Shared Care Guideline for the Use of Methylphenidate, Dexamfetamine, Lisdexamfetamine dimesylate & Atomoxetine for the Management of Attention-deficit Hyperactivity Disorder (ADHD) in Adult Patients (age 18-64 years)

(Applicable for Luton and Bedfordshire Areas only)

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust

Version number:	4
Consultation Groups	
Approved by (Sponsor Group)	Bedfordshire, Luton & Milton Keynes Area Prescribing Committee ELFT Medicine Management Committee
Ratified by:	ELFT Medicine Management Committee
Date ratified:	Sept 2022
Name and Job Title of author:	ICB & ELFT Pharmacists
Executive Director lead:	Paul Gilluley
Implementation Date:	August 2022
Last Review Date	August 2022
Next Review date:	July 2024

Services	**Applicable to**
Trustwide	
Mental Health and LD	√
Community Health Services	

Contents

DOCUMENT TO BE SCANNED/UPLOADED **INTO ELECTRONIC RECORDS AND FILED IN NOTES**

To be completed by the specialist initiating the treatment	
GP Practice Details: Name: …… Address: …… Tel no: …… Mob no: …… NHS.net e-mail: ……	**Patient Details:** Name: …… Address: …… DOB: Hospital number: …… NHS number (10 digits): ……
Specialist name: …… **CMHT:** …… **Contact details**: Address: ..... Tel no: …… Mob no: …… NHS.net e-mail: ……	
Diagnosis: ……	**Medicine name, form, dose and frequency to be prescribed by GP:** ☐ ……

1. Introduction

ADHD is a neurodevelopmental condition which manifests as cognitive and behavioral 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).

As their brains mature, a significant proportion of adolescents will acquire the necessary skills to be able to manage without medication. However, some adolescents will still endure significant impairment due to ADHD and will continue to need medication during the transition into adulthood, and during adult life.

ADHD is thought to be a persistent condition from childhood and a diagnosis 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, behavioral and educational

or occupational needs.

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

2. Guidance Overview

The remit of this guideline is to provide guidance on the shared care of adults who may be prescribed atomoxetine, dexamfetamine, lisdexamfetamine and methylphenidate in the following scenarios:

- 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 the UK 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

3. Treatment of ADHD in Adults

NICE Guideline 87 states the following with respect to the treatment of ADHD in Adults:-

- 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.

* Domain refers to areas of function, e.g. interpersonal relationships, education and occupational attainment, and risk awareness. (Ref NICE NG 87, pg 63)

** Environmental Modifications are changes made to physical environment in order to minimise the impact of a person's ADHD on their day-to-day life e.g. changes to seating arrangements, changes to lighting and noise optimising work or education to have shorter periods of focus with movement breaks etc. (Ref NICE NG 87 pg 63)

- Consider non-pharmacological treatment for adults with ADHD who have:
    - Made an informed choice not to have medication
    - Difficulty adhering to medication
    - Found medication to be ineffective or cannot tolerate it.

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
- 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.

4. Referral and Assessment Process

Adult patients identified by GP as having possible ADHD

- GP to refer to local Adult Psychiatric Specialist service (ELFT) for assessment by completing the referral form (Appendix 1).
- 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 and the patient's GP via a shared care agreement once the patient has been established on a stable dose (after approximately 12 weeks).
- Transfer of care to the patient's GP may be requested for stable patients following the first annual review (approximately 12 months after stabilisation of treatment).
- For patients who have a confirmed diagnosis of ADHD from elsewhere, ELFT will initiate and stabilise treatment before requesting shared care or transfer of care (as outlined above).
- If patients de-stabilise in primary care, whilst under shared care or following transfer of care, GPs should refer back to ELFT for review.
- For patients receiving ADHD diagnosis from https://psychiatry-uk.com/right-to-choose/ who

would like to commence ADHD treatment; they will need to be referred into ELFT for Part 3 for initiation and titration of ADHD medication. The referral will require the baseline ECG, blood tests (full blood count, urea and electrolytes, liver function tests), vitals (blood pressure, heart rate, weight) and up to date medical history (see Appendix 1).

