Working in Partnership

SHARED CARE PRESCRIBING GUIDELINE

Shared Care and Transfer of Care Guideline for stimulants and non-stimulants used for the Management of Attention-deficit Hyperactivity Disorder (ADHD) in Adult Patients (age 18- 64 years)

This shared care guideline is only applicable for use for patients within Bedfordshire and Luton who are under the care of East London Foundation Trust (ELFT) clinicians.

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Consultation Groups	**BLMK ICS and associated stakeholders in the community ELFT ADHD services ELFT mental health services Luton and Bedfordshire**
Approved by (Sponsor Group)	**BLMK ICS Area Prescribing Committee ELFT Medicine Management Committee**
Ratified by:	**BLMK ICS Area Prescribing Committee ELFT Medicine Management Committee**
Date ratified:	**XXXXXXXXX**
Name and Job Title of author:	**BLMK ICS ELFT Pharmacists**
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General Shared Care Guideline (SCG) Principles

- Medicines considered suitable for shared care are those which should be initiated by a Specialist, but where prescribing and monitoring responsibility may be transferred to Primary Care. Due to their potential side effects, shared care medicines usually require monitoring and review by the Specialist to determine whether the medicines should be continued. The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement.

- The transfer of prescribing responsibility from the Specialist to the patient's General Practitioner (GP) or Primary Care prescriber should occur when both parties are in agreement that the patient's condition is stable or predictable, and that the Primary Care prescriber has the relevant knowledge, skills and access to equipment to allow them to monitor treatment as indicated in this shared care prescribing guideline.

- The aim of this guideline is to equip Primary Care prescribers with the information to confidently take on clinical and legal responsibility for prescribing the medication under a shared care agreement within their own level of competence.

- Within the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS), shared care guidelines are produced and updated through a robust governance process, following consultation with a wide range of key stakeholders. On this basis for BLMK ICS approved shared care guidelines, it is anticipated that Primary Care prescribers, upon individual assessment, will accept shared care for the patient if they felt it was clinically appropriate to do so and seek patient consent.

- Where a request for shared care is made by the specialist via clinical correspondence, **shared care agreement is assumed.** Specialist services **are not required** to complete any specific forms. Primary Care prescriber **are not required to** send confirmation in writing via letter or approved electronic communication for acceptance of shared care.

- If the Primary Care prescriber feels that a request for shared care cannot be accepted, i.e. falls outside of their own level of competence, they should initially seek further information or advice from the clinician who is sharing care responsibilities or from another experienced colleague in line with the General Medical Council (GMC) guidance.

- If the Primary Care prescriber is still not satisfied clinically to accept shared care, they should make appropriate arrangements for the patient's continuing care where possible. This may include asking another colleague in their practice to undertake the shared care. In the event that other colleagues in the practice also decline to share care, the Primary Care prescriber could seek assistance and advice from their Primary Care Network (PCN) (e.g. PCN Pharmacist).

- If the decision, after discussion with the PCN, is to decline shared care, the Primary Care prescriber must notify the Specialist clinician of their decision and reason (See appendix 1) to decline as soon as they can and in a timely manner (within a maximum of 14 to 21 days upon receipt of request) in writing and ensure the patient is aware of the change. In this scenario, the prescribing responsibility for the patient remains entirely with the Specialist. This principle also applies where shared care needs to be terminated in primary care e.g. due to lack of patient engagement. It is anticipated that these would be very rare events.

General Shared Care Guideline (SCG) Principles

- Where the hospital or Specialist clinician retains responsibility for monitoring drug therapy and/or making dosage adjustments, the Primary Care prescriber must be informed of any dose changes made as soon as possible to avoid medication errors. Similarly, if the Primary Care prescriber makes changes to the patient's medication regimen, the Primary Care prescriber must inform the Specialist in a timely manner. Primary Care prescribers can contact the Specialist team for advice, training and support as required.

- An agreed method of communication of blood test results and results of investigations between the Specialist, the Primary Care prescriber, the Community Pharmacist and the patient should be agreed at the onset of shared care and documented in the patient's notes in both Secondary care and Primary Care. Blood test results can usually be accessed electronically by both Secondary Care and Primary Care prescribers in the majority of cases. For some medications and in certain cases, the patient may elect to have a patient-held monitoring booklet, e.g. those on warfarin and lithium therapy.

- The principles above apply to shared care arrangements that involve the Specialist service sharing care with GPs and/or other Primary Care prescribers, e.g. Community Nursing Services. Where patient care is transferred from one Specialist service or GP practice to another, a new shared care agreement request must be commenced.

Stimulants and non-stimulants used for the Management of Attention-Deficit Hyperactivity Disorder (ADHD) in Adult Patients (age 18- 64 years)

Introduction and Aims of Shared Care (including a brief overview of the condition being treated for):

This shared care guideline is only applicable for use for patients within Bedfordshire and Luton who are under the care of ELFT clinicians.

ADHD is a neurodevelopmental condition which manifests as cognitive and behavioural deficits. It is characterised by the core symptoms of persistent hyperactivity, impulsiveness and inattention. As well as presence of core symptoms identified, there must be clear evidence of psychological, social and/or educational or occupational impairment plus some impairment in two or more settings (home, at work, social, occupational).

ADHD is a neurodevelopmental condition and can present from childhood. A diagnosis of ADHD should only be made by a Specialist Psychiatrist or appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD.

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:

- meet the diagnostic criteria DSM-5 or ICD-10 (hyperkinetic disorder) and
- cause 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 2 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.

NICE guidelines on the treatment of ADHD recommend that drug treatment of ADHD should form part of a comprehensive treatment programme that focuses on psychological, behavioural and educational or occupational needs.

The purpose of this guideline is to provide guidance on the shared care of adults and/ or young people continuing treatment from pre-18 years old, who may be prescribed **atomoxetine, guanfacine dexamfetamine, lisdexamfetamine and methylphenidate i**n the following scenarios (see appendix 2 for flow chart of care pathway):

- Continuation of therapy via a shared care guideline for adult patients who have been diagnosed with ADHD and who have been initiated and stabilised on treatment by the Secondary care Specialist.
- Continuation of therapy via a shared care guideline for patients who have been prescribed ADHD medication under the Children and Adolescent Mental Health service (CAHMS) and who have now been transferred to the adult service.
- Continuation of therapy for patients who have relocated to BLMK from another area of the UK or from abroad. Continuation of therapy will only be considered for patients with evidence of ADHD diagnosis i.e. clinic letters from treating physician.
- Transfer of care* for stable patients following the first annual review.

This shared care guideline excludes:

- Treatment of children and young people (6-17 years)
- Treatment of children under 6 years
- Treatment of adults ≥ 65 years - Refer to the Older Adults Persons service

See NICE Guideline 87: Attention deficit and hyperactivity disorder: Diagnosis and management https://www.nice.org.uk/guidance/ng87 for further details.

***Transfer of care**

The Specialist and the GP may agree to a transfer of care arrangement where the GP agrees to take over the full clinical responsibility for the patient – this should only be considered when the person's clinical condition is stable and/or predictable. See Transfer of Care letter (appendix 3).

