ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

Shared care agreement for the treatment of ADHD in Children & Young People (6-17 years): Luton and Bedfordshire

Version number :	11.0
Consultation Groups	CAMHS ELFT/ Community paediatricians BLMK/ BLMK ICB APC and primary care/ Medicines committee
Approved by (Sponsor Group)	BLMK ICB APC/ ELFT medicines committee
Ratified by:	BLMK ICB APC/ ELFT medicines committee
Date ratified:	January 2023
Name of originator/author:	Iffah Salim (CAMHS pharmacist)
Executive Director lead :	Andrea Okoloekwe (Chief Pharmacist) David Bridle (Medical Director)
Implementation Date :	January 2023
Last Review Date	January 2023
Next Review date:	January 2026

Services	Applicable
Trustwide	Yes
Mental Health and LD	Yes
Community Health Services	Yes

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

Patient name	**NHS number**
Address	
Consultant/ Community Paediatrician name **Signature**	**Service contact number/ email**
Service address	

INTRODUCTION

Attention Deficit Hyperactivity Disorder (ADHD) is a behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention.

Two main diagnostic criteria are in current use – the International Classification of Mental and Behavioural Disorders 10th revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5). ICD-10 uses a narrower diagnostic category, which includes those with more severe symptoms and impairment. DSM-5 has a broader, more inclusive definition, which includes a number of different ADHD subtypes. Severe ADHD corresponds approximately to the ICD-10 diagnosis of hyperkinetic disorder.

Based on the narrower criteria of ICD-10, hyperkinetic disorder is estimated to occur in about 1–2% of children and young people in the UK. Using the broader criteria of DSM-5, ADHD is thought to affect about 3–9% of school-age children and young people in the UK, and about 2% of adults worldwide.

Drug treatment of ADHD should only be initiated by an appropriately qualified healthcare professional with expertise in ADHD and should be based on a comprehensive assessment and diagnosis. Drug treatment is not indicated in all patients with this syndrome and the decision to use medication must be based on a thorough assessment of the severity of the symptoms.

Purpose of shared care agreement

The remit of this guideline is to provide guidance on the shared care of children and adolescents aged 6-17 years who are prescribed methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine or guanfacine for the treatment of ADHD / hyperkinetic disorder.

It assumes a partnership and an agreement between a hospital specialist, GP and the patient/carer and also sets out responsibilities for each party. The intention of shared care should be explained to the patient/carer and be accepted by them prior to commencement of shared care. Patients are under regular follow-up and this provides an opportunity to discuss drug therapy. Intrinsic in the shared care agreement is that the prescribing doctor should be

appropriately supported by a system of communication and cooperation in the management of patients.

Exception to shared care agreement: Children under 6 years with diagnosis of ADHD

ADHD NICE guidance (NG87, updated Sept 2019), states medication can be started for children **5 years and over** if their ADHD symptoms are '*causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed*'. However, ADHD medication is licensed for children 6 years and over and so, treatment of this population would fall **outside** the remit of the ADHD shared care. Agreement of any prescribing for children 5 -6 years old would, where appropriate, would need to be locally agreed with the GP service. Otherwise, it must be retained within the specialist service, and transfer of care under the shared care agreement can be implemented for the child once they are 6 years old.

Target audience

ELFT, Child and Adolescent Mental Health Services (CAMHS), community paediatricians, General Practitioners (GPs), Non-Medical Prescribers (NMPs), specialist child and adolescent ADHD services e.g. those based within Child Development Centres, advanced clinical pharmacists and both nurses (RMN) and clinical nurse specialists in Luton (LT) and Bedfordshire (BD)

Please note; For the purpose for this shared care:

The use of the term NMP refers to both a clinical specialist nurse and an advanced level practice pharmacist, who are also prescribers. Target audience refers to all those professionals/ teams who are involved in the pathway for ADHD treatment. The overall clinical responsibility for the care of a child/ young person lies with the assigned consultant and/ or assigned community paediatrician and GP (for primary care).