- The local Adult Psychiatric Specialist (ELFT) 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.

CAMHS patients who transition into adult services

- CAMHS to inform Secondary care 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.
- CAMHS to inform the GP any decision to stop or alter the treatment plan prior to transition to adult services.
- Should on-going prescription of psychostimulants be considered necessary, GP to continue prescribing as per existing shared care agreement
- ELFT 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 psychostimulants should be advised of the need for safe storage to prevent diversion and potential abuse. Patients should be reminded that although medication is not licensed in adult ADHD, it may continue to be effective.
- Only adolescents who show clear improvement with ADHD medication should be considered for on-going treatment as adults.

5. Shared Care Responsibilities

The aim of this document is to provide information to allow patients to be managed safely via shared care (initially) and subsequent transfer of prescribing and monitoring across the Primary and Secondary care interface. It assumes a partnership and an agreement between a hospital specialist, GP and the patient/carer and also sets out responsibilities for each party. If the patient requires specialist input, the patient can be re-referred back into secondary care services for review. Any changes to medication will be done by ELFT and only after stabilisation of treatment will the patient's care be transferred back (after 12 months, following a period of shared care) to primary care for ongoing prescriptions. Any changes made will be communicated clearly in a letter to the GP.

The intention to share care should be explained to the patient by the Specialist and accepted by the patient. Once agreement has been reached with the patient, the Specialist should contact the GP and invite them to participate in a shared care arrangement. Agreement to share care will be assumed unless the GP advises otherwise. Patients stabilised on treatment are expected to be taken up by primary 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).

Under this shared care agreement, patients will be under regular follow up and this provides an opportunity to discuss drug therapy. Intrinsic to the shared care agreement is that the prescribing doctor should be appropriately supported by a system of communication and co-operation in the management of patients.

The doctor who prescribes the medicine has clinical responsibility for the drug and the consequences of its use.

6. Transfer of Care

- In the longer term (after the first annual review has taken place), 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 or predictable. See Transfer of Care letter (appendix 2).
- The Specialist must contact the GP to request Transfer of care and the GP is required to formally accept in writing (NB this differs from the shared care arrangement by which it has been agreed that it is assumed the GP will accept 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 ADHD treatment in the long term
    - details of annual health check criteria
    - details of a step-up or step-down plan should any problems arise in the future
    - contact numbers for access to immediate specialist advice
    - details of an easy route back into secondary care. This will include a direct access telephone number and email address and outline time frames for response – urgent advice – within 48hrs, routine advice – within 2 weeks.

7. Summary adult psychiatric specialist responsibilities

- For newly diagnosed adult patients, or where there has been a change in medication, carry out baseline assessments (see Appendix 1), 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 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.
- Following initiation of ADHD medication, titrate dose and once patient is stable (usually within 8-12

weeks of last change in dosage), request shared care with GP.

- Patients who are under shared care with primary care will require a first annual review with a specialist. The date of annual review will be calculated a year from the date of stabilisation.
- If any problems arise following initiation of shared care, or transfer of care, patients are to be escalated to the specialist ADHD service for a review. Once the patient is stable the shared care arrangement will resume and another annual review will be conducted by the specialist a year from the date of stabilisation as described above. The annual review should include a discussion about efficacy and adverse effects of ADHD medication. If there is a change in cardiovascular health i.e. development of hypertension, persistent tachycardia, or any other cardiac disorder please refer back to specialist team for further advice.
- Send written correspondence to GP, ensuring that the dose and frequency of medication is clearly documented. If prescribing long-acting methylphenidate, prescribe by brand name (as different brands are not interchangeable).
- Whilst under shared care, the Adult Psychiatric outpatient clinic will continue to monitor and supervise the patient as per protocol (see Appendix 3)
- Review the patient as appropriate regularly and liaise with the GP should treatment be varied or discontinued.
- The Adult Psychiatric outpatient clinic should advise female patients at the onset of treatment or at first visit (if transferred from another team / hospital) that if they are breastfeeding, wish to conceive or if they become pregnant while taking medications that they should contact the Specialist as soon as possible to discuss treatment options.
- Should medication no longer be considered necessary or is not tolerated, the patient is able to stop treatment. A withdrawal approach is not necessary.
- Dose adjustment will usually be the responsibility of the initiating specialist team unless care has been transferred and directions have been specified in the medical letter to the GP.
- Ensure the patient has adequate supply of medication until GP supply can be arranged
- Report adverse events to the CSM/MHRA via Yellow card located in BNF or online www.yellowcard.gov.uk

