Shropshire Community Health NHS
NHS Trust

NHS
Telford and Wrekin
Clinical Commissioning Group

Methylphenidate Shared Care Agreement

(Immediate-release methylphenidate, Equasym®, Equasym XL®, Concerta XL®, Medikinet XL®, Xenidate XL®)

Effective Shared Care Agreement

Section 1: Shared Care arrangements and responsibilities

Section 1.1 Agreement to transfer of prescribing of Methylphenidate

Patient details

Name: _____

Address: _____

Date of Birth: _____

NHS number: _____

Contact details
Specialist:
Address:

Email:

Contact number:

GP

Address:

Email:

Contact number:

Patient

Name:

Contact number:

Agreement to shared care, to be signed by GP and Specialist before prescribing is transferred to GP

Specialist Signature: _____

Date: _____

GP Signature: _____

Date: _____

Patient Signature: _____

Date: _____

Section 1.2:

Areas of responsibility for shared care

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of methylphenidate for treatment of patients with attention deficit hyperactivity disorder (ADHD) can be shared between the specialist and General Practitioner (GP). GPs are invited to participate. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist.

Sharing of care assumes good communication between the specialist, GP and patient. The intention to share care should be explained to the patient by the doctor initiating treatment. It is important that patients are consulted about treatment and are in agreement with it. Patients with ADHD will be under regular specialist follow-up, which provides an opportunity to discuss drug therapy.

The prescriber of the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Roles & Responsibilities

Specialist's responsibilities
1 Confirm diagnosis of ADHD following full assessment.
2 Carry out a pre-drug treatment assessment[1]. This must include • A full mental health history & social assessment • A full history & physical examination, including: ○ Assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms ○ Heart rate and blood pressure (plot on a centile chart) ○ Height and weight (plot on a growth chart) ○ Family history of cardiac disease and examination of the cardiovascular system • An electrocardiogram (ECG) if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination. • Risk assessment for substance misuse or drug diversion.
3 Initiate treatment and titrate dose over 4-6 week period[1].
4 After titration and dose stabilisation write to the patient's GP to request agreement to shared care.
5 Provide advice and support to parents/carers (including description of common drug side effects) and advice to teachers (where appropriate). Parents, teachers and children/young people should be asked to record symptoms and side effects particularly at dose changes.
6 Review patient every 3 months or sooner if indicated.
7 Monitor height – measure every 6 months (plot on a growth chart)[1]
8 Monitor weight – measure 3 and 6 months after the start of treatment, and every 6 months thereafter[1]
9 Monitor onset or worsening of psychiatric symptoms (such as depression, suicidal thoughts, hostility, anxiety, agitation, psychosis, or mania) and symptoms suggestive of heart disease[2].

10	Monitor heart rate and blood pressure before and after each dose change, and every 3 months[1].
11	Provide GP with regular (every 3-6 months) reports on heart rate, blood pressure, weight and height.
12	Ensure that treatment is interrupted at least yearly to determine whether continuation is needed[2]
13	Stop treatment at any appropriate time, communicate change or cessation of treatment to GP.

General Practitioner's responsibilities	
1	Respond to specialists request regarding shared care as soon as possible – ensure that treatment has been initiated, titrated and stabilised before agreeing to shared care[3]. NB Do not diagnose or start drug treatment for ADHD in children and young people in primary care[1].
2	Issue monthly prescriptions as advised by specialist – maximum of 30 days recommended[4] (NB. CD requirements)
3	Monitoring the patient's overall health and well-being (as well as parents/carers) annually.
4	Report adverse drug reactions to specialist.
5	Act upon results communicated by specialist.
6	Referral back to specialist for early appointment if patient or parents raise concerns.

Patient/parent's responsibilities	
1	To attend appointments
2	To have the recommended tests.
3	To inform the GP if health problems arise.
4	To be aware of drug actions and side effects and report any relevant symptoms (parents will be provided with written and verbal advice on side effects).