The specialist must contact the GP to request transfer of care and the GP is required to formally accept in writing (note- this differs from the share care arrangement, which assumes there is an agreement the GP will accept the shared care, unless they state otherwise).
Prior to transfer of care, the specialist should provide the GP with a clear management plan which should include:

- Recommendations around the continuation of the ADHD treatment in the long term
- Details of the annual health check criteria
- Details of a step-up or step-down plan should any problems arise in the future
- Contact details for access to immediate specialist advice.
- Details of an easy route back into secondary care. This should include a direct access telephone number, email address and time frames for response. For e.g. urgent advice within 48 hours, routine advice, up to two weeks.

Referral and assessment process

GP to refer to local Adult Psychiatric Specialist service (ELFT) for assessment by completing the referral form (see appendix 4).

The assessment/treatment process includes:

- **Part 1**: a first appointment for a full psychiatric assessment to exclude any other mental health illness which could be contributing to current symptoms. This will help to identify and treat co-morbid diagnoses.
- **Part 2** includes completion of full diagnostic ADHD interview (DIVA-5) and collateral history from the additional tools.
- **Part 3**: patients will be offered medication if their ADHD symptoms are still causing a significant impairment in at least one domain* after environmental modifications** have been implemented and reviewed. Treatment will only be commenced after baseline tests (supplied with referral) have been reviewed and arrangements put in place for the patient to have ongoing blood pressure and heart rate monitoring during titration of ADHD treatment. If the patient does not want to commence pharmacological treatment, the specialist physician should discuss non-pharmacological options and signpost accordingly.

Care can be shared between local Adult Psychiatric Specialist (ELFT) and the patient's GP via a shared care agreement once the patient has been established on a stable dose (after approximately 12 weeks).

- If patients de-stabilise in primary care, whilst under shared care or following transfer of care, GPs should refer back to ELFT for review.
- The local ELFT Adult Psychiatric Specialist who is initiating therapy should discuss with the patient and their family or carers (if applicable) about treatment options, including treatment aims, available options, medication and alternative/additional interventions, side effects, the monitoring protocol and ongoing responsibilities for care (specialist, shared care and transfer of care).
- The possibility of stopping medication and reasons should also be discussed.

Transfer of care to the patient's GP may be requested for stable patients (approximately 12 weeks

after stabilisation of treatment).

If a patient has received an ADHD diagnosis **from another accredited provider as part of the NHS Right to Choose process** (e.g. Psychiatry UK)- shared care should be arranged between that provider and the patient's GP directly.

CAMHS patients who transition into adult services

- CAMHS to refer, where appropriate, to the relevant adult ADHD service, adolescents approaching their 18th birthday, who have been identified as someone who will require on-going support with management of their ADHD.
- Adolescents approaching adulthood, who have co-morbid mental health conditions/needs, should be referred via CAMHS to the relevant adult mental health services
- CAMHS to inform the GP of any decision to stop or alter the treatment plan prior to transition to adult services. GP to continue prescribing as per existing shared care agreement, where children/ adolescents from CAMHS require ongoing prescriptions of stimulants or non-stimulants.
- ELFT ADHD service/ specialist to initiate a new shared care agreement for ongoing prescribing and monitoring with the patients GP once patient has been transitioned into adult services.
- Patients that need to continue on stimulants or non-stimulants should be advised of the need for safe storage to prevent diversion and potential abuse.
- Only adolescents who are stable and have shown a good response to ADHD medication (licensed and unlicensed in adults) should be allowed to continue into adulthood.

1. AREAS OF RESPONSIBILITY

Secondary/Tertiary Care Prescribers or Specialist Team

- For newly diagnosed adult patients, or where there has been a change in medication, carry out baseline assessments (see Appendix 4), initiate treatment and prescribe until patient is stable. NICE recommends lisdexamfetamine or methylphenidate as first-line choices. Where more than one agent is considered suitable, the product with the lowest acquisition cost should be considered.
- The Adult Psychiatric Outpatient clinic will accept, where appropriate, the transfer of patients from CAMHS who are approaching their 18th birthday and require on-going support and medication to manage their ADHD.
- The Adult Psychiatric Outpatient clinic will accept the transfer of patients who are being transferred from Tertiary care back to Secondary care.
- To obtain patient informed consent for sharing of care between the Specialist, Primary Care prescriber and patient. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily and must be documented in the patient's notes.
- To confirm the working diagnosis.
- To confirm that the patient's condition has a predictable course of progression and the patient's care can be suitably maintained by Primary Care, following their medicine being optimised with satisfactory investigation results and the patient being established on a stable dose (after approximately 12 weeks).
- If shared care is considered appropriate for the patient, the patient's treatment regimen is confirmed, and benefit from treatment is demonstrated, the Specialist will contact the Primary Care prescriber to initiate shared care.
- At the point of initial contact, the Specialist should check if the Primary Care prescriber can access blood test results electronically. If access is unavailable, the Specialist and the Primary Care prescriber should agree a process of communication to ensure blood test results and relevant

results of investigations can be accessed by both parties in a timely manner.

- Following the request to the patient's Primary Care prescriber to initiate shared care; to ensure that the patient has an adequate supply of medication until shared care arrangements are in place. Further prescriptions will be issued if, for unforeseen reasons, arrangements for shared care are not in place by the anticipated start date of the shared care (usually within 28 days or once the patient is stabilised on the medication). Patients should not be put in a position where they are unsure where to obtain supplies of their medication.
- To ensure that the Primary Care prescriber has sufficient information to enable them to monitor treatment, identify medicines interactions, and prescribe safely. This should include access or direction to a current copy of the SCG and contact details for the initiating Specialist. As a partner in the shared care agreement, the patient should, where appropriate, be provided with access or direction to a copy of the shared care guideline.
- **The Specialist will provide the patient's Primary Care prescriber with the following information:**
  - diagnosis of the patient's condition with the relevant clinical details
  - details of the patient's specialist treatment to date
  - details of treatments to be undertaken by the Primary Care prescriber (including reasons for choice of treatment, medicine or medicine combination, frequency of treatment, number of months of treatment to be given before review by the Specialist)
  - the date from which the Primary Care prescriber should prescribe the treatment
  - details of other specialist treatments being received by the patient that are not included in shared care
  - details of monitoring arrangements required
- **Whenever the Specialist sees the patient, he/she will:**
  - send a written summary to the patient's Primary Care prescriber in a timely manner, noting details of any relevant blood test results or investigations if applicable
  - confirm that ongoing treatment with the monitored medicine is appropriate
  - confirm the current dosage and clearly highlight any changes made both to the patient and in writing to the patient's Primary Care prescriber who will action any of them as required
- **The Specialist team will:**
  - provide training, advice and guidance (as appropriate) for Primary Care prescribers if necessary to support the shared care agreement
  - provide contact details for both working and non-working hours
  - supply details for fast track referral back to secondary/specialist care
  - provide the patient with details of their treatment, follow-up appointments, monitoring requirements and, where appropriate, nurse specialist contact details
  - provide continued support for the Primary Care prescriber and answer any questions they may have on the treatment and the condition for which the medicine is being used.
- **Prior to requesting shared care prescribing, the Specialist will:**
  - Ensure that patients (and their caregivers, where appropriate) are aware of and understand their responsibilities to attend appointments and the need for continued monitoring arrangements.
  - The Specialist will document the decision to share care of the treatment with the Primary Care prescriber via the shared care guideline in the patient's hospital medical notes. If the Primary Care prescriber declines the request for shared care, the Specialist will retain the prescribing responsibility for the medication. This should also be documented in the patient's medical notes

All of the above information should be provided to the Primary Care Prescriber in writing via a letter or approved electronic communication.

