National shared care protocol:

Lisdexamfetamine for patients within adult services

1 January 2025, Version 1

TLS Amber – 3 Months

Review date – January 2028

The content of this shared care protocol was correct as of January 2022. As well as these protocols, please ensure that summaries of product characteristics (SPCs), British national formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

Specialist responsibilities

- Assess the patient and provide diagnosis. Ensure the diagnosis is within scope of this shared care protocol (section 2) and communicated to primary care.
- Use a shared decision making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling (see section 11), to enable them to reach an informed decision. Obtain and document consent. Provide an appropriate patient information leaflet.
- Ensure the patient and/or their carer understands that treatment may be stopped if they do not attend for monitoring and treatment review
- Assess for contraindications and cautions (see section 4) and interactions (see section 7).
- Conduct required baseline investigations and initial monitoring (see section 8).
- Initiate and optimise treatment as outlined in section 5. Prescribe is normally for at least 12 weeks until the patient is stable and dose optimised.
- Prescribe in line with controlled drug prescription requirements (section 6).

- Once treatment is optimised, complete the shared care documentation and send to patient's GP practice detailing the diagnosis, current and ongoing dose, any relevant test results and when the next monitoring is required. Include contact information (section 13).
- Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Conduct the required monitoring in section 8 and communicate the results to primary care. This monitoring, and other responsibilities below, may be carried out by a healthcare professional in primary or secondary care with expertise and training in ADHD, depending on local arrangements.
- Determine the duration of treatment and frequency of review. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate. Trial discontinuations can be managed in primary care within the competence of the prescriber (section 8) with advice/input from the specialist.
- Prescribing when a woman becomes or wishes to become pregnant can be managed in primary care with advice/input from the specialist.
- Provide advice to primary care on the management of adverse effects if required.

Primary care responsibilities

- Respond to the request from the specialist as soon as practicable if they are **unable** to support shared care (in writing or via secure email). It is asked that this be undertaken within 14 days of the request being made, where possible.
- If shared care is accepted, prescribe ongoing treatment as detailed in the specialists request and as per section 5 taking into account any potential drug interactions in section 7.
- Prescribe in line with controlled drug prescription requirements (section 6).
- Adjust the dose of lisdexamfetamine prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 9. Communicate any abnormal results to the specialist.
- Assess for possible interactions with lisdexamfetamine when starting new medicines (see section 7)
- Manage any adverse effects as detailed in section 10 and discuss with specialist team when required.
- Stop lisdexamfetamine and make an urgent referral for appropriate care when contra-indications are suspected.
- Seek advice/input from the specialist if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist. Trial discontinuations can be managed in primary care within the competence of the prescriber with advice/input from the specialist.

Patient and/or carer responsibilities

- Take lisdexamfetamine as prescribed and avoid abrupt withdrawal unless advised by their prescriber.
- Attend regularly for monitoring and review appointments with primary care and specialist, and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend.
- Report adverse effects to their GP. Seek immediate medical attention if they develop any symptoms as detailed in section 11.
- Report the use of any over the counter (OTC) medications to their prescriber and be aware they should discuss the use of lisdexamfetamine with their pharmacist before purchasing any OTC medicines.
- Be aware that lisdexamfetamine can affect cognitive function and is subject to drug driving laws, therefore patients must ensure their ability to drive is not impaired before driving (see section 11).
- Avoid alcohol during treatment, as it may make some side effects worse. Avoid recreational drugs.
- Lisdexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store lisdexamfetamine safely and securely. It must not be shared with anyone else.
- Patients of childbearing potential should take a pregnancy test if they think they could be pregnant, and inform the specialist or GP immediately if they become pregnant or wish to become pregnant.

1. Background

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Lisdexamfetamine dimesylate is metabolised following administration to dexamfetamine and therefore has the same sympathomimetic mechanism of action with central stimulant and anorectic activity. It is indicated as part of a comprehensive treatment programme for the treatment of attention deficit hyperactivity disorder (ADHD) when the response to a 6-week trial of methylphenidate treatment is considered clinically inadequate. It may be offered as a first line pharmacological treatment option for adults with ADHD who have been appropriately diagnosed (see NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management). NICE recommends that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs.

Lisdexamfetamine is a schedule 2 controlled substance; all legal requirements for prescribing controlled drugs should be followed. See NICE Guidance NG46 Controlled drugs: safe use and management.

Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) but is approaching their 18th birthday, it is expected that CAMHS will refer to the appropriate adult service if need for ongoing treatment is anticipated.

Pharmacological treatment of ADHD may be needed for extended periods. When lisdexamfetamine is used for extended periods (over 12 months) its usefulness should be re-evaluated at least yearly by a healthcare professional with expertise in ADHD, and consideration given to trial periods off medication to assess the patient's functioning without pharmacotherapy.

2. Indications

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Licensed indication: attention deficit hyperactivity disorder (ADHD) in adults

See SPC for full details of licensed indication.

3. Locally agreed off-label use

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To be agreed and completed locally (include supporting information)

N/A

4. Contraindications and cautions

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This information does not replace the Summary of Product Characteristics (SPC), and should be read in conjunction with it. Please see BNF & SPC for comprehensive information.

Contraindications:

- Known hypersensitivity to the active substance, any of the excipients, or sympathomimetic amines.
- Glaucoma.
- Concomitant use of monoamine oxidase inhibitors (MAOI) or within 14 days of MAOI treatment.
- Hyperthyroidism or thyrotoxicosis.

For patients with the following contraindications, lisdexamfetamine can be prescribed under certain circumstances after a risk benefit consideration by the specialist has been taken into account:

- Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder.
- Diagnosis or history of severe and episodic (Type I) bipolar (affective) disorder (that is not well-controlled).
- Certain pre-existing cardiovascular disorders constitute contraindications unless specialist cardiac advice is obtained and documented. These include moderate hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias, disorders caused by the dysfunction of ion channels, and structural cardiac abnormalities.
- Pre-existing cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke.

Cautions:

- History of substance or alcohol abuse.
- Phaeochromocytoma.
- Family history of sudden cardiac or unexplained death, ventricular arrhythmia, tics or Tourette's syndrome.
- Underlying medical conditions or concomitant drugs which can increase the QT-interval or heart rate, or elevate blood pressure (e.g. cardiac disease, electrolyte disturbance).
- History of seizure disorders (discontinue if seizures occur).
- Susceptibility to angle-closure glaucoma.
- Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour), tics, Tourette's syndrome, anxiety, or bipolar disorder.
- Depressive symptoms; patients should be screened for risk of bipolar disorder, including psychiatric and family histories.
- Severe renal impairment; GFR 15-30mL/min/1.73m^2 or CrCl less than 30mL/min. Dose reduction is required, see section 5.
- Hepatic insufficiency (due to lack of data).
- Pregnancy or breast-feeding (see section 12).
- Potential for abuse, misuse, or diversion.

5. Initiation and ongoing dose regimen

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- Transfer of monitoring and prescribing to primary care is normally after the patient has been on treatment for at least 12 weeks, is stable and the dose optimised with satisfactory investigation results for at least 4 weeks.
- The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
- Dose or formulation adjustments can be managed in primary care with advice/input from the specialist.
- Termination of treatment can be managed in primary care within the competence of the prescriber (section 8) with advice/input from the specialist.

Initial stabilisation:

30 mg taken once daily in the morning, increased in increments of 20 mg at intervals no shorter than 1 week. Lower starting doses may be used if clinically appropriate (off-label use).

The loading period must be prescribed by the initiating specialist.

Maintenance dose (following initial stabilisation):

Maximum 70 mg per day.

Lisdexamfetamine must be prescribed by the initiating specialist during initiation and dose stabilisation.

Conditions requiring dose adjustment:

In severe renal impairment (GFR 15-30mL/min/1.73m^2 or CrCl less than 30mL/min), the recommended maximum dose is 50 mg per day.

Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. This should be undertaken and supervised by the specialist who will advise the patient and GP of the outcome. Alternatively, this can be managed in primary care within the competence of the prescriber (section 8).