8. Summary of GP/Primary Care Prescriber responsibilities

- Reply to the request for shared care as soon as practicable if the request to share care is declined. Agreement to share care will be assumed unless the GP advises otherwise.
- Prescribe ADHD treatment at the dose and formulation recommended. If prescribing long-acting methylphenidate, prescribe by brand name (as different brands are not interchangeable).
- Adjust dose or formulation as advised by the specialist.
- Monitor the patient's overall health and well-being. (See Appendix 3)
- Contact the Specialist to discuss any significant changes in the patient's condition.
- Inform Specialist of any emerging side effects.
- 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) 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

- Report adverse events to the Specialist and the MHRA/CSM via Yellow card located in the current BNF or online www.yellowcard.gov.uk
- Refer any patient who becomes pregnant or who wishes to plan a pregnancy to the Specialist team for an urgent review.
- When transfer of care is requested, reply to the request for transfer of care as soon as practicable (note: acceptance of transfer of care is not assumed, as it is for shared care, and therefore a response is required).
- Following transfer of care, conduct an annual review. The review should include discussion with the patient about whether they wish to continue treatment and the effects of missed doses, planned dose reductions, and periods of no treatment should be evaluated.

SUMMARY OF PATIENTS RESPONSIBILITIES

- Report to the specialist or GP if he or she does not have a clear understanding of the treatment.
- Share any concerns in relation to treatment with stimulants or atomoxetine.
- Inform specialist or GP of any other medication being taken, including over-the- counter products
- Report any adverse effects to specialist or GP whilst taking ADHD medication.
- To inform DVLA of their diagnoses (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.
- Attend appointments and comply with medication and any monitoring requirements
- To contact the Specialist team as soon as possible if a patient becomes pregnant or who wishes to plan a pregnancy.

9. Physical Health Monitoring

Routine blood tests and ECGs are not currently recommended for patients taking ADHD medication unless there is a clinical indication.

For adult patients suspected of having ADHD symptoms, GPs to complete necessary pre-treatment assessment as indicated (see Appendix 1) prior to referral to ELFT specialist. ELFT specialist to ensure that full pre-treatment assessment has been completed prior to accepting the referral for ADHD assessment.

See Appendix 3 for physical health monitoring standards.

10. ADHD medications

Methylphenidate or lisdexamfetamine are considered the stimulants of choice in the UK for adults with ADHD. Modified–release preparations of methylphenidate are preferable to immediate release preparations as they pose less risk of abuse and improve adherence. If methylphenidate or lisdexamfetamine are ineffective or unacceptable, atomoxetine or dexamfetamine may be considered.

NB: Prescribers should note that ADHD drugs are not generally licensed for use in adult patients therefore, prescribing for adult patients is regarded as an “off label” use of a licensed product.

