management Committee (HMMC) guidance and West Essex Medicines Optimisation Programme Board (WEMOPB) guidance updates include:* Rebadging with HWE ICB and removal of WECCG header
* Review date removed and replaced with standard statement.
* Removal of reference to WECCG and new contact email
 |
| October 2024 | * Updated with wording on swallowing difficulties and patient consent to shared care
* Updated contact details for WEST Essex Community Pediatric service
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