6. Pharmaceutical aspects

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Route of administration:	Oral

Formulation:	Lisdexamfetamine dimesylate 30mg 50mg and 70mg hard capsules (Elvanse Adult®) Lisdexamfetamine dimesylate 20mg, 30mg, 40mg, 50mg, 60mg and 70mg hard capsules (Elvanse®) – use in adults may be considered off-label. See SPC for full details.
Administration details:	The dose may be taken with or without food Lisdexamfetamine capsules may be swallowed whole, or the capsule opened and the entire contents emptied and mixed with a soft food such as yogurt or in a glass of water or orange juice. See SPC for further information If a dose is missed then the next scheduled dose should be taken as usual; a double dose should not be taken to make up for a missed dose. Afternoon doses should be avoided because of the potential for insomnia
Other important information:	Lisdexamfetamine is a schedule 2 controlled drug and is subject to legal prescription requirements. It has the potential for misuse and diversion. Patients should be advised to avoid alcohol which may exacerbate the central nervous system (CNS) side-effects of lisdexamfetamine Amfetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amfetamines may interfere with urinary steroid determinations. **In times of medicine shortages, local guidance is available to support clinicians to manage supply disruptions. Management of Stock Shortages (Remedy BNSSG ICB)**

7. Significant medicine interactions

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The following list is not exhaustive. Please see BNF or SPC for comprehensive information and recommended management.

The following medicines must not be prescribed without consultation with the specialist:

- **Mono-amine oxidase inhibitors (MAOIs) and other sympathomimetics** (e.g. rasagiline, selegiline, safinamide) – additive hypertensive effect

Other clinically significant interactions

- **Selective serotonin reuptake inhibitors (SSRIs) (e.g. fluoxetine, paroxetine)**: may increase exposure to lisdexamfetamine, risk of serotonin syndrome
- **Serotonergic drugs, bupropion, tapentadol, tramadol:** Risk of serotonin syndrome
- **Tricyclic antidepressants (TCAs) and nabilone**: may increase risk of cardiovascular adverse events.
- **Ascorbic acid and other agents and conditions (thiazide diuretics, diets high in animal protein, diabetes, respiratory acidosis)** that acidify urine increase urinary excretion and decrease the half-life of amfetamine.
- **Sodium bicarbonate and other agents and conditions (diets high in fruits and vegetables, urinary tract infections and vomiting)** that alkalinise urine decrease urinary excretion and extend the half-life of lisdexamfetamine**.**
- **Antihypertensives, including guanethidine**: effects may be reduced by lisdexamfetamine
- **Lithium, phenothiazines, haloperidol**: may reduce the effects of lisdexamfetamine
- **Opioids** (including tapentadol and tramadol): analgesic effects may be increased by lisdexamfetamine
- **Alcohol:** Limited data is available, therefore caution is advised as alcohol may exacerbate the CNS side effects of lisdexamfetamine
- **Apraclonidine:** effects decreased by lisdexamfetamine.
- **Ritonavir, tipranavir:** may increase exposure to lisdexamfetamine
- **Safinamide:** predicted to increase the risk of severe hypertension when given with lisdexamfetamine
- **Atomoxetine**: increased risk of adverse effects

8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist

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Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.

Baseline investigations:

- A medical history and cardiovascular assessment, taking into account conditions that may be contraindications, risk of pregnancy (where applicable), and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required
- A risk assessment for substance misuse and drug diversion

- Blood pressure (BP) and heart rate
- Height, weight and body mass index (BMI)
- Appetite
- Arrange for electrocardiogram (ECG), only if the patient has any of the following:
    - History of congenital heart disease or previous cardiac surgery
    - Sudden death in a first-degree relative under 40 years suggesting a cardiac disease
    - Shortness of breath on exertion compared with peers
    - Fainting on exertion or in response to fright or noise
    - Palpitations
    - Chest pain suggestive of cardiac origin
    - Signs of heart failure, heart murmur or hypertension
    - Current treatment with a medicine that may increase cardiac risk

Initial monitoring:

- After every change of dose: assess heart rate and blood pressure, changes in weight, and any new or worsening psychiatric symptoms. The specialist should determine the appropriate timing for this monitoring.
- Monitor for aggressive behaviour or hostility
- Assessment of symptom improvement. Discontinue if no improvement is observed after reaching normal therapeutic doses.

Ongoing monitoring:

Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This may be in primary or secondary care, depending on local arrangements, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If continuing medication, document the reasons why.

Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone.

In BNSSG the annual review is done in primary care for patients registered at GP practices signed up to the ADHD locally enhanced service (LES) and by the specialist team where the GP practice is not signed up to the LES.

Patients should be encouraged to consider stopping the medication every 1 to 5 years, with the guidance of the specialist clinic if desired. If desired and clinically appropriate, lisdexamfetamine can be restarted by the GP, referral back into the ADHD service is not necessary.

9. Ongoing monitoring requirements to be undertaken by primary care

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See section 10 for further guidance on management of adverse effects/responding to monitoring results.