A summary of the licensed indications for each of the ADHD drugs is given below in section 16. For full up to date details and Licensing Information for ADHD drugs, clinicians should refer to individual Summary of Characteristics (SPCs) www.medicines.org.uk/emc or the most recent version of the electronic BNF; https://bnf.nice.org.uk

11. Summary of Licensed Indications

Methylphenidate
Methylphenidate is licensed for use in children aged 6 years of age and over. It is not licensed for initiation in adults per se however; it is acknowledged that it may be appropriate to continue treatment into adulthood. (Ref: Concerta XL® SPC)

Atomoxetine
Atomoxetine is licensed for the treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children of 6 years and older, in adolescents and in adults as part of a comprehensive treatment programme. When used in adults, the presence of symptoms of ADHD that were pre-existing in childhood should be confirmed. Atomoxetine should not be initiated when the verification of childhood ADHD symptoms is uncertain. (Ref: Strattera® SPC).

Dexamfetamine
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)

Lisdexamfetamine
Lisdexamfetamine is indicated as part of a comprehensive treatment programme for attention deficit/hyperactivity disorder (ADHD) in children aged 6 years and over when response to previous Methylphenidate treatment is considered clinically inadequate.
In adolescents whose symptoms persist into adulthood and who have shown clear benefit from treatment, it may be appropriate to continue treatment into adulthood. (Ref: Elvanse® SPC)

12. Prescribing Information

a. For newly diagnosed adult patients commencing drug treatment, medication should be initiated by a Specialist Psychiatrist
b. Existing patients (either adults being transferred from Tertiary care to Secondary care or patients being transferred from CAMHS to adult services), medication should be continued as specified by Tertiary care Specialist / CAMHS team (as applicable).
c. Clinicians should refer to the current BNF/ SPCs and Section 16 of this document for each drug for full information on dosage, contraindications / side effects / drug interactions etc.
d. Drug treatment should be continued for as long as clinically effective and reviewed annually to assess need for continued treatment. Effects of missed doses, planned dose reductions, and periods of no treatment should be evaluated. The first annual review will be carried out by

the specialist team, with subsequent reviews undertaken by the GP if transfer of care has been agreed.

e. As drug costs are subject to change, GPs will be advised of the most cost-effective preparations and sufficient information will be provided to enable the switch to be undertaken via Scriptswitch or Optimise.

f. Prescribers must follow the schedule 2 controlled drugs requirements when prescribing methylphenidate, dexamfetamine or lisdexamfetamine as these drugs are schedule 2 controlled drugs. Atomoxetine is not classed as a schedule 2 controlled drug and normal prescription requirements apply.

   A prescription for methylphenidate, dexamfetamine or lisdexamfetamine requires:

   - the total quantity to be prescribed to be written in words and figures
   - a maximum supply of 28 days
   - signature in the prescriber's own handwriting where computer generated prescriptions are issued and not sent via the Electronic Prescription Service (EPS). In primary care, all prescriptions should be sent via EPS where possible.
   - use of indelible ink if prescription handwritten, signed and dated by prescriber, name and address of patient, form and strength of preparation, dose and frequency in the prescriber's own handwriting

13. DVLA

Patients must inform DVLA if ADHD or ADHD medication affects their ability to drive safely. This information is applicable for patients who are also applying for their provisional license.