Assessment

All young people presenting with significant symptoms of ADHD will be given a full and comprehensive assessment by the multi-disciplinary team, including a child and adolescent psychiatrist or community paediatrician. An assessment report will be sent to the GP, and a 'patient friendly' copy provided to parent/carer and where appropriate to the young person.

Once diagnosed with ADHD, there will be a discussion with the patient and their family or carers about relevant treatment options. Treatment aims, available options, medication and alternative/additional interventions, side effects and the monitoring protocol will be discussed. Written medication information should be provided for the parent/carer and young person where appropriate.

Physical Screen

The CAMHS team and/ or community paediatrician and/ or NMP will undertake a baseline physical examination of any young person before commencing medication. This will include measurement of height, weight, pulse, blood pressure and heart sounds which should be compared to reference centiles. A more thorough physical examination may be required in some young people, particularly if there is a medical or family history of serious cardiac disease, a history of sudden death in young family members, or abnormal findings on cardiac examination.

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

For those young people up to 17 years old (under care of CAMHS) requiring a more thorough cardiac assessment (which may require ECG measurement and interpretation), a referral will be made to the paediatric cardiology department at the local acute trust. For those young people up to 18 years old (under care of community paediatricians), a further specialist cardiac evaluation should be performed where clinically indicated.

Blood tests and ECG will only be recommended if clinically indicated. If there are concerns with regards to the young person's physical health, a referral to the GP/ community paediatrician for further assessment may be considered.

DOSE AND ADMINISTRATION

For new patients commencing drug treatment, medication should be initiated by CAMHS, community paediatrician or non-medical prescriber (NMP).

First choice

Unless contraindicated, either short or long acting methylphenidate should be the first line choice of drug treatment.

Second choice

If medication is ineffective after a period of 6-weeks treatment with methylphenidate at a therapeutic dose, switching to lisdexamfetamine should be considered. Dexamfetamine can be used as an alternative if the longer acting profile of lisdexamfetamine cannot be tolerated.

Alternative choices (poor response/ unable to tolerate)

Atomoxetine or guanfacine should be reserved as last line alternatives if the young person is unable to tolerate methylphenidate or lisdexamfetamine, or if their symptoms have not responded to separate 6-week trials of both of these drugs, irrespective of trialling alternative preparations or doses.

Initial, titration and maximum doses for children aged 6 years and older

	Age	Dosing
Methylphenidate NICE bnf online (2022)	Child 6–17 years	Initially 5 mg 1–2 times daily, increased if necessary at weekly intervals by 5–10 mg daily; licensed max. 60 mg daily in 2–3 divided doses but may be increased to 2.1 mg/kg daily in 2–3 divided doses (max. 90 mg daily) under the direction of a specialist
Atomoxetine NICE bnf online (2022)	Child 6-17 years, *(body-weight under 70 kg)*	Initially 500 micrograms/kg daily for 7 days, increased according to response; usual maintenance 1.2 mg/kg daily, but may be increased

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

		to 1.8 mg/kg daily (max. 120 mg daily) [unlicensed] under the direction of a specialist.
	Child 6–17 years, *(body-weight over 70 kg)*	Initially 40 mg daily for 7 days, increased according to response; usual maintenance 80 mg daily, but may be increased to max. 120 mg daily [unlicensed] under the direction of a specialist
Lisdexamfetamine NICE bnf online (2022)	Child 6-17 years	Initially 30mg once daily, alternatively initially 20mg once daily increased in steps of 10-20mg every week. Discontinue if response insufficient after 1 month; maximum 70mg per day under direction of specialist.
Dexamfetamine NICE bnf online (2022)	Child 6–17 years	Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required, usual maximum 1 mg/kg daily, up to 20 mg daily (40 mg daily has been required in some children under direction of specialist); maintenance dose to be given in 2–4 divided doses.
Guanfacine NICE bnf online (2022)	Child 13-17 years *(body weight 41.5-49.4kg)*	Initially 1mg daily, adjusted in steps of 1mg every week if necessary and if tolerated; maintenance 0.05 – 0.12 mg/kg once daily (max. per dose 5mg)
	Child 13-17 years *(body weight 49.5-58.4 kg)*	Initially 1mg daily, adjusted in steps of 1mg every week if necessary and if tolerated; maintenance 0.05 – 0.12 mg/kg once daily (max. per dose 6mg)
	Child 13-17 years *(body weight 58.5kg and above)*	Initially 1mg daily, adjusted in steps of 1mg every week if necessary and if tolerated; maintenance 0.05 – 0.12 mg/kg once daily (max. per dose 7mg)