Monitoring and advice	Frequency
• Blood pressure and heart rate • Weight and appetite • Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g. tics, anxiety, symptoms of bipolar disorder). Ask patients “Do you believe your mental wellbeing has suffered due to your ADHD medications?” • Explore whether patient is experiencing any difficulties with sleep	Every 6 months, and after any change of dose recommended by specialist team.
• Assessment of adherence, and for any indication of lisdexamfetamine abuse, misuse, or diversion	As required, based on the patient’s needs and individual circumstances
• Review to ensure patient has been offered and attended an annual review with a healthcare professional with expertise in ADHD	Annually

(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.

10. Adverse effects and other management

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Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit www.mhra.gov.uk/yellowcard

For information on incidence of ADRs see relevant summaries of product characteristics

Result	Action for primary care
As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance.	
Resting HR greater than 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP	• In context of recent dose increase, revert to previous dose and discuss with specialist for ongoing management • In absence of recent dose changes, reduce dose by half and discuss with specialist or cardiology for further advice.
New or worsening seizures	Stop treatment and discuss with specialist. Discontinuation may be indicated.
Anorexia or weight loss, weight or BMI outside healthy range	Exclude other reasons for weight loss. Give advice as per NICE NG87: • take medication with or after food, not before • 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 Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medication may be required.

Insomnia, sleep disturbance/nightmares, sedation, sexual dysfunction	Review timing of doses and continue treatment unless severe, Give advice on sleep hygiene. Discuss with specialist if required
Nausea, diarrhoea, abdominal cramps, constipation, dry mouth, headache, dizziness, enuresis, increased daytime urination, tics	Continue treatment unless severe. Some symptoms may be alleviated by concomitant food intake. Discuss with specialist if required
New or worsening psychiatric or neuropsychiatric symptoms, e.g. mania, depression, paranoia, anxiety and agitation	Discuss with specialist. Stop treatment and consider referral to acute mental health team if suicidal thoughts, mania, or psychosis are present
Symptoms of serotonin syndrome, e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea	Discontinue lisdexamfetamine as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary. Discuss with specialist team to determine whether lisdexamfetamine can be re-started.
Suspicion of abuse, misuse, or diversion	Discuss with specialist team

11. Advice to patients and carers

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The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

The patient/carer should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:

- Any mood changes, such as depression, paranoia, anxiety or agitation, psychosis, mania and suicidal ideation
- Palpitations, chest pain or syncope
- Cerebrovascular symptoms, such as severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language, or memory
- Abdominal pain, malaise, jaundice or darkening of urine

- Skin rashes, or bruising easily
- Any visual changes such as difficulty with accommodation or blurring of vision
- If they suspect they may be pregnant, or are planning a pregnancy. Patients of childbearing potential should use appropriate contraception, and take a pregnancy test if they think there is a possibility they could be pregnant.

The patient/carer should be advised:

- Attend regularly for monitoring and review appointments with primary care and specialist, and keep contact details up to date with both prescribers. It may not be safe to continue prescribing without regular review, and patients should be aware that their medicines could be stopped if they do not attend appointments.
- Lisdexamfetamine can affect impair cognitive function and is subject to drug driving laws, therefore patients must ensure their ability to drive is not impaired before driving. For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including amfetamines, see drugs and driving: the law. People who drive must inform the DVLA if their ADHD, or medicines affect their ability to drive safely. See https://www.gov.uk/adhd-and-driving
- Avoid alcohol while taking lisdexamfetamine, as it may make some side effects worse. Avoid recreational drugs. Due to the risks of severe depression, and fatigue, abrupt withdrawal after a prolonged period of intake of high doses of lisdexamfetamine should be avoided. Patients wishing to reduce their dose or stop lisdexamfetamine treatment should discuss with their specialist before doing so.
- Lisdexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store lisdexamfetamine safely and securely. It must not be shared with anyone else. There are restrictions on travelling with controlled drugs: see https://www.gov.uk/guidance/controlled-drugs-personal-licences.

Patient information:

- Royal College of Psychiatrists – ADHD in adults. https://www.rcpsych.ac.uk/mental-health/problems-disorders/adhd-in-adults
- NHS – Attention deficit hyperactivity disorder. https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

12. Pregnancy, paternal exposure and breast feeding

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It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.