14. Contact Details

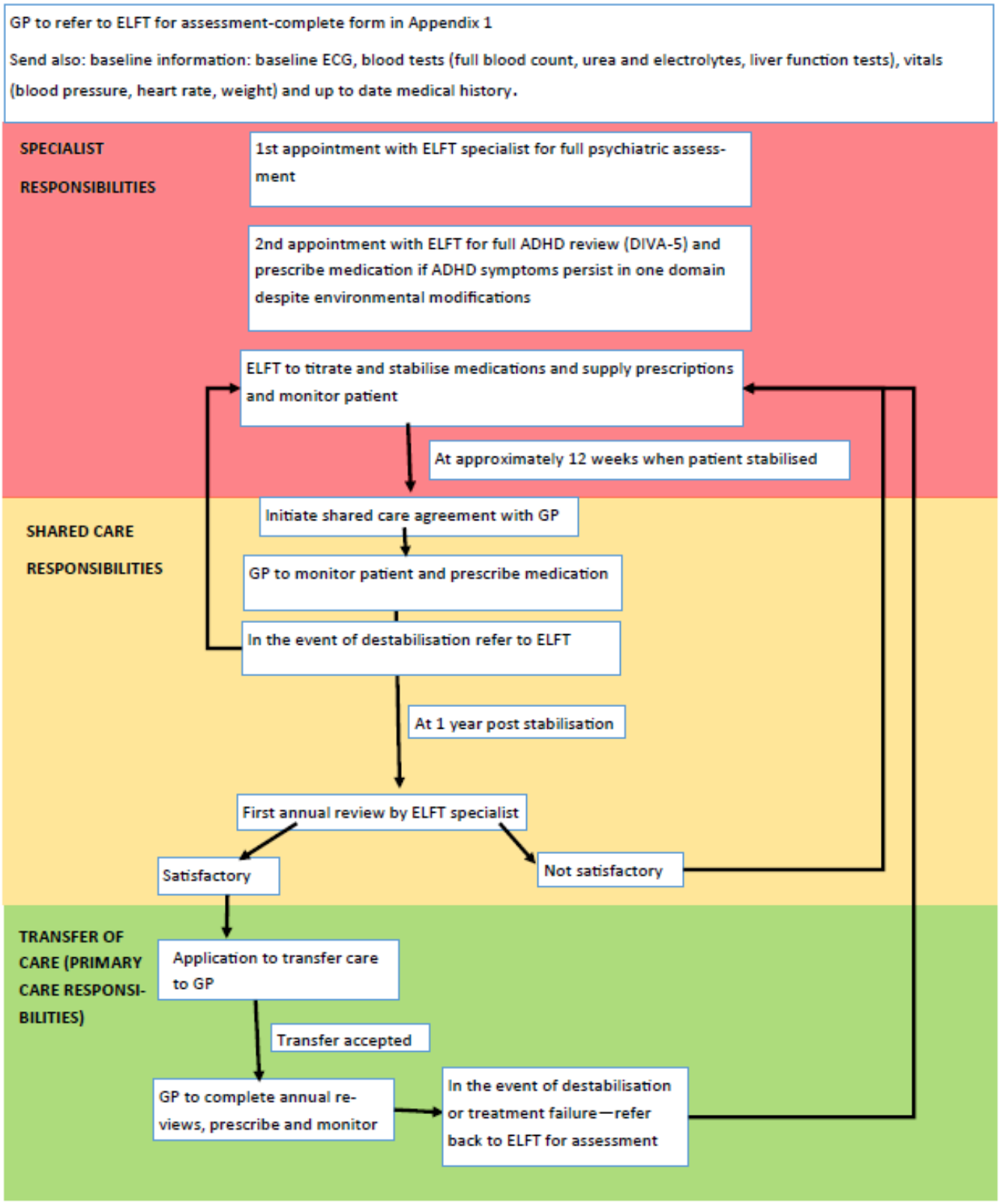
In case of any issues or queries with respect to shared care, or following transfer of care, GPs should contact the respective CMHT via the following contact numbers/emails.

	Phone number	**E-mail**	**Address**
Ampthill CMHT	01525 758400	elt-tr.ampthillcmht@nhs.net	Meadow Lodge at Steppingley Hospital Ampthill Road Ampthill MK45 1AB
Biggleswade CMHT	01767 224922	elt-tr.biggleswadecmht@nhs.net	Spring House, Biggleswade Hospital Potton Road Biggleswade SG18 0EJ
Leighton Buzzard CMHT	01525 751133	elt-tr.Leightonbuzzardcmht@nhs.net	Crombie House 36 Hockliffe Street Leighton Buzzard, Bedfordshire LU7 1HJ