Methylphenidate: immediate- and modified-release dose equivalents (mg) (SPC, 2018a-b)

*IR-MPH	**Concerta XL	Equasym XL	Medikinet XL
10	-	10	10
15	18	-	-
20	-	20	20
30	36	30	30

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

-	-	-	40
45	54	-	-
60	72	60	-

*IR MPH = Methylphenidate immediate release

**Matoride XL® tablets, Xenidate XL® tablets, Delmosart XL® tablets and Xaggitin XL® tablets are all bioequivalent to Concerta XL®. Please refer to the latest copy of the BNF, or the Summary of Product Characteristics for further details of the different brands, including their available strengths.

Please note- for bioequivalent brand to Concerta XL, clinicians are advised to prescribe the cost effective option (if tolerated and clinically appropriate)

Comparison of pharmacokinetic profiles of Concerta XL, Medikinet XL and Equasym XL
(SPS, 2018)

	Concerta XL	Equasym XL	Medikinet XL
Composition *(percentage immediate:extended release)*	22:78	30:70	50:50
Release profile	Maximum plasma concentration at 1-2 hours, second peak at 6-8 hours	Maximum plasma concentration at 1.5 hours, followed by a second peak at 6 hours, followed by a gradual decline	Maximum plasma concentration reached rapidly, second peak at 3-4 hours
Duration of action	Up to 12 hours	Up to 8 hours	Up to 8 hours
Administration	Swallow whole with liquid. Must not be chewed, crushed or divided.	Can be swallowed whole with liquid, or opened and the contents sprinkled onto a small amount (tablespoon) of applesauce or yoghurt and given immediately. Capsules and contents not to be crushed or chewed	Can be swallowed whole with liquid, or opened and the contents sprinkled onto a small amount (tablespoon) of applesauce or yoghurt and given immediately. Capsules and contents not to be crushed or chewed

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

Food requirements	Can be given with or without food	To be taken with or after breakfast	To be taken with or after breakfast
Frequency	Once daily in the morning	Once daily in the morning	Once daily in the morning
Immediate-release methylphenidate equivalent	Three times daily	Twice daily	Twice daily

Doses used should be in accordance with the current edition of the BNF and relevant NICE guidance, and any interactions, cautions and contraindications should be taken into account.

During the titration phase, doses are gradually increased until there is no further clinical improvement in ADHD (that is, symptom reduction, behaviour change, improvements in education and/or relationships) and side effects are tolerable.

Where a young person has been initiated on an ADHD medication, the CAMHS clinician, NMP and/or community paediatrician will contact the patient's GP, to request agreement to enter into a formal shared care arrangement. Supply of the medication would only be taken over by the young person's GP once the young person has been stabilised on a particular dose (i.e. deemed to be stable after review by the community paediatric service and on a stable dose of medication which controls symptoms with no side-effects) which will normally be within a 3 month time period. A total period of up to three months should be sufficient to allow commencement of shared care so long as the patient is stable. During the period when shared care is being arranged the community paediatrician, NMP or CAMHS team will continue to provide the monthly prescriptions. A final 28-day prescription should be issued by the community paediatrician, NMP or CAMHS team once the patient is moved over to shared care to allow the GP enough time to issue the next supply.

