Child and Adolescent Mental Health Services (CAMHS)

Effective shared care agreement (ESCA) for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) with METHYLPHENIDATE

This form must be completed by the hospital specialist/consultant (may include specialist nurse non-medical prescribers) and sent to the GP for approval. It must be signed by the GP and returned to the team before the patient is informed that the GP will prescribe the medication.

SECONDARY CARE SECTION TO BE COMPLETED BY INITIATING CONSULTANT/SPECIALIST

Patient's Name: _____ **NHS Number**: _____

Date of Birth: _____ **ESCA Date**: _____

One copy of information leaflet given to patient

One copy of agreement sent to GP

One copy filed in patients notes

Consultant/Specialist Name (please print):_____

Consultant/Specialist Signature:_____

Support contact number:_____

(if not listed overleaf)

Email address / Fax no:_____

PRIMARY CARE SECTION TO BE COMPLETED BY GENERAL PRACTITIONER

I agree*/don't agree* to enter into a shared care arrangement for the treatment of the above patient with this medicine (*delete as appropriate)

GP Name: _____

Signature: _____ **Date**: _____

Once signed please email or fax back to the team.

CONSENT SECTION TO BE COMPLETED BY PATIENT / REPRESENTATIVE

I agree*/don't agree* to enter into a shared care arrangement for the above treatment (*delete as appropriate)

Parent / Representative Name: _____**Signature**:_____

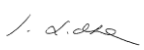
Date:_____

BACK UP ADVICE AND SUPPORT

Contact details	Telephone
Sandwell Base	**0121 612 6620**

Contact details	Telephone
Wolverhampton Base	**01902 444 021**

Version Control			
Version	**Date of Approval**	**Author/s**	**Brief Description of Changes**
1.0	2006	Dr Win	New ESCA
2.0	July 2013	Dr Win	Revised front page, new signatories
4.0	Nov 2018	Mr Narinder Sangha	Separated out individual drugs for treatment of ADHD into separate ESCA's. Now includes hospital specialists/ NMP' and section for parents/carers signature.

This shared care agreement has been approved for use by:		**Signature**	**Date**
BCPFT MMC Chair	Dr J Lidher		15/10/2018
Wolverhampton City CCG Prescribing Lead	Dr A Stone		18/12/2018
Sandwell & West Birmingham CCG Medicines Quality	Jonathan Boyd		20th Dec 2018

AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE

The aim of an Effective Shared Care Agreement (ESCA) is to provide information to general practitioners (GPs) and hospital staff about complex or high cost therapies that their patients may receive following specialist referral. An ESCA will be written only when it has been agreed that shared care is an appropriate option, and will include a statement of specialist and GP responsibilities.

ESCA's will ensure that all GPs have sufficient information to enable them to undertake prescribing responsibility for specialist therapies and other therapies that may affect or interact with specialist therapies.

It is not the intention to insist that GPs prescribe this therapy and any doctor who does not wish to undertake the clinical and legal responsibility for this drug is not so obliged.

The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

RESPONSIBILITIES AND ROLES

Specialist responsibilities
• Arrange comprehensive assessment of the child and be responsible for making the diagnosis and considering alternative diagnoses, co-morbid diagnoses and cautions/ contra-indications to treatment. • Initiate treatment with stimulants. Prescribe by brand for modified release preparations. Inform the GP promptly about changes in treatment or dosage, any important adverse events or if other interacting medicines are prescribed/recommended. • Monitor the patient's condition and response to treatment regularly and keep the GP informed. • Provide a comprehensive baseline physical assessment as recommended in the NICE guidelines, and ensure that height, weight, blood pressure, pulse and appetite are monitored at the recommended time intervals using the chart in the appendix. Communicate the results of tests to the GP as soon as possible. • Explain the possible side effects of the drug and interactions to parents. • Provide written guidance for parents (at specialist's discretion). • Be available for back-up advice on any of the above during working hours. • Report all suspected adverse drug reactions (in children under 18 years of age), to the Medicines and Healthcare Regulatory Agency (MHRA) via **www.mhra.gov.uk/yellowcard** • Send a letter and shared care agreement form to the GP to obtain consent to share prescribing and monitoring responsibilities. • Advise GP's of any dosage adjustments required, when to refer back, and when and how to stop treatment. • Ensure clear arrangements for back up, advice and support.

General Practitioner responsibilities
• Prescribe **Methylphenidate** once notified by the specialist. • Prescribe by brand for sustained release preparations. • Ensure that the treatment is not continued if the patient fails to attend the specialist clinic for over a year. • Check that patient is being monitored as specified in section on specialist responsibility. • Report to and seek advice from the specialist on any aspect of patient care that is of concern to the GP and may affect treatment. • Refer back to the specialist if the patient's condition deteriorates. • Monitor the patient for side effects and report all suspected adverse drug reactions (in children under 18 years of age), to the specialist and to the MHRA via **www.mhra.gov.uk/yellowcard** • Stop the treatment if advised by the specialist.