Primary Care Prescribers

- To prescribe within their own level of competence. The (GMC) guidance on "Good practice in prescribing and managing medicines and devices" states that doctors are responsible for the prescriptions they sign and their decisions and actions when they supply and administer medicines and devices, or authorise or instruct others to do so. They must be prepared to explain and justify

their decisions and actions when prescribing, administering and managing medicines.

- The same principles apply to non-medical prescribers as well as medical prescribers as outlined in the "Competency Framework for all Prescribers".
- To confirm that the patient or carer consents to sharing of care between the Specialist, Primary Care prescriber and patient. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily and must be documented in the patient's notes.
- If shared care is accepted, commencement of shared care must be clearly documented in the patient's Primary Care medical notes.
- If declining the request for shared care, the decision and rationale should be explained to the Specialist in writing as soon as is possible and in a timely manner, within a maximum of 14 to 21 days upon receipt of request. The patient should also be informed of the decision.
- Ensure that he/she has the information and knowledge to understand the therapeutic issues relating to the patient's clinical condition.
- Undergo any additional training necessary in order to carry out the prescribing and monitoring.
- Agree that in his/her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within Secondary/Specialist care.
- Prescribe ADHD medication at the dose and formulation recommended. If prescribing long-acting methylphenidate, prescribe by brand name (as different brands are not interchangeable).
- Prescribe the maintenance medication in accordance with the written instructions contained within the SCG or other written information provided, and communicate any changes of dosage made in Primary Care to the patient. It is the responsibility of the prescriber making a dose change to communicate this to the patient.
- Inform the Specialist if there is suspicion of abuse of stimulant ADHD medication. Medication requests for longer than a month (e.g. covering holidays) should be discussed with the Specialist if necessary and can be issued at the prescriber's discretion.
- The GP may restart (stimulants) or re-titrate (atomoxetine, guanfacine) after a period of non-compliance or a deliberate trial without medication where:
    - the medication was previously of benefit
    - adverse ADHD symptoms remain
    - after consideration of any changes in the patient's medical or social circumstances
    - less than one year has passed since it was discontinued
    - the GP may refer back to, or phone for advice from, the specialist team if required e.g. been off ADHD medication for more than a year
- Report any adverse effect in the treatment of the patient to the Specialist team, and via the MHRA Yellow Card Scheme https://yellowcard.mhra.gov.uk/.
- The Primary Care prescriber will ensure that the patient is monitored as outlined in the SCG and will take the advice of the referring Specialist if there are any amendments to the suggested monitoring schedule.
- The Primary Care prescriber will ensure a robust monitoring system is in place to ensure that the patient attends the appropriate appointments in Primary Care for follow-up and monitoring, and that defaulters from follow-up are contacted to arrange alternative appointments. It is the Primary Care prescriber's responsibility to decide whether to continue treatment for a patient who does not attend appointments required for follow-up and monitoring, and to inform the Specialist of any action taken.
- Refer any patient who becomes pregnant or who wishes to plan a pregnancy to the Specialist team for an urgent review.
- Primary Care prescribers are not expected to be asked to participate in a shared care arrangement where:
    - no locally approved SCG exists, or the medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care agreement
    - the prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care

- Where community nurse involvement is required in the administration of medicines under a SCG, nurses should be provided with adequate information and guidance by the prescriber or the Specialist. Arrangements should be made in good time for any potential problems to be resolved to ensure that patient care is not compromised.

Patient and/or carer

- To provide their informed consent for sharing of their care with the Specialist and Primary Care prescriber. Consenting parties must have sufficient, accurate, timely information in an understandable and accessible format. Consent must be given voluntarily and must be documented in the patient's notes. Supporting information is available from NICE "Making decisions about your care".
- To take their medication as agreed, unless otherwise instructed by an appropriate healthcare professional.
- To meet all necessary monitoring arrangements to ensure the safe prescribing of their medication, and to alert the prescriber where these arrangements are not met.
- To attend all follow-up appointments with the Primary Care prescriber and Specialist. If the patient is unable to attend any appointments, they should inform the relevant practitioner as soon as possible and arrange an alternative appointment.
- Inform healthcare professionals of their current medications prior to receiving any new prescribed or over-the-counter medication.
- Report all suspected adverse reactions to medicines to their specialist and/or Primary Care prescriber.
- Store their medication securely away from children and according to the medication instructions.
- Read the information supplied by their Primary Care prescriber, Specialist and Pharmacist and contact the relevant practitioner if they do not understand any of the information given.
- An agreed method of communication of results of investigations between the Specialist, the Primary Care prescriber, the Community Pharmacist and the patient should be agreed at the onset of therapy.
- To inform DVLA of their diagnosis (If ADHD will affect ability to drive) and treatment (if ADHD treatment will affect the ability to drive) and, if relevant, to inform their vehicle insurance provider.
- To contact the Specialist team as soon as possible if a patient becomes pregnant or who wishes to plan a pregnancy.

Community Pharmacist

- Know where to access locally agreed shared care guidelines to aid professional clinical check of prescription prior to dispensing.
- Professionally check prescriptions to ensure they are safe for the patient and contact the Primary Care prescriber if necessary to clarify their intentions.
- Fulfil legal prescriptions for medication for the patient unless they are considered unsafe.
- Counsel the patient on the proper use of their medication.
- Advise patients suspected of experiencing an adverse reaction to their medicines to contact their Primary Care prescriber or Specialist/Specialist nurse team.

2. COMMUNICATION AND SUPPORT

Hospital / Specialist contact information *(The referral letter will indicate named consultant)* **Hospital name and address:** **Bedford ADHD Service** Florence Ball House Bedford, MK40 2NT elft.DECARHUB@nhs.net 01234 880422 / 01234 275450 **Central Bedfordshire ADHD services** Biggleswade Community Mental Health Team Spring House, Biggleswade Hospital Potton Road Biggleswade, SG18 0EJ elft.biggleswade.cmht@nhs.net elt-tr.biggleswadecmht@nhs.net 01767 224922 Dunstable Community Mental Health Team Beacon House 5 Regent Street Dunstable, Bedfordshire, LU6 1LP elt-tr.dunstablecmht@nhs.net 01582 709200 Leighton Buzzard Community Mental Health Team Crombie House 36 Hockliffe Street Leighton Buzzard, Bedfordshire, LU7 1HJ elt-tr.leightonbuzzardcmht@nhs.net 01525 751133 Ampthill Community Mental Health Team Meadow Lodge at Steppingley Hospital Ampthill Road Ampthill, MK45 1AB elt-tr.ampthillcmht@nhs.net 01525 758400 **Luton ADHD Services** Luton Community Mental Health Hub- North Luton Community Mental Health Hub- South Charter House Alma Street Luton, LU1 2PJ elft.luton.north.hub@nhs.net 01525 638 400 elft.luton.south.hub@nhs.net 01525 638 392	**Out-of-hours contact details & procedures:** ADHD services are only open weekdays. Service can be emailed/ voicemails can be left out of hours from the team to respond to during work hours In crisis advice is to contact: Out of hours crisis team Call 111

Specialist support / resources available to Primary Care prescriber including patient information:

AADD-UK
AADD-UK is a site for and by adults with ADHD. Aimed at raising awareness of ADHD in adulthood.
ADDA
ADDA is a source for information and resources exclusively for and about adult ADHD. ADDA brings together scientific perspectives and the human experience.
Adders
This site aims to promote awareness of ADHD and provide information and practical advice to sufferers and families in the UK and around the world. The site contains a lot of information, downloadable resources and a comprehensive list of local support groups.
ADDISS
The National Attention Deficit Disorder Information and Support Service. This site offers information about ADHD, resources and special sections for parents, children, teenagers and professionals.
ADHD Foundation
The ADHD Foundation provides services to ADHD sufferers and families in that area. Their website has a lot of information on ADHD.
Very Well Mind
Very Well Mind provides health and wellness information by health professionals. Whether you are looking for ways to better manage stress, understand a condition like ADHD, or learn more about guidance available.