Symptoms and side effects should be recorded, where appropriate, for progress reviews, on standard scales (for example, Conners' 10-item scale) by parents and teachers.

MONITORING STANDARDS (In line with current NICE guidance)

All physical health monitoring should be undertaken by the community paediatricians, NMP and/ or and CAMHS teams during the initiation and stabilisation period of ADHD medications. Once the patient is stabilised then physical health monitoring should be undertaken at every review appointment (usually 6 monthly, then annually thereafter, however please refer to the specific parameter below for further information). Clinicians to monitor these parameters at other times as clinically required.

Parameter	Frequency of monitoring/ medication	Action
Efficacy/ Medication review	Annually and when doses are changed	Medication information provided to parent/carer and young person. Rating scales may be used
Non-specific side effects	At each appointment	Review and monitor for adverse effects, possible drug interactions, changes to

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

		medication regime, deteriorating behaviour. Communicate any relevant medical information to consultant/ GP. Concerns about requests for unnecessarily frequent prescriptions should be communicated to specialist clinic.
Weight and height	Height: baseline then 6-monthly. <u>Weight – Children under 10 years:</u> measure every 3 months. <u>Children & Young people 10 years and older:</u> measure weight at 3 and 6 months after starting treatment, and 6 months thereafter or more if concerns arise.	Plot height and weight on a growth chart. If weight loss is a clinical concern, consider the following strategies: • Taking medication either with or after food, rather than before meals • Taking additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off • Obtaining dietary advice • Consuming high-calorie foods of good nutritional value • Taking a planned break from treatment • Changing medication If a young person has not met the height expected for their age, consider a planned break in treatment over the school holidays to allow 'catch up' growth.
Cardiovascular	<u>Pulse & Blood pressure</u> Baseline and before and after each dose change and every 6 months.	Do not offer routine blood tests (including liver function tests) or ECGs to people taking medication for ADHD unless there is a clinical indication. (NICE 2018) If a person taking ADHD medication has sustained resting tachycardia (more than 120 beats per minute), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on 2 occasions, reduce their dose and refer them to a paediatric hypertension specialist or adult physician. (NICE 2018).
	<u>ECG if indicated</u> Baseline (specialist team), repeated only when necessary	Baseline ECG should be taken if the ADHD treatment may affect the QT interval (atomoxetine), and/ or relevant cardiac history (personal and/ or immediate family) Do not offer routine ECGs to patients taking medication for ADHD unless there is a clinical indication.
	<u>Routine Full Blood Count (including</u>	**Do not offer** routine blood tests to patients taking medication ADHD unless there is a

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

	LFTs) Only when clinically indicated	clinical indication (methylphenidate). Specialist CAMHS team to undertake this should a routine blood test be clinically indicated.
Tics	At each appointment	If the patient taking stimulants develops tics, think about whether: • The tics are related to the stimulant (tics naturally wax and wane) and; • The impairment associated with the tics outweighs the benefits if ADHD treatment
Sexual dysfunction (Atomoxetine)	At each appointment	Monitor for erectile and ejaculatory dysfunction (adverse effects of atomoxetine)
Seizures	Duration of treatment/ monitored at each appointment	If a patient with ADHD develops new seizures or a worsening of existing seizures, review their ADHD medication and stop any medication that might be contributing to the seizures. After investigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of seizures.
Sleep	At each appointment	Monitor for changes in sleep pattern (e.g. with a sleep diary) and adjust medication accordingly
Worsening behaviour	At each appointment	Monitor the behavioural response to medication, and if behaviour worsens adjust medication and review the diagnosis.
Stimulant diversion	At each appointment	Healthcare professionals and parents or carers should monitor changes in the potential for stimulant misuse and diversion, which may come with changes in circumstances and age.
Liver impairment (Atomoxetine)	Duration of treatment with atomoxetine	Be vigilant for abdominal pain, unexplained nauseas, malaise, darkening of the urine or jaundice. Routine testing of LFTs is not recommended.
Suicidal thinking and self-harming behaviour (Atomoxetine)	During the initial months or after a change of dose	Patients and/or carers should be warned about the potential for suicidal thinking and self-harming behaviour.