Dunstable CMHT	01582 709200	elt-tr.dunstableCMHT@nhs.net	Beacon House 5 Regent Street Dunstable, Bedfordshire LU6 1LP
Brantwood CMHT (Luton)	01582 708617	elft.brantwood-cmht-referral@nhs.net	Floor 3 Charter House Alma Street Luton LU1 2PJ
Dallow Downs CMHT (Luton)	01525 638400, 638401, 638402	elft.dallowdowns-cmht-referral@nhs.net	Floor 3 Charter House Alma Street Luton LU1 2PJ
Stockwood CMHT (Luton)	01525 638394	elft.stockwood-cmht-referral@nhs.net	Floor 2 Charter House Alma Street Luton LU1 2PJ
Wardown CMHT (Luton)	01582-708609	elft.wardown-cmht-referral@nhs.net	Floor 2 Charter House Alma Street Luton LU1 2PJ
Triage and Brief Intervention Team (TABI) (Bedford)	01234-880422	elt-tr.bedfordtriagecmht@nhs.net	Florence Ball House 3 Kimbolton Road Bedford MK20 2PU
Recovery Team (Bedford)	01234 880433	elft.bedfordcmhtrecovery@nhs.net	Florence Ball House 3 Kimbolton Road Bedford MK20 2PU
Non CPA Team (Bedford)	01234 880411	elft.bedfordmdtreviewcmht@nhs.net	Florence ball House 3 Kimbolton Road Bedford MK20 2PU

NOTE: There is a generic email for Luton CMHTs as well (in addition): elft.lutoncmhtreferrals@nhs.net

15. Flow Chart of Care Pathway



16. SUMMARY OF MAIN FEATURES OF TREATMENT OPTIONS FOR ADHD

For full up to date details and Licensing Information for ADHD drugs, clinicians should refer to individual Summary of Characteristics (SPCs) www.medicines.org.uk/emc or the most recent version of the electronic BNF www.bnf.org/products/bnf-online/ https://bnf.nice.org.uk/

	Methylphenidate Immediate- release tablets	Methylphenidate modified-release			Atomoxetine capsules	Lisdexamfetamine capsules	Dexamfetamine tablets
Formulation	Ritalin® 10mg Medikinet® 5mg 10mg, 20mg tablets Methylphendiate 5mg, 10mg, 20mg tablets	Equasym® XL 10,20,30mg capsules Immediate – release component (30% of dose), modified release component (70% of dose)	Concerta ® XL 18mg, 27mg, 36mg tablets Immediate – release component (22% of dose), modified release component (78% of dose)	Medikinet ® XL 5mg,10mg, 20mg, 30mg, 40mg capsules Immediate release component (50% of the dose) modified release component (50% of dose)	Strattera®/ Atomoxetine 10mg,18mg, 25mg,40mg,60mg, 80mg, 100mg	Elvanse ® 30mg,50mg,70mg	Amfexa®/ Dexamfetamine 5mg

Licensing & Dose (see sections 10, 11 and 12 of this document for more details)	**Unlicensed**: Initial: 5mg 2 or 3 times a day. Titrate against symptoms and side effects at weekly intervals. Max: 100mg daily in up to 4 divided doses	**Unlicensed:** If initiating with Equasym® XL, 10mg daily (before breakfast) 10mg daily is equivalent to 5mg BD Methylphenidate immediate release. Titrate against symptoms and side effects at weekly intervals. Max 100mg daily.	**Unlicensed:** If initiating with Concerta® XL, use 18mg daily, adjusted at weekly intervals. 18mg daily is equivalent to 5mg TDS Methylphenidate immediate release. Titrate against symptoms and side effects at weekly intervals Max 108mg daily	**Unlicensed:** If initiating with Medikinet® XL, use 10mg daily (with breakfast). 10mg daily is equivalent to 5mg BD Methylphenidate immediate release. Titrate against symptoms and side effects at weekly intervals. Max: 100mg daily	**Licensed only:** *As part of a comprehensive treatment programme for ADHD in adults who have shown clear benefit from treatment in childhood* Initial (in those with a body weight of > 70kg): 40mg daily minimum of 7 days, then titrate as required. Initial (in those with a body weight of < 70kg): 500 micrograms / kg daily minimum of 7 days, then titrate as required. Usual maintenance dose 80-100mg/day. Max: 120mg (unlicensed).	**Licensed only:** *For ADHD in adults who have shown clear benefits from treatment in childhood.* Initial: 30mg once daily in the morning. Titrate according to response/tolerability. May be increased at weekly intervals by 20mg increments Max 70mg daily	**Unlicensed:** Initial: 5mg twice a day. Titrate against symptoms and side effects, increasing at weekly intervals as required. Max 60mg/day in 2-4 divided doses
Duration of Action	3-4 hours	8 hours	12 hours	6-8 hours	24 hours	8 hours	4 hours