ADHD and Work
ADHD UK Welfare Pack
A welfare pack to help people with ADHD in the workplace.
Access to Work Information Booklet
A work booklet to support people with ADHD and other disabilities access work.
Guidance on how to manage an employee with ADHD
Practical tips and a free support plan to support a co-worker with ADHD.
ADHD Coaching
A tool to address the core symptoms of ADHD through individualised or group assistance and support.

ADHD and Relationships
ADHD Aware
Online Support Group and guidance on how ADHD can affect relationships and marriage.
The Mini ADHD Coach -
Guidance on how to handle relationships when you have ADHD.
Melissa Orlov's website
Up-to-date resources under "videos and podcasts" specifically around ADHD and marriage.
Guidance on Relationships Social Skills
Guidance on living with ADHD, focusing on relationships and social skills.
Guidance on Marriage and Partnerships
Guidance on living with ADHD, focusing on marriage and partnerships.
Talk ADHD Podcast
The ADHD Couple podcast

3. CLINICAL INFORMATION

Indication(s):	Attention Deficit Hyperactivity Disorder (ADHD) **Stimulants** <u>Methylphenidate</u> Licensed for use in children aged 6 years of age and over and adults for ADHD. (Ref: Concerta XL® SPC). <u>Lisdexamfetamine</u> Licensed for use in children aged 6 years and over with ADHD when response to previous Methylphenidate treatment is considered clinically inadequate. It can be continued, where appropriate, into adulthood (Ref: Elvanse® SPC). <u>Dexamfetamine</u> Dexamfetamine is indicated as part of a comprehensive treatment programme for attention- deficit/hyperactivity disorder (ADHD) in children and adolescents aged 6 to 17 years when response to previous Methylphenidate treatment is considered clinically inadequate. Dexamfetamine is not licensed for use in adults. The safety and efficacy of Dexamfetamine in adults have not been established (Ref: Amfexa® SPC). **Non- stimulants** <u>Atomoxetine</u> Licensed for the treatment of ADHD in children 6 years and older, in adolescents and in adults (Ref: Strattera® SPC). <u>Guanfacine</u> Licensed for the treatment of ADHD in children 6- 17 years. It is not licensed for use in adults for ADHD as the safety and efficacy of guanfacine in adults with ADHD have not been established. Use in adults is therefore off licence (off-label use). It should only be considered on the advice of a tertiary ADHD service as recommended in the NICE guidance. Guanfacine can be continued for adults started on this medication as children/ adolescents.
Place in therapy:	Offer medication to adults with ADHD if their ADHD symptoms are still causing a significant impairment in at least one domain after environmental modifications have been implemented and reviewed. Domains refer to areas of function, for example, interpersonal relationships, education and occupational attainment, and risk awareness. NICE Guideline 87 states the following with respect to the Medication Choice for ADHD in Adults: • Offer lisdexamfetamine or methylphenidate as first-line

	pharmacological treatment (NB: **methylphenidate** is the preferred first line treatment for adults with ADHD due to a lower cost compared with lisdexamfetamine). • Where more than one agent is considered suitable, the drug with the lowest acquisition cost should be chosen. • Consider switching to lisdexamfetamine for adults who have had a 6-week trial of methylphenidate at an adequate dose but have not derived enough benefit in terms of reduced ADHD symptoms and associated impairment. • Consider switching to methylphenidate for adults who have had a 6-week trial of lisdexamfetamine at an adequate dose but have not derived enough benefit in terms of reduced ADHD symptoms and associated impairment. • Consider dexamfetamine for adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate its longer effect profile. • Offer atomoxetine to patients who cannot tolerate lisdexamfetamine or methylphenidate **or** their symptoms have not responded to separate 6-week trials of both treatments, having considered alternative preparations and adequate dose. • Consider Guanfacine as a last line option.
Therapeutic summary:	Methylphenidate is a mild central nervous system (CNS) stimulant. The mode of therapeutic action in ADHD is not known. Methylphenidate is thought to block the reuptake of noradrenaline and dopamine into the presynaptic neurone and increase the release of these monoamines into the extraneuronal space. Lisdexamfetamine dimesylate is a pharmacologically inactive prodrug. After oral administration, lisdexamfetamine is rapidly absorbed from the gastrointestinal tract and hydrolysed primarily by red blood cells to dexamfetamine, which is responsible for the drug's activity. It is thought to be due to its ability to block the reuptake of noradrenaline and dopamine into the presynaptic neuron and increase the release of these monoamines into the extraneuronal space. Atomoxetine is a highly selective and potent inhibitor of the pre-synaptic noradrenaline transporter. Guanfacine is a selective alpha$_{2A}$-adrenergic receptor agonist. Guanfacine is a non-stimulant. Research suggests guanfacine modulates signalling in the prefrontal cortex and basal ganglia through direct modification of synaptic noradrenalin transmission at the alpha$_{2A}$-adrenergic receptors. Through their different modes of action, ADHD medication help to improve attention, concentration and reduce hyperactivity and impulsivity.
Initiation and ongoing dose regime and Route of administration:	*Note: initiation of shared care with Primary Care is normally after the patient's dose has been optimised and with satisfactory investigation results and the patient being established on a stable dose (after approximately 12 weeks).* All dose or formulation adjustments will be the responsibility of the initiating Specialist unless directions have been discussed and agreed with the Primary Care prescriber. Termination of treatment will be the