DURATION OF TREATMENT

Treatment should generally be continued for as long as it is effective, and should be reviewed at least annually. The symptoms of hyperactivity may diminish during the course of adolescence, though patients may continue to complain of impulsivity and inattention. It is common to tail off treatment as the young person completes their schooling. This should be done gradually to avoid rebound effects.

TREATMENT INTO ADULTHOOD (18 YEARS AND OVER)

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

Young persons who are 17 years old and still under the care of, and stabilised on ADHD medication from, the community paediatrician/ NMP and/ or the CAMHS team, should be reviewed to determine if medication needs to be continued beyond their 18th birthday.

If medication is no longer required, the community paediatrician/ NMP and/ or the CAMHS team will be responsible for tapering off and discontinuing the medication. The young person can then be discharged from the service by their 18th birthday.

Where it is deemed appropriate for the young person to continue medication beyond their 18th birthday, it is the responsibility of the Paediatrician/CAMHS team to advise the GP and arrange for transfer of care to the adult provision*.

For the purpose of this shared care, the adult provision would mean referral to the local adult ADHD service and/ or the adult mental health service (AMHT). Both provisions have their own admission criteria, and acceptance and timelines to when the young person will be seen are based on that particular service criteria.

Where there is no locally agreed appropriate adult ADHD service and/ or the young person is not accepted by the adult ADHD service/ AMHT, then the CAMHS team/ NMP/ Paediatrician would inform the relevant GP and arrange for discharge of the young person back to the GP, with any additional advice/ support.

SHARED CARE RESPONSIBILITY

Specialist *(Consultant Psychiatrist/ Consultant Paediatrician/ Non-Medical Prescriber/ CAMHS Registrar)*

1. Contact the GP/NMP if the patient has been referred for assessment by an alternate route other than GP/NMP referral.
2. Where patient are assessed for ADHD by the specialist team. The team is to provide confirmation of the diagnosis of ADHD in written correspondence to the GP.
3. Initiate treatment, prescribe ADHD medication for new initiations, until young person is stable and/ or for the first three months, whichever is sooner. The specialist will also provide, where appropriate, a 28 day prescription following a dose/ medication change.
4. Ensure that patient/carers understand their treatment regimen and any monitoring or follow up that is required (using advocacy if appropriate).
5. Provide the parent/carer/ young person, where appropriate, with verbal and written medication information, as well as a web link to the shared care guidance.
6. Specialist to request shared care when patient is stable or within a three month period, whichever is sooner. However, shared care CANNOT be requested earlier than one month after treatment initiation. During this transition period paediatrician, NMP and/ or CAMHS to continue to supply monthly prescriptions.
7. Specialist to provide GP with written correspondence providing details of the medication and requesting on-going monthly supply of the medication, as part of the shared care agreement.

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

8. All physical health monitoring to be completed by paediatrician, CAMHS team and/ or NMP during initiation and stabilisation of ADHD medication.
9. Following stabilisation, at a minimum the child/ young person should be reviewed/ physical health monitoring completed every six months, for the first year and thereafter annually.
10. Clinical supervision of the patient by routine clinic follow-up on a regular basis.
11. Send a letter to the GP after each clinic attendance ensuring medication prescribed and current dose is stated.
12. Inform GP of any changes to the prescription in writing and inform GP of the young person's progress following reviews.
13. Inform the GP in writing, following supply of 28 day prescription for a dose and/ or medication change.
14. Where the patient is stable the patient should be reviewed minimum annually and the GP informed of the young person's progress and changes in treatment in writing.
15. Evaluate any reported adverse effects by GP, patient, parent/carer.
16. Inform GP of patients who do not attend clinic appointments, and advise the GP on course of action in regards to supplying further prescriptions.
17. Inform GP, by letter, of clinic visits and action taken for management of patient.
18. Ensure that backup advice is available for patient and GP at all times.
19. Where an adult ADHD service is available, the young person should be referred by the specialist service prior to their 18th birthday.
20. Advise the GP of which specialist will provide future monitoring of the patient, should they need to continue treatment once they reach adulthood.
21. If there is no adult service, refer the patient back to the GP and where appropriate provide advice and/ or appropriate course of action for individuals requiring on-going treatment.
22. Inform and decide with GP any action if patient has not been reviewed within 6 months of the last appointment. This may include the decision to continue treatment as before, or withdraw/ stop treatment.
23. Where a young person has been discharged from the CAMHS team, and then is re-referred back the GP, the consultant will assess suitability for accepting back into the CAMHS team. Where clinically appropriate the consultant will provide advice/ support to the GP and/ or accept YP back onto the CAMHS caseload.