Controlled Drug	Yes	Yes	Yes	Yes	No	Yes	Yes
Type of medication	Stimulant				Non stimulant	Stimulant	Stimulant
Abuse Potential	Yes – modified release preparation thought to have less abuse potential and thus, is preferred treatment choice				No	Yes	Yes
Can be used in common ADHD comorbidities such as tics and Tourette's and marked anxiety	No - Stimulants have been reported to exacerbate motor and phonic tics and Tourette's syndrome.				Yes	No	No
Physical monitoring	See Appendix 3 Agree monitoring schedule with GP and consultant/specialist for adults						
Interactions	For more detailed information on interactions, cautions, contra-indications and side-effects, please refer to manufacturer's Summary of Product Characteristics and the current BNF						
	Warfarin Anti- convulsants Selected tricyclic and serotonin reuptake inhibitors Alcohol				Monoamine oxidase inhibitors Anti-hypertensive drugs Salbutamol CYP2D6 inhibitors (SSRI's, quinidine, terbinafine)	Monoamine oxidase inhibitors Anti-hypertensive drugs Lithium carbonate Haloperidol	Monoamine oxidase inhibitors
Adverse effects	Gastro-intestinal symptoms (stomachache, affected appetite, dry mouth, nausea & vomiting) Psychiatric disorders (insomnia, abnormal behaviour, aggression,				Gastro-intestinal Nervous system	Gastro-intestinal Skin & subcutaneous	Gastro-intestinal Nervous system

	agitation, anxiety) Nervous system disorders (dizziness, drowsiness, headache, dyskinesia) Cardiac disorders (palpitations, tachycardia) Musculoskeletal and connective tissue disorders (arthralgia) Skin & subcutaneous tissue (rash, pruritus, urticarial, alopecia)	disorders Skin & subcutaneous tissue	tissue	disorders Skin & subcutaneous tissue Cardiac disorders
Cautions	Psychiatric disorders, anxiety, agitation, tics, family history Tourette syndrome, drug or alcohol dependence, epilepsy, susceptibility to angle- closure glaucoma,	Cardiovascular (hypertension & Cerebrovascular disease Psychiatric disorders Tics, history of seizures, aggressive behaviour, hostility or emotional lability, susceptible to angle- closure glaucoma	Anorexia, history of cardiovascular disease or abnormalities, psychiatric disorders, aggressive behaviour, tics, Tourettes, susceptibility to angle closure glaucoma	Anorexia, mild hypertension, psychiatric disorders, aggressive behaviour, hostility during initiation, epilepsy, tics, Tourettes, susceptibility to angle-closure glaucoma
Contra- indications	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	Phaeochromocytoma.	Symptomatic cardiovascular disease (moderate to severe hypertension, advanced arteriosclerosis), hyperexcitability or agitation, hyperthyroidism.	Cardiovascular disease (moderate to severe hypertension, structural cardiac abnormalities, advanced arteriosclerosis), hyperexcitability or agitation, hyperthyroidism, history of drug or alcohol abuse

Adjunctive treatment regime

Patients may also be prescribed melatonin by the specialist ADHD team.
Patients may also require additional psychotropic medications for other mental health diagnoses following an assessment by a specialist.