Parent/carers role
• Ask the specialist or GP anything he or she does not understand about the treatment. • Try to put into practice any behavioural or psychological programmes and report back to the specialist about their effectiveness. • Report any adverse effects to the specialist or GP. • Attend agreed review appointments.

SUPPORTING INFORMATION

Licensed indications

Attention Deficit Hyperactivity Disorder (ADHD) is a heterogeneous behavioural syndrome characterised by the core symptoms of inattention, hyperactivity and impulsivity. ADHD should only be diagnosed by a specialist psychiatrist, paediatrician, or other healthcare professional with training and expertise in the diagnosis of ADHD. Diagnosis of ADHD should be made according to DSM-IV criteria or the guidelines in ICD-10 and should also be based on a complete history and evaluation of the patient, including a full clinical and psychosocial assessment, full developmental and psychiatric history, and assessment of mental state. Diagnosis cannot be made solely on the presence of one or more symptom.

Methylphenidate is licensed for the treatment of ADHD in the UK. It should form part of a comprehensive treatment programme for ADHD that includes psychological, behavioural and educational advice and interventions. The indication for drug treatment is the presence of impairment resulting from ADHD.

Therapeutic Use

The aim of stimulant medication as part of a comprehensive treatment programme is to stabilise children with a behavioural syndrome characterised by symptoms which may include chronic history of short attention span, distractibility, emotional lability, impulsivity and moderate to severe hyperactivity.

METHYLPHENIDATE

Dosage and Administration

The basic principle is to start with a low dose consistent with starting doses in the British National Formulary (BNF) and/or Summary of Product Characteristics (SPC) and titrate the dose at weekly intervals until there is no further improvement in symptoms, behaviour, education and/or relationships and side effects are tolerable. Dose reductions should be considered if side effects become troublesome. The sustained release preparations prescribed are Concerta XL, Equasym XL and Medikinet XL. Different versions of modified-release preparations may not have the same clinical effect, due to differences in release profiles (see below for further details). The immediate release preparation may be prescribed generically.

Immediate release preparations

Child 6-17 years: Initially 5mg one to two times a day (e.g. breakfast and lunch), increasing the dose and frequency of administration if necessary by weekly increments of 5-10mg in the daily dose. Usual maximum up to 60mg daily (2.1mg/kg daily) in 2-3 divided doses, but can be increased to maximum 90mg daily (in 2-3 divided doses) under the direction of a specialist. Discontinue if no response after 1 month. If effect wears off in evening (with rebound hyperactivity) a dose at bedtime may be appropriate (establish need with trial bedtime dose). Treatment may be started using a modified-release preparation.

Modified release preparations

Medikinet XL
Child 6-17 years: Start with 10mg every morning with/after breakfast and titrate gradually at weekly intervals according to response. The licensed maximum dose is 60mg once daily but higher doses can be used if necessary under the direction of a specialist up to 2.1mg/kg daily (max. 90mg daily). Capsules are available in strengths of 5mg, 10mg, 20mg, 30mg, 40mg, 50mg and 60mg. Medikinet XL capsules may be swallowed whole, or the capsule may be opened and the capsule contents sprinkled onto a tablespoon of apple sauce or yoghurt, then swallowed immediately without chewing. Consists of an immediate-release component (50% of the dose) and a modified-release component (50% of the dose).

Equasym XL
Child 6-17 years: Start with 10mg every morning before breakfast and titrate gradually at weekly intervals according to response. The licensed maximum dose is 60mg once daily but higher doses can be used if necessary under the direction of a specialist up to 2.1mg/kg daily (max. 90mg daily). Capsules are available in strengths of 10mg, 20mg and 30mg. Equasym XL capsules may be swallowed whole, or the capsule may be opened and the capsule contents sprinkled onto a tablespoon of apple sauce. The capsules and capsule contents must not be crushed or chewed. Consists of an immediate-release component (30% of the dose) and a modified-release component (70% of the dose).

Concerta XL
Child 6-17 years: Start with 18mg every morning, with or without food. The dose should be increased if necessary in 18mg increments at approximately weekly intervals according to response. The licensed maximum dose is 54mg once daily (2.1mg kg daily) but higher doses can be used up to max.

108mg daily under the direction of a specialist. Consists of an immediate-release component (22% of the dose) and a modified-release component (78% of the dose).