General Practitioner

1. All young people who present with characteristic symptoms of ADHD should be referred for an assessment.
2. Treatment for ADHD would need to be initiated by the specialist *(Consultant Psychiatrist/ Consultant Paediatrician/ Specialist Non-Medical Prescriber/ CAMHS*

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

speciality doctor).

3. Young people diagnosed outside of the county/ borough and already taking medication should be referred for reassessment and ongoing monitoring. The GP should continue to prescribe in the intervening period unless this is contraindicated. If any adverse effects or contraindications are identified, this should be communicated to the specialist team.

4. Agreement to shared care is assumed. Where the GP decides that they do not wish to accept the shared-care request, they should notify the specialist team to opt out of the arrangement.

5. Upon acceptance of shared care request from the specialist, GP/ GP-NMP to continue to supply monthly repeat of ADHD medication after the initial the initial stabilisation period by the specialist team for new initiations and/ or where there has been a dose/ medication change, in line with the specialist's recommendation.

6. If the GP/GP-NMP has a specific concern about prescribing for a particular patient under this Shared Care Protocol, they should discuss this with the specialist team.

7. Check the patient is attending CAMHS/ paediatrician appointment before re-issuing further prescriptions.

8. Methylphenidate, dexamfetamine and lisdexamfetamine are Schedule 2 Controlled Drugs and prescriptions must be issued on a monthly basis. Medications requests for longer than a month (e.g. covering patients' holidays) should be discussed with the paediatrician, NMP and/ or the CAMHS team and can be issued at the prescriber's discretion.

9. Requests for an alteration in the regular dosage should be referred back to the specialist team.

10. Report and discuss with the specialists any adverse effects of medication, possible drug interactions, changes to the patient's medication regimen, deteriorating behaviour, suspected diversion/ misuse and/ or relevant medical information including any test results.

11. Physical health monitoring to be undertaken by CAMHS team and/ or paediatrician. However, GP to undertake physical health monitoring at other times as clinically required.

ICB

1. To provide feedback to trusts via Trust Medicines Committee.

2. To support GPs to make the decision whether or not to accept clinical responsibility for prescribing.

3. To support trusts in resolving issues that may arise as a result of shared care.

Patient/Carer

Ensure they have a clear understanding of their treatment

Report any adverse effects to their GP or specialist

Report any changes in symptoms to the GP or specialist

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

Inform the specialist and/ or GP of any other medication being taken, including over the counter Medication

Attend appointments and ensure child takes medication as prescribed as well as follow any monitoring requirements

To contact the specialist team as soon as possible if there are any changes which impact taking ADHD medication, including young person planning to become pregnant and/or becomes. pregnant (females only).