	responsibility of the Specialist. **<u>Initial stabilisation</u>:** The starting dose should be prescribed as per the SPC/ BNF and initiated by the specialist service. **<u>Maintenance dose (following initial stabilisation)</u>:** The initial maintenance dose should be prescribed by the specialist service. Response should be assessed before transferring ongoing prescribing of medication to primary care. **<u>Conditions requiring dose adjustment</u>:** Side effects to medication Renal or hepatic impairment Interactions with concomitant medications (see interactions section for further information) Reduced efficacy over time Product shortages requiring change in dose and/ or formulation
Duration of treatment:	There is no set duration for ADHD treatment. An individual can remain on medication if there is ongoing benefit and there are no side effects.
Preparations available (Manufacturer):	Biphasic stimulant medication (applicable to methylphenidate only) to be prescribed by brand due to varying bioequivalence. All other products to be prescribed generically e.g. Lisdexamfetamine, Dexamfetamine, Atomoxetine and Guanfacine. Biphasic stimulants: Methylphenidate modified release (bioequivalent brand products)- Xaggitin XL (first choice)/ Delmosrt PR/Xenidate XL/ Affenid XL/ Concerta XL- 18mg/ 27mg/ 36mg/ 54mg tablets. ** All modified release formulations of methylphenidate must be prescribed by brand name ** This is because the ratio of immediate to extended-release methylphenidate components varies between products, affecting release profiles, bioavailability and clinical effect. See Drug Safety Update from MHRA for further details and advice regarding long-acting (modified-release) methylphenidate preparations and caution if switching between products due to differences in formulations. - Xaggitin XL: consists of an immediate-release component (22% of dose) and a modified-release component (78% of dose). - Concerta XL: consists of an immediate-release component (22% of dose) and a modified-release component (78% of dose). - Equasym XL: consists of an immediate-release component (30% of dose) and a modified-release component (70% of dose). - Medikinet XL: consists of an immediate-release component (50% of dose) and a modified-release component (50% of dose) Dexamfetamine tablets- 5mg/ 10mg/ 20mg Lisdexamfetamine (Elvanse Adult®) capsules- 30mg/ 50mg/ 70mg Atomoxetine (generic) capsules- 10mg/ 18mg/ 25mg/ 40mg/ 60mg Guanfacine MR (Intuniv®) tablets- 1mg/ 2mg/ 3mg/ 4mg

	Please note: Brand of Methylphenidate should be prescribed as per formulary, and where there is a bioequivalent medication, the product with the lowest acquisition cost should be prescribed.
Summary of adverse effects: *(See Summary of Product Characteristics (SPC) for full list)* **Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme.**	**Frequency/ likelihood** — **Adverse effect**
	Methylphenidate
	Very common (≥ 1/10) — Insomnia, nervousness, headache Common (≥ 1/100 to < 1/10) — Reduced appetite, hypertension, GI side effects, changes in heart rate in BP, irritability, mood swings, insomnia, agitation, anxiety, depression and depressed mood, tics
	Lisdexamfetamine
	Very common (≥ 1/10) — Decreased appetite, insomnia, headache, reduced weight, insomnia, nervousness Common (≥ 1/100 to < 1/10) — Anxiety, affect lability, psychomotor hyperactivity, bruxism, dizziness, restlessness, tremor, tachycardia, palpitation, dyspnoea, GI side effects, erectile dysfunction, chest pain, irritability, fatigue, feeling jittery, increased BP, reduced weight
	Dexamfetamine
	Very common (≥ 1/10) — Decreased appetite, reduced weight gain and weight loss during prolonged use in children Common (≥ 1/100 to < 1/10) — Arrhythmia, palpitations, tachycardia, abdominal pain and cramps, nausea, vomiting, dry mouth, changes in BP/ HR, arthralgia, vertigo, dyskinesia, headache, hyperactivity, abnormal behaviour, aggression, excitation, anorexia, anxiety, depression, irritability
	Atomoxetine
	Very common (≥ 1/10) — Reduced appetite, headache, somnolence, abdominal pain, nausea, vomiting, increase in BP and heart rate Common (≥ 1/100 to < 1/10) — Loss of appetite, Irritability, mood swings, insomnia, agitation, anxiety, depression and depressed mood, tics, reduced weight, fatigue, constipation, dizziness

<table>
<tr><td></td><td colspan="2">Guanfacine</td></tr>
<tr><td></td><td>Very common (≥ 1/10)

Common (≥ 1/100 to <1/10)</td><td>Somnolence, headache, fatigue, abdominal pain

Reduced appetite, depression, anxiety, affect lability, insomnia, nightmares, lethargy, dizziness, sedation, bradycardia, hypotension, orthostatic hypotension, GI side effects, enuresis, irritability, reduced BP, increased weight</td></tr>
<tr><td>Monitoring requirements by Specialist (baseline investigations, initial monitoring and ongoing monitoring):</td><td colspan="2"><u>Baseline investigations</u>:
Treatment will only be commenced after baseline tests (supplied with referral) have been reviewed and arrangements put in place for the patient to have ongoing blood pressure and heart rate monitoring during titration of ADHD treatment.
Referral to specialist service will require:
• Baseline ECG (if service user as pre-existing heart condition)
• Cardiovascular risk assessment
• Blood tests (full blood count, urea and electrolytes, liver function tests)
• Physical health observations: (blood pressure, heart rate, height, weight)
• Medical history
• Risk assessment of substance misuse (diversion)

<u>Initial monitoring</u>: (Monitoring at baseline and during initiation is the responsibility of the Specialist until the patient is optimised and stabilised on the medicine with no anticipated further changes)
• Weight: Baseline, months 3 & 6, then annually thereafter
• Blood pressure and pulse: Baseline, before and after dose change and then 6 monthly thereafter
• Risk of suicidal ideation/ intent/ self-harming behaviours- Atomoxetine

<u>Ongoing monitoring</u>:
• Weight: Baseline, months 3 & 6, then annually thereafter
• Blood pressure and pulse: Baseline, before and after dose change and then 6 monthly thereafter
• Risk of suicidal ideation/ intent/ self-harming behaviours (Atomoxetine)
• Risk of substance misuse
• Sexual dysfunction (Atomoxetine)
• Changes in sleep pattern
• Seizures
• Tics</td></tr>
</table>

Ongoing monitoring requirements by Primary Care prescriber:	Monitoring	Frequency	Action for Primary Care prescriber
	Efficacy and non-specific side effects	At reviews and/ or when needed	Adjust dose as appropriate- seek specialist advice if this is not sufficient
	Weight/ pulse/ blood pressure	Weight- Baseline, months 3 & 6, then annually thereafter BP/ pulse- Baseline, before and after dose change and then 6 monthly thereafter	Consider monitoring of BMI of adults with ADHD if there has been weight change as a result of their treatment and changing medication (refer back to Specialist) if weight change persists. Sustained resting tachycardia (>120 bpm), arrhythmia or clinically significant high systolic blood pressure after two measurements, consider dose reduction and refer to adult physician /specialist
	Full blood count	Only if needed	Low threshold for repeat FBC rather than routine e.g. recurrent infections, purpuric rash or based on medical history
	ECG	Baseline and annual	ECG only to be completed if known known cardiovascular conditions/ history and/ or risk factors
	Cardiovascular risk assessment	Annual	To include: enquiry about a history of cardiac symptoms such as syncope (fainting), breathlessness, palpitations, or congenital cardiac abnormalities, family diagnosis of cardiovascular disease/sudden cardiac death before the age of 40 years
	Substance misuse risk assessment	As required	Concerns about requests for frequent prescriptions deemed unnecessary should be communicated to consultant/specialist
	Suicide-related behaviour.	As required	Risk of suicidal ideation/ intent/ self-harming behaviours (Atomoxetine)