Pregnancy:

The active metabolite of lisdexamfetamine, dexamfetamine, is thought to cross the placenta. The limited data available shows an increased risk of premature birth and preeclampsia. Infants may also develop withdrawal symptoms such as dysphoria, hyperexcitability and pronounced exhaustion.

If a patient becomes pregnant or is planning a pregnancy during treatment they should discuss treatment options with their specialist. Ongoing prescribing in pregnancy may be managed in primary care within the competence of the prescriber with advice/input from the specialist. Lisdexamfetamine should only be used during pregnancy if the potential benefit outweighs the risks.

Healthcare professional information available from: https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-AMFETAMINES-IN-PREGNANCY/

Breastfeeding:

There is no published evidence for safety of lisdexamfetamine in breastfeeding. The manufacturers recommend against use, and the UK Drugs in Lactation Service recommend caution (see link below). Lisdexamfetamine metabolites, including dexamfetamine, are excreted in human milk, therefore a risk to infants cannot be excluded. An individual risk assessment must be made, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman.

Healthcare professional information available from: Breastfeeding Medicines Advice service – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Paternal exposure:

No evidence regarding adverse outcomes following paternal exposure was identified. Further information for patients: https://www.medicinesinpregnancy.org/leaflets-a-z/lisdexamfetamine/

13. Specialist contact information

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Name: *Dr Dietmar Hank*

Role and specialty: Consultant Psychiatrist and Clinical Lead Adult ADHD service, AWP

Daytime telephone number: 01275 796262 M-F 9-5

Email address: *Awp.specialisedadhdservices@nhs.net*

Alternative contact: *[insert contact information, e.g. for clinic or specialist nurse]*

Out of hours contact details: *[insert contact information, e.g. for duty doctor]*

14. Additional information

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Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed of any changes to the patient's GP or their contact details.

15. References

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- NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via https://www.nice.org.uk/guidance/ng87/ on 15/01/2025
- eBNF. Lisdexamfetamine, Accessed via https://bnf.nice.org.uk/ on 15/01/2025
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- NICE. NG46: Controlled drugs: safe use and management. April 2016. Accessed via https://www.nice.org.uk/guidance/ng46/ on 15/01/2025
- Gov.uk: Drugs and driving: the lawGov.uk. Drugs and driving: the law. Accessed via https://www.gov.uk/drug-driving-law on 15/01/2025
- NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: last revised December 2024. Accessed via https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/amfetamines/ on 15/01/2025

16. Other relevant national guidance

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- NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/

- General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care
- NICE NG197: Shared decision making. Last updated June 2021. https://www.nice.org.uk/guidance/ng197/.

17. Local arrangements for referral

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Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.

Contact specialist for advice if:

- The patient finds the medication intolerable for any given reason
- If there is concern about observed mental or physical side effects (e.g. depression or hypertension)
- The side effects mentioned above, do not appear to be of a temporary and short lived nature.

Contact named responsible clinician in writing or via secure email detailed in clinic letter. See flow diagram below for referral pathways for GP practices signed up to the ADHD LES.

Approved by BNSSG JFG: January 2025
Review date: September 2027
Version 1

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

NHS England

KEY: Who does what?

Adult Clinic
GP
CAMHS/CP

Adult patient scores positively on screening questions by GP. Referral form completed.

Full assessment (no previous diagnosis)

New Patient Treatment and stabilisation package: up to **6 months. Check BP, pulse and weight at first appointment after initiation**

Enhanced support from ADHD clinic in the form of phone line and urgent review if required.

CAMHS have an ongoing patient approaching 18

Transition Assessment (from child to adult Service)

Medication is initiated and stabilised by ADHD clinic (initial prescribing at least 3 months) and then handed over to GP with SCP

GP provides ongoing repeat prescriptions as per SCP

Follow-up in GP surgery to include:
1. Six-monthly BP, pulse, weight (can be monitored by HCA)
2. Annual review of drug treatment as per review proforma (can be done by any competent clinician)

Community Paeds have an ongoing patient approaching 18 and **stable** on medication. BP, pulse and weight checked prior to discharge.

Adult patient with existing ADHD diagnosis from NHS service but is either from out of area or has lapsed treatment but wishes to continue/resume same treatment.

Patients under CAMHs will generally be more complex and may be more likely to require adult specialist input at transition. Patients under Community Paediatrics will generally be defined as more stable and able to be moved to care of the GP at transition.