MEDICATION INFORMATION

Below are suggested resources where professionals can access information, both for themselves and either direct and/ or print off for parents/ carers

Professionals

BNF (hardcopy) and/ or online BNF which can be accessed at the following link if your organisation has a subscription:
https://www.medicinescomplete.com/mc/bnf/current/
Summary of Product Characteristics:
http://www.medicines.org.uk/emc/

Parent/carer and young person

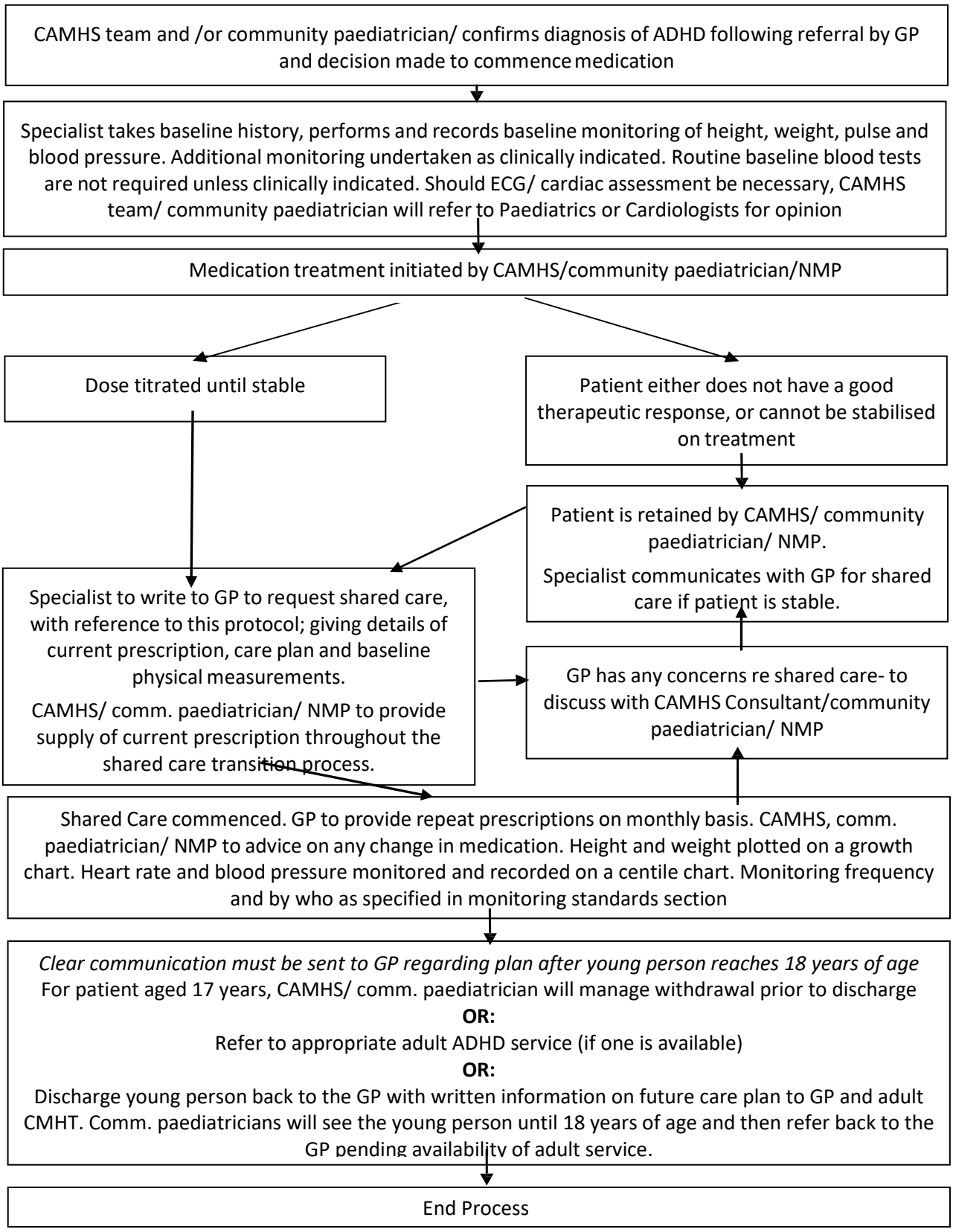
Summary of Product Characteristics (patient information leaflet)
http://www.medicines.org.uk/emc/
Medicines for Children
http://www.medicinesforchildren.org.uk/
NHS website
https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