	Sexual dysfunction (Atomoxetine)	As required	Be aware that young people and adults with ADHD may develop sexual dysfunction (i.e. erectile and ejaculatory dysfunction) as potential adverse effects of atomoxetine
	Seizures	When needed	If a person with ADHD develops new seizures or a worsening of existing seizures, GP to refer back to Specialist for review of ADHD medication and to stop any medication that might be contributing to the seizures. After investigation, the ADHD medication may be cautiously reintroduced if it is unlikely to be the cause of the seizures.
Clinically relevant drug interactions and advice on management: ***Note: This does not replace the SPC and should be read in conjunction with it.***	**Drug interaction**		**Management / Action for Primary Care prescriber**
	Methylphenidate + MAOI		Methylphenidate is contraindicated in patients being treated (currently or within the preceding 2 weeks) with non-selective, irreversible MAO-inhibitors.
	+ Alcohol		Advisable for patients to abstain from alcohol during treatment.
	+SSRIs		Seek advice from specialist service. Methylphenidate must be discontinued as soon as possible if serotonin syndrome is suspected.
	+ Dopaminergic drugs (including antipsychotics)		Seek advice from specialist service
	Lisdexamfetamine + MAOI		Should not be administered during or within 14 days following the administration of monoamine oxidase inhibitors (MAOI) because it can increase the release of norepinephrine and other monoamines. This can cause severe headaches and other signs of hypertensive crisis.
	+ Chlorpromazine Blocks dopamine and norepinephrine receptors, thus inhibiting the central stimulant effects of amphetamines		Seek advice from specialist team

	+ Haloperidol blocks dopamine receptors, thus inhibiting the central stimulant effects of amphetamines	Seek Advice from specialist team
	+ Lithium carbonate The anorectic and stimulatory effects of amfetamines may be inhibited by lithium carbonate	Seek advice from specialist team Continue to monitor lithium level and associated bloods as per national recommendations.
	+ Alcohol	Limited data on the possible interaction with alcohol. Advise patients to avoid alcohol whilst on stimulants.
	Dexamfetamine Atomoxetine	Dexamfetamine is predicted to increase the risk of adverse effects when given with Atomoxetine. Manufacturer advises caution.
	+ Bupropion	Bupropion might enhance the risk of serotonin syndrome when given with Dexamfetamine. MHRA advises monitor.
	+ Citalopram/ + Duloxetine/ + Escitalopram/ + Mirtazapine/ + Sertraline/ + St Johns wort/ +Tramadol	Both Dexamfetamine and listed antidepressant can increase the risk of serotonin syndrome.
	+ Fluoxetine/ + Paroxetine	Predicted to increase the exposure to Dexamfetamine. Manufacturer makes no recommendation.
	+ Lithium	Both Dexamfetamine and Lithium can increase the risk of serotonin syndrome.
	+ MAOI	Because of possible hypertensive crisis, dexamfetamine is contraindicated in patients being treated (currently or within the preceding 2 weeks) with non-selective, irreversible MAO-inhibitors
	Warfarin	Dexamfetamine might increase the anticoagulant effect of Warfarin. Manufacturer advises monitor INR and adjust dose.

	Atomoxetine + Bupropion	Bupropion is predicted to markedly increases the exposure to Atomoxetine- seek advice from specialist service.
	+ Dexamfetamine	Dexamfetamine is predicted to increase the risk of adverse effects when given with Atomoxetine. Use with caution- seek advice from specialist service.
	+ Fluoxetine/ Paroxetine	Fluoxetine is predicted to markedly increase the exposure to Atomoxetine. Dose adjustment advised- seek support from specialist service.
	+ Salbutamol	Atomoxetine is predicted to increase the risk of cardiovascular adverse effects when given with Salbutamol (high-dose)- seek advice from specialist service.
	+ Terbutaline	Atomoxetine is predicted to increase the risk of cardiovascular adverse effects when given with Terbutaline (high-dose). Manufacturer advises caution.
	Guanfacine + Alcohol	Both Guanfacine and alcohol can increase the risk of hypotension- advise to avoid whilst on treatment
	+Carbamazepine	Carbamazepine is predicted to decrease the concentration of Guanfacine. Manufacturer advises adjust Guanfacine dose.
	+ Clonidine	Both Guanfacine and Clonidine can increase the risk of hypotension.
	+ SSRIs	Can increase risk of sedation
	Please see SPC for comprehensive information.	

Clinically relevant precautions and contraindications: ***Note: This does not replace the SPC and should be read in conjunction with it.***	**Cautions/Precautions:** Methylphenidate Psychiatric disorders, anxiety, agitation, tics, family history Tourette syndrome, drug or alcohol dependence, epilepsy, susceptibility to angle-closure glaucoma. Lisdexamfetamine Anorexia, history of cardiovascular disease or abnormalities, psychiatric disorders, aggressive behaviour, tics, Tourettes, susceptibility to angle closure glaucoma. Dexamfetamine History of epilepsy (discontinue if seizures occur); mild hypertension; susceptibility to angle-closure glaucoma; tics; Tourette syndrome (discontinue use if tics occur). Monitor height and weight as growth restriction may occur during prolonged therapy Atomoxetine Precaution- Atomoxetine use in suicide related behaviours. Atomoxetine should be administered with caution to patients treated with high dose nebulised or systemically administered salbutamol (or other beta2 agonists) because cardiovascular effects can be potentiated. There is the potential for an increased risk of QT interval prolongation when atomoxetine is administered with other QT prolonging drugs, (such as neuroleptics, class IA and III antiarrhythmics, moxifloxacin, erythromycin, methadone mefloquine, tricyclic antidepressants, lithium or cisapride) drugs that cause electrolyte imbalance (such as thiazide diuretics) and drugs that inhibit CYP2D6. Atomoxetine should be used cautiously with antihypertensive drugs and other agents which increase blood pressure. Guanfacine Bradycardia (risk of torsade de pointes); heart block (risk of torsade de pointes); history of cardiovascular disease; history of QT-interval prolongation; hypokalaemia (risk of torsade de pointes). **Contraindications:** All medicines Known hypersensitivity to the active substance or any of the excipients. Methylphenidate Severe depression, suicidal ideation, anorexia nervosa, psychosis, uncontrolled bipolar disorder, hyperthyroidism, cardiovascular disease (including heart failure, cardiomyopathy, severe hypertension and arrhythmias), structural cardiac abnormalities, phaeochromocytoma, vasculitis, cerebrovascular disorders. Lisdexamfetamine Symptomatic cardiovascular disease (moderate to severe hypertension, advanced arteriosclerosis), hyperexcitability or agitation, hyperthyroidism. Dexamfetamine