17. References

1. NICE guideline 87: Attention deficit hyperactivity disorder: diagnosis and management https://www.nice.org.uk/guidance/ng87
2. NICE pathway for treatment of Adults with ADHD; Sep 2013 http://pathways.nice.org.uk/pathways/attention-deficithyperactivity-disorder
3. BNF – May 2015
4. East London NHS Foundation Trust shared care guidelines for Methylphenidate, Atomoxetine, Dexamfetamine and Lisdexamfetamine for ADHD in Children & Young People (6-17 years). 2014
5. British Association for Psychopharmacology 2014; Evidence based guidelines for the pharmacological management of attention deficit hyperactivity disorder: Update on recommendations
6. Taylor D et al (2014).The Maudsley Prescribing Guidelines in Psychiatry .11th ed. London: Wiley
7. Pharmacological treatments for ADHD. Parker C. Progress in Neurology and Psychiatry 2009;13: 17-26. Doi 10.1002/pnp.128 http://www.progressnp.com/view/Mjk3Mzc1LpBLzExOTAxMS9udWxs/journalArticlePdf.htm l.
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9. Camden and Islington NHS Foundation Trust shared care guidelines for Methylphenidate, Dexamfetamine, Lisdexamfetamine and Atomoxetine in adults, 2015
10. Electronic Medicines Compendium – access to Summaries of Product Characteristics of Atomoxetine, Lisdexamfetamine, Methylphenidate http://www.medicines.org.uk/emc
11. Maudsley Prescribing in Psychiatry. 12th Edition page 384-389

Appendix 1: Referral Form

NHS
East London
NHS Foundation Trust

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

Appendix 2: 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/adhd-shared-care-guideline-for-the-management-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,

Nurse/Doctor Name
Job Title

Appendix 3: Monitoring Standards in line with current NICE guidance

Parameter	Frequency of monitoring/medication	Action	By Whom
Efficacy	At each appointment and when doses are changed	Rating scales may be used	Specialist or GP
Non- specific side effects	At each appointment	Review and monitor adverse effects, possible drug interactions, changes to medication regime, deteriorating behaviour. Communicate any relevant medical information to consultant/GP.	Specialist or GP
Weight	Baseline, months 3 & 6, then annually 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	GP– baseline GP or Specialist: months 3 & 6 GP – annual and request patient's keep a track of their weight and report any changes.
Pulse & Blood Pressure	Baseline, before and after dose change and then 6 monthly thereafter	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	GP – baseline Specialist whilst titrating the dose GP – before and after dose change and annually
Full Blood Count (FBC)	Baseline only if indicated (Methylphenidate)	Low threshold for repeat FBC rather than routine e.g. recurrent infections, purpuric rash or based on medical history	GP only if required.
Cardiovascular risk assessment	Baseline Throughout therapy	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	GP GP
Baseline ECG	Only if known or suspected history	Referral to cardiologist	GP – annually if known cardiovascular history

	(NB – it is a clinical decision whether or not an ECG is indicated)		
Liver Function	Throughout therapy (Atomoxetine)	Be vigilant for abdominal pain, unexplained nausea, malaise, darkening of urine or jaundice. Routine testing of LFTs not recommended	Specialist (if using atomoxetine) GP: baseline
Suicidal thinking and self- harming behaviour	During the initial months or after a change of dose (Atomoxetine)	Patients and carers should be warned about the potential for suicidal thinking and self-harming behaviour	Specialist or GP Patient or carer(s)
Risk assessment of substance misuse (diversion)	Baseline Throughout therapy	Enquire about known substance use in patient or that of close family member or carer Concerns about requests for frequent prescriptions deemed unnecessary should be communicated to consultant/specialist	Specialist or GP
Sexual dysfunction (Atomoxetine)	Throughout therapy	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.	Specialist or GP
Changes in sleep patterns	Throughout therapy	Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly.	Specialist
Seizures	Throughout therapy	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.	Specialist or GP
Tics	Throughout therapy	If a person taking stimulants develops tics, Specialist to consider whether:-The tics are related to the stimulant (tics naturally wax and wane) **and** The impairment associated with the tics outweighs the benefits of ADHD	Specialist