CONTACT NUMBERS FOR ADVICE AND SUPPORT

East London Foundation Trust	
Iffah Salim CAMHS Pharmacist (London localities)	Email: elft.pharmacynewham@nhs.net
Luton and Bedfordshire pharmacy team	Email: elft.pharmacyluton@nhs.net
ICB	
Luton and Bedfordshire CHMTs	
Community paediatrician, Edwin Lobo Centre	01582 700300
Community paediatrician, Union St. clinic	01234 310071
Child Development Centre, Hill Rise	01234 310278
Hospital paediatrician, Bedford Hospital	01234 355122

This shared care **ONLY** applies to services which fall under ELFT- **Bedfordshire and Luton**

ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine



ADHD/Hyperkinetic Disorder for Children & Young People (6-17 years) SHARED CARE agreement: Methylphenidate, Atomoxetine, Dexamfetamine, Lisdexamfetamine and Guanfacine

REFERENCES:

NICE BNF *Atomoxetine.* Available at: https://bnf.nice.org.uk/drugs/atomoxetine/#indications-and-dose (accessed January 2023)

NICE BNF *Dexamfetamine sulfate*. Available at: https://bnf.nice.org.uk/drugs/dexamfetamine-sulfate/#indications-and-dose (accessed January 2023)

NICE BNF Guanfacine. Available at: https://bnf.nice.org.uk/drugs/guanfacine/#indications-and-dose (accessed January 2023)

NICE BNFC (2018c) *Lisdexamfetamine mesilate*. Available at: https://bnf.nice.org.uk/drugs/lisdexamfetamine-mesilate/#indications-and-dose (accessed January 2023)

NICE BNFC (2018d) *Methylphenidate hydrochloride*. Available at: https://bnf.nice.org.uk/drugs/methylphenidate-hydrochloride/#indications-and-dose (accessed January 2023)

European Clinical Guidelines for hyperkinetic disorder — first upgrade.Taylor E et al. Eur Child Adolesc Psychiatry 2004;13(Suppl 1):17-30.

MHRA Drug Safety Update: Atomoxetine (Strattera▼): increases in blood pressure and heart rate—new contraindications, warnings, and advice for monitoring – article date January 2012 http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON140666

NICE (updated Sept 2019), *Attention deficit hyperactivity disorder: diagnosis and management [NG87].*
Available at: https://www.nice.org.uk/guidance/ng87 (accessed January 2023)

Pharmacological treatments for ADHD. Parker C. Progress in Neurology and Psychiatry 2009;13: 17–26. doi: 10.1002/pnp.128. Available at: http://www.progressnp.com/view/Mjk3Mzc1L0pBLzExOTAxMS9udWxs/journalArticlePdf.html

Prescribing in ADHD; Bulletin 302 (April 2022); https://www.prescqipp.info/our-resources/bulletins/bulletin-302-prescribing-in-adhd/ (accessed January 2023)

SPC (2018a) *Concerta XL 18mg prolonged release tablets.* Available at: https://www.medicines.org.uk/emc/product/6872 (accessed January 2023)

SPC (2018b) *Medikinet 10mg modified-release capsules, hard.* Available at: https://www.medicines.org.uk/emc/product/313 (accessed January 2023)

SPC (2018c) *Equasym XL 10mg Capsules.* Available at: https://www.medicines.org.uk/emc/product/3887 (accessed January 2023)

SPC (2022) Intuniv tabs 1mg (Guanfacine). Available at: https://www.medicines.org.uk/emc/product/5099/smpc (accessed January 2023)

SPS (11.2020) *London Medicines Information Service – Extended-release methylphenidate – a review of the pharmacokinetic profiles available.* Available at: https://www.sps.nhs.uk/articles/extended-release-methylphenidate-a-review-of-the-pharmacokinetic-profiles-of-available-products/ (accessed January 2023)