	Advanced arteriosclerosis; anorexia; arrhythmias (life-threatening); cardiomyopathies; cardiovascular disease; cerebrovascular disorders; heart failure; history of alcohol abuse; history of drug abuse; hyperexcitability; hyperthyroidism; moderate hypertension; psychiatric disorders; psychosis; severe hypertension; structural cardiac abnormalities; suicidal tendencies Atomoxetine Atomoxetine should not be used with MAOIs/ should not be used in patients with severe cardiovascular or cerebrovascular disorders/ phaeochromocytoma. Guanfacine Hypersensitivity to the active substance or to any of the excipients. Please see SPC for comprehensive information.
Renal impairment:	**Methylphenidate:** Methylphenidate has not been studied in patients with renal impairment. Caution should be exercised in these patients. **Lisdexamfetamine**- Manufacturer advises max. dose 50mg daily in severe impairment (creatinine clearance less than 30 ml/min). **Dexamfetamine:** Has not been studied in patients with renal impairment. Caution should be exercised in these patients by taking care with dosage. **Atomoxetine**: No information available. Dose adjustment is unlikely to be necessary but be aware that atomoxetine may exacerbate hypertension in patients with end stage renal disease. **Guanfacine**- Dose reduction may be required in severe impairment (GFR 15-29 ml/min) and end-stage renal disease (GFR <15 ml/min) or in patients requiring dialysis (no information available in children with renal impairment).
Hepatic impairment:	**Methylphenidate:** Methylphenidate has not been studied in patients with hepatic impairment. Caution should be exercised in these patients. **Lisdexamfetamine:** No information available. Caution should be exercised. **Dexamfetamine:** Has not been studied in patients with hepatic impairment. Caution should be exercised in these patients by taking care with dosage. **Atomoxetine**- Manufacturer advises halve dose in moderate impairment and quarter dose in severe impairment. **Guanfacine**- Manufacturer advises caution (pharmacokinetics have not been assessed in paediatric patients with hepatic impairment).
Advice to patients and carers: *The Specialist will counsel*	**The patient should be advised to report any of the following signs or symptoms to their Primary Care prescriber without delay:** • Significant reduction in appetite and weight • Significant deterioration/ reduction in sleep pattern

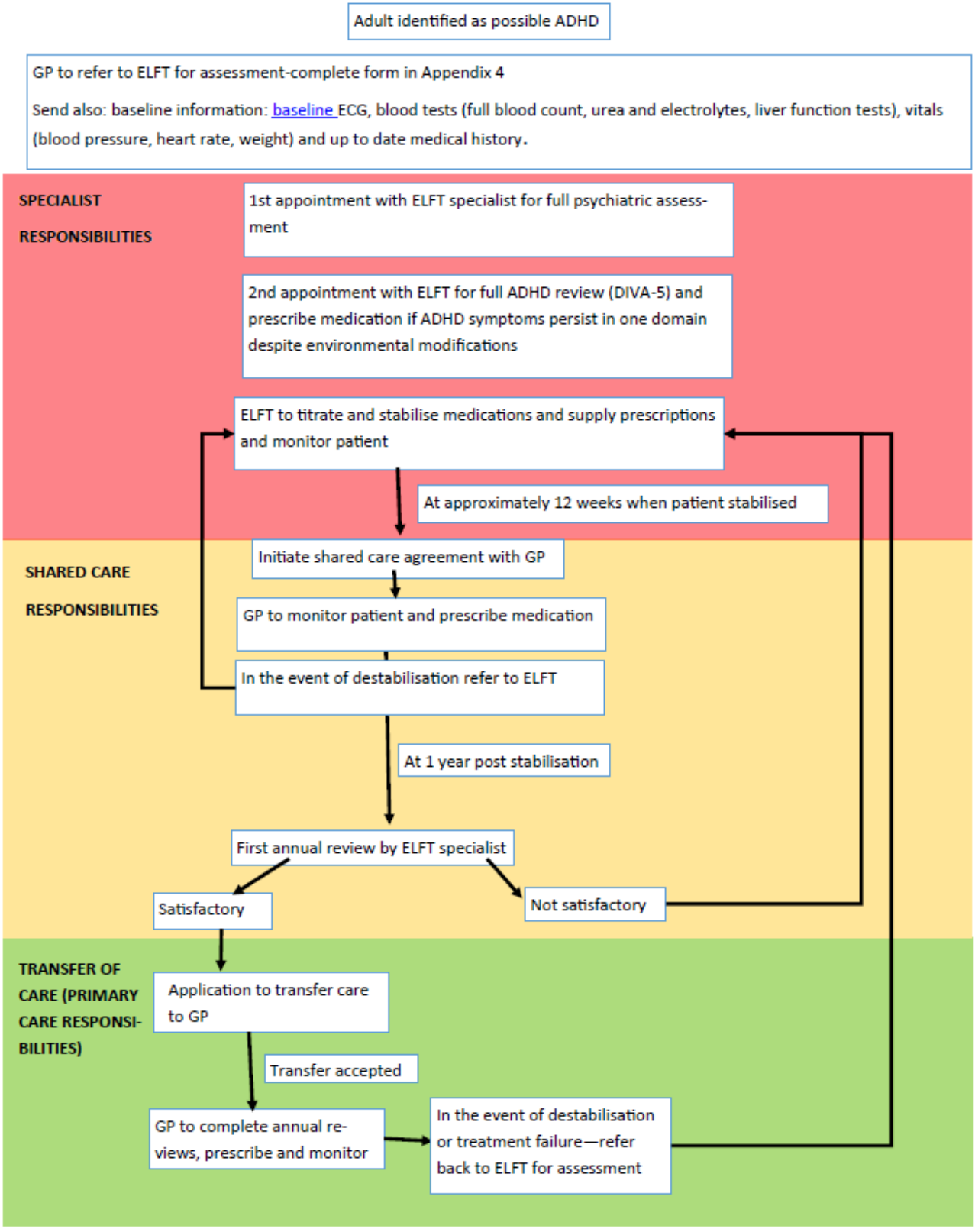
the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.	• Significant changes in mood e.g. low mood, anxiety • Distressing thoughts/ feelings including self-harm and suicidal thoughts.
Pregnancy, paternal exposure and breastfeeding: *It is the Specialist's responsibility to provide advice on the need for contraception to male and female patients where applicable on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the Primary Care prescriber and the Specialist.*	**Pregnancy:** • Methylphenidate: limited experience- avoid unless potential benefit outweighs risk • Lisdexamfetamine: Manufacturer advises use only if potential benefit outweighs risk. • Dexamfetamine: Avoid (retrospective evidence of uncertain significance suggesting possible embryotoxicity). • Atomoxetine: Manufacturer advises avoid unless potential benefit outweighs risk. • Guanfacine: Manufacturer advises avoid—toxicity in *animal* studies. Patient information is available from: Bumps - Best use of medicines in pregnancy. **Breastfeeding:** Healthcare professional information available from: https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd • Methylphenidate: Limited information available—avoid. • Lisdexamfetamine: Manufacturer advises avoid—present in human milk. • Dexamfetamine: Significant amount in milk—avoid. • Atomoxetine: Avoid-present in milk in *animal* studies. • Guanfacine: Manufacturer advises avoid—present in milk in *animal* studies.
Practical issues and Supply of ancillary equipment (where relevant):	• Methylphenidate, Dexamfetamine and Lisdexamfetamine are schedule 2 controlled drugs and so prescriptions should be provided for max 30 days and written as per controlled drug requirements. • Methylphenidate modified release should be prescribed brand by due to differing release profiles between Medikinet XL (type medication), Equasym XL and Xaggitin XL (type medication) • Xaggitin XL has a range of bio-equivalent products which can be prescribed interchangeably (if the patient is able to tolerate). • The patient should be prescribed the brand with the lowest acquisition cost and as per formulary agreement with BLMK ICS.
Key references:	Nice BNF: https://bnf.nice.org.uk/ (accessed April 2024) EMC medicines Atomoxetine/ Guanfacine/ Methylphenidate/ Lisdexamfetamine: https://www.medicines.org.uk/emc (accessed April 2024) Attention deficit hyperactivity disorder: diagnosis and management (NG87), 14 March 2018, updated 13 Sept 2019 https://www.nice.org.uk/guidance/ng87 (accessed April 2024) Attention deficit hyperactivity disorder (QS39), 30 July 2013, updated 14