Note: Concerta XL now has a number of bioequivalent formulations which are available as alternatives. These include **Delmosart MR, Xenidate XL and Xaggitin XL** and may be prescribed subject to local formulary approval.

Dose equivalence and conversion

For Concerta XL, total daily dose of 15mg of standard release formulation is considered equivalent to 18mg of sustained release preparation.

Contraindications

Uncontrolled bipolar disorder, glaucoma, hyperthyroidism or thyrotoxicosis, cardiovascular disease (including heart failure, cardiomyopathy, severe hypertension, arrhythmias), structural cardiac abnormalities, phaeochromocytoma, vasculitis, cerebrovascular disorders, anorexia nervosa, psychosis, severe depression, suicidal ideation.

Cautions

Drug or alcohol dependence, epilepsy, anxiety or agitation, tics or a family history of Tourette syndrome. Also monitor for psychiatric disorders.

Side-effects

Common or very common side effects: Abdominal pain; aggression; alopecia; anorexia; arrhythmias; arthralgia; asthenia; changes in blood pressure; cough; depression; diarrhoea; dizziness; drowsiness; dry mouth; dyspepsia; fever; growth restriction; headache; insomnia; irritability; movement disorders; nasopharyngitis; nausea; nervousness; palpitation; pruritus; rash; reduced weight gain; tachycardia; tics; vomiting

Drug Interactions

Methylphenidate may inhibit the metabolism of coumarin anti-coagulants, anticonvulsants (e.g. Phenobarbital, phenytoin, primidone) and some antidepressants (tricyclic and selective serotonin reuptake inhibitors).

Methylphenidate may also interact with anti-hypertensive drugs, drugs that elevate blood pressure, alcohol, centrally acting alpha-2 agonists and dopaminergic drugs. Refer to the current edition of the BNF or SPC for a full list of interactions.

Monitoring

Prior to prescribing, a baseline evaluation of the patients' cardiovascular status including blood pressure and heart rate should be conducted. A comprehensive history of the patient should be taken, and pre-treatment height and weight should be recorded on a monitoring chart (see appendix).

For patients requiring long-term **Methylphenidate** therapy, weight, height and appetite should be recorded at least every 6 months with maintenance of a chart. Blood pressure and pulse should be recorded on a chart at each adjustment of dose and then at least every 6 months. Development of new or worsening of pre-existing psychiatric disorders should be monitored at every adjustment of dose and then at least every 6 months and at every visit. The patient's response to medication should be assessed by the specialist at each review; and the question of whether to continue or stop medication should be addressed.

NICE CG72: Drug holidays are not routinely recommended; however, consideration should be given to the parent or carer and child or young person with ADHD working with their healthcare professional to find the best pattern of use, which may include periods without drug treatment. If growth is significantly affected by drug treatment, the option of a planned break in treatment over school holidays should be considered to allow 'catch-up' growth to occur.

For full details of the licensed indications, dosage and administration, cautions, contraindications, side effects, drug interactions and monitoring, refer to the current edition of the BNF, BNFc and SPC.

Methylphenidate is a **schedule 2 controlled drug**. Legislation for controlled drug prescription writing is set out in the BNF in the section on 'Controlled Drugs and Drug dependence'.

References

- BNF/BNFc. BMJ Group/Royal Pharmaceutical Society of Great Britain. BNF App Accessed October 2017.
- Summary of Product Characteristics (SPC). Accessed October 2017 via www.medicines.org.uk/emc
- National Institute for Health and Clinical Excellence. Clinical Guideline 72. *Attention deficit hyperactivity disorder: Diagnosis and management*. September 2008. Last updated February 2016.
- Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines in Psychiatry. Twelfth edition. The South London and Maudsley NHS Foundation Trust, Oxleas NHS Foundation Trust. 2015.

Appendix

Chart for ongoing monitoring during Methylphenidate treatment

For Specialist to complete

As outlined in the prescribing information in more detail, growth, psychiatric and cardiovascular status should be regularly monitored:

- Blood pressure and pulse should be recorded at each adjustment of dose and then at least every 6 months
- Height, weight and appetite should be recorded at least 6-monthly with maintenance of a growth chart
- Development of *de novo* or worsening of pre-existing psychiatric disorders should be monitored at every adjustment of dose and then at least every 6 months and at every visit

Date of initial assessment:_____ Patient name:_____
Date of birth: _____NHS No:_____

	Baseline	Subsequent appointments					
Date of assessment							
Reason for assessment							
Blood pressure*							
Heart rate*							
Body weight (kg)**							
Height (cm)**							
Appetite							

*Blood pressure and heart rate should be recorded at each adjustment of dose and then at least every 6 months
**Height, weight and appetite should be recorded at least 6-monthly with maintenance of a growth chart