BACK-UP ADVICE AND SUPPORT

Contact details	Telephone No.	Bleep:	Fax:	Email address:
Specialist:				
Other:				

Section 2:

Supporting information

See Summary of Product Characteristics (SPC) Methylphenidate (immediate-release methylphenidate, Equasym®, Equasym XL®, Concerta XL®, Medikinet XL®, Xenidate XL®) for full prescribing information **www.emc.medicines.org.uk**

ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of inattention, hyperactivity and impulsivity. Not every person with ADHD has all of these symptoms – some people are predominantly hyperactive and impulsive; others are mainly inattentive. Symptoms of ADHD are distributed throughout the population and vary in severity; only those people with at least a moderate degree of psychological, social and/or educational or occupational impairment in multiple settings should be diagnosed with ADHD. Determining the severity of ADHD is a matter for clinical judgment, taking into account severity of impairment, pervasiveness, individual factors and familial and social context.

Symptoms of ADHD can overlap with those of other disorders, and ADHD cannot be considered a categorical diagnosis. Therefore care in differential diagnosis is needed. ADHD is also persistent and many young people with ADHD will go on to have significant difficulties in adult life.

Diagnosis

Diagnosis should only be made by a specialist psychiatrist, paediatrician or other healthcare professional with training and expertise in the diagnosis of ADHD[1].

Do not diagnose or start drug treatment for ADHD in children and young people in primary care. If a child or young person is currently receiving drug treatment for ADHD and has not yet been assessed in secondary care, refer to a paediatrician, child psychiatrist or to a specialist ADHD CAMHS as a clinical priority[1].

Drug treatment

Drug treatment is not recommended for pre-school children and it should not be a first-line treatment for school-age children and young people with moderate ADHD and moderate impairment[1].

Drug treatment should:-

- only be started by a healthcare professional with expertise in ADHD
- be based on comprehensive assessment
- always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions[1].

Indication

Methylphenidate is indicated in children > 6 years of age & adolescents as part of a comprehensive treatment programme for ADHD when remedial measures alone prove insufficient.

Presentation and availability

Methylphenidate is available in immediate release (methylphenidate hydrochloride) and modified release formulations (Concerta XL®, Equasym XL®, Xenidate XL® and Medikinet XL®).

It is a controlled drug and prescriptions must comply with full legal requirements (see BNF)

Methylphenidate: immediate- and modified-release equivalents (mg)[1]

IR-MPH	Concerta XL®	Equasym XL®	Medikinet XL®	Xenidate XL®
10	-	10	10	-
15	18	-	-	18
20	-	20	20	-
30	36	30	30	36
-	-	-	40	-
45	54	-	-	54
60	72*	60	-	
IR-MPH: immediate-release methylphenidate; Concerta XL, Equasym XL, Xenidate XL and Medikinet XL: brands of modified-release methylphenidate. * licensed up to 54mg				

Monitoring[1]

- Consider using standard symptoms and side effect rating scales during treatment as an adjunct to clinical assessment.
- Routine blood tests and ECGs are not recommended unless there is a clinical indication.
- Measure height every 6 months (plot on growth chart). If growth is affected significantly consider a break in drug treatment over school holidays to allow 'catch-up' growth.
- Measure weight 3 and 6 months after the start of treatment, and every 6 months thereafter (plot on growth chart).
- Monitor heart rate and blood pressure and record on a centile chart before and after each dose change, and every 3 months. Sustained resting tachycardia, arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measure on two occasions should prompt dose reduction and referral.

Safety

The most common adverse events reported with treatment are decreased appetite, insomnia, headache and stomach ache.

[1] Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults. NICE clinical guideline 72. September 2008
[2] MHRA. Drug Safety Update. January 2010 pages 5-6
[3] MTRAC Guidelines Methylphenidate for the treatment of attention deficit hyperactivity disorder. VS 02/18
[4] A guide to good practice in the management of controlled drugs in primary care (England). National Prescribing Centre (Second Edition). February 2007