	March 2018 https://www.nice.org.uk/guidance/qs39 (accessed April 2024) BLMK ADHD adult shared care guidance (June 2018) Prescribing available medicines to treat ADHD (SPS), 27 Sept 2023, updated 17 April 2024: https://www.sps.nhs.uk/articles/prescribing-available-medicines-to-treat-adhd/ (accessed April 2024). Shared Care Guideline for Adult Patients with Attention Deficit Hyperactivity Disorder (ADHD) (Psychiatry UK) (accessed May 2024)
This shared care guideline is to be read in conjunction with the following documents: RMOC Shared Care Guidance – https://www.england.nhs.uk/medicines-2/regional-medicines-optimisation-committees-advice/shared-care-protocols/ NHSE/NHSCC guidance – items which should not be routinely prescribed in Primary Care: guidance for CCGs – link here NHSE policy – Responsibility for prescribing between Primary & Secondary/Tertiary Care – link here	

Appendix 1 – Possible Reasons for a Primary Care Prescriber to decline to accept shared care:

1	I do not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care. I have consulted with other Primary Care prescribers in my practice who support my decision. I have discussed my decision with the patient and request that prescribing for this individual remains with you due to the sound clinical basis given above.
2	The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement (medicine not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine).
3	The patient has not had the minimum duration of supply of medication to be provided by the initiating Specialist. Therefore, please contact the patient as soon as possible in order to provide them with the appropriate length of supply of the medication before transferring the prescribing responsibility to the Primary Care prescriber.
4	The patient has not been optimised/stabilised on this medication. Therefore, please contact the patient as soon as possible in order to provide them with the medication until the patient is optimised on this medication before transferring the prescribing responsibility to the Primary Care prescriber.
5	Shared Care Guideline and/or relevant clinical information as stipulated in the guideline not received. Therefore, please contact the patient as soon as possible in order to provide them with the medication until I receive the appropriate Shared Care Guideline before transferring the prescribing responsibility.
6	Other (Primary Care prescriber to complete if there are other reasons why shared care cannot be accepted or why shared care is to be discontinued if already started, e.g. adverse effects): ……

Appendix 2: Flowchart of pathway



Appendix 3: Transfer of care agreement

NHS
East London
NHS Foundation Trust

Transfer of care agreement

Patient Name		**NHS No**	
Address			
Date of Birth			
Current Diagnosis & ICD Code(s)			
Current Medications and dose			
Investigations performed on …../…../…..			

Dear GP,

Mr / Mrs /Ms ---------- has been prescribed ADHD treatment for the above diagnosis. He/she has been on the treatment under shared care and is now stable and benefiting from continuing on this treatment.

We would like to transfer the care of this patient and request your agreement to receive the care of this patient from …./……/…….in accordance with the transfer of care guidelines (approval date ---------) enclosed (also available at:https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/guideline/attention-deficit-hyperactivity-disorder-adhd-shared-care-guideline-for-the-management-of-adhd-in-adults/

Patient information has been given outlining potential aims and side effects of this treatment. The patient has given consent to treatment under this transfer of care (with your agreement) and has agreed to comply with instructions and follow up requirements.

We have also informed the patient that the medication may be discontinued if not proving effective.

Yours sincerely,

Doctor/ Clinical Practitioner
Job Title

Appendix 4: Referral Form

Referral Form
Services for Adults with ADHD (ELFT)

We need information to ensure referrals are managed in an efficient manner and reduce unavoidable delays. If you need advice about the referral process or suitability of your referral you are welcome to contact the catchment area CMHT by telephone to discuss the referral.
We accept referrals from GP/Health Care Professionals but need the agreement of the GP to undertake shared care of the service user.

Reasons of the Referral:

a) Diagnostic Assessment of Adult ADHD
b) Medication Review for someone already diagnosed with Adult ADHD
c) Transfer of ADHD follow up (please attach a copy of the diagnostic report if available).

Referrer Details:

Name:

Address:

Telephone Number:

Designation:

Details of the Person Referred:

Name:

NHS Number:

Gender:

Date of Birth:

Current Address:

Telephone Number(s): Home: Mobile:

Has the person consented to the referral: Yes No

Does the person have any communication needs and / require information in a format other than standard print: Yes No

Does the person want someone to contact us on their behalf when arranging an initial appointment: Yes No
If yes, name and contact details:

GP Details:

Name:

Surgery:

Telephone number:

ADHD: Core Features Checklist (please choose option 1 or option 2)

Option 1:

Please request the service user to answer the questions below, and please fill it on behalf of the service user each of the criteria shown using the scale below. As per the answer, place an X in the box that best describes how the service user has felt and conducted themselves **over the past 6 months.**

		Never	Rarely	Some-times	Often	Very Often
1	How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2	How often do you have difficulty getting things in order when you have to do a task that requires organisation?					
3	How often do you have problems remembering appointments or obligations?					
4	When you have a task that required a lot of thought, how often do you avoid or delay getting started?					
5	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6	How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Has the service user had any problems in the following areas?

a) Obtaining or sustaining education:
b) Obtaining or sustaining employment:
c) Initiating or sustaining social relationships:
d) Any impact on daily life:

Option 2:

Service user can fill the following self-rating scale and they can be enclosed along with the referral.

Adult ADHD Self-Report Scale (free) (Kessler et al, 2005)
https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf

Weiss Functional Impairment scale (free) (CADDRA, 2014)
https://www.caddra.ca/wp-content/uploads/WFIRS-S.pdf

A. Essential Information for all the Referrals:

Any previous diagnosis of a mental health or neurodevelopmental condition (e.g. Autism, Dyslexia, Dyspraxia) if applicable:

Family History of ADHD:

Substance Misuse History:

Any physical health problems including any medication currently prescribed (if applicable):

- History of cardiovascular disease: Yes No
- Family history of cardiovascular disease before age 55: Yes No
- History of tics or epilepsy: Yes No
- History of liver or disease: Yes No

(Please add any further details if Yes to any of the above)

Baseline physical health checklist: Please include the reading of the following:

- Blood pressure:
- Pulse rate:
- Weight:
- Height:
- ECG (if service user has a pre-existing cardiac condition):

Any risk to self or others:

ADDITIONAL INFORMATION

Please use the space below to provide any other relevant information
(e.g. current risks, access to support, what the person wishes to obtain from the assessment)

Please send the completed referral with information enclosed/attached to:

For ADHD referrals for **Bedford**:
Bedford TABI Team Elt-tr.bedfortriagecmht@nhs.net

For ADHD referrals for **Central Bedfordshire**:
Ampthill elt-tr.ampthillcmht@nhs.net
Biggleswade elt-tr.biggleswadecmht@nhs.net
Leighton Buzzard elt-tr.leightonbuzzardcmht@nhs.net

For ADHD referrals for **Luton**:
Dallow Downs elft.dallowdowns-cmht-referral@nhs.net
Brantwood elft.brantwood-cmht-referral@nhs.net
Wardown elft.wardown-cmht-referral@nhs.net
Stockwood elft.stockwood-cmht-referral@nhs.net