STATES OF JERSEY

PRESCRIPTION OF MEDICATION FOR ADHD (S.R.9/2025): RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES AND THE MINISTER FOR SOCIAL SECURITY

Presented to the States on 29th January 2025
by the Minister for Health and Social Services

STATES GREFFE

PRESCRIPTION OF MEDICATION FOR ADHD (S.R.9/2024): JOINT RESPONSE MINISTER FOR HEALTH AND SOCIAL SERVICES AND THE MINISTER FOR SOCIAL SECURITY

Ministerial Response to:	S.R.9/2025
Ministerial Response required by:	28th January 2025
Review title:	Prescription of Medication for ADHD
Scrutiny Panel:	Health and Social Security Scrutiny Panel

INTRODUCTION

We welcome the publication of S.R.9/2024 - Prescription of Medication for ADHD and would wish to thank the Panel for carrying out this review of the current procedures in place for prescribing medication to adults with Attention Deficit Hyperactivity Disorder (ADHD).

FINDINGS

	Findings	Comments
1	Repeat prescriptions for ADHD medication provided under Health and Community Services can only be issued by a psychiatrist. The Panel learned that there is currently one on Island psychiatrist and was informed that the psychiatrist was spending the majority of their time issuing repeat prescriptions.	Prescriptions for ADHD medicines can be issued by other practitioners; Currently this prescribing is undertaken in secondary care by one (part-time) Consultant Psychiatrist, who is supported by a junior doctor. Between them, they currently have a prescribing caseload of 360 patients.
2	Health and Community Services have tried to recruit nurses who are specialised in ADHD and can provide a diagnosis, however, they are extremely rare. In addition, most nurses with this specialised skill may not feel fulfilled in writing 300+ prescriptions per month – the current caseload.	Noted
3	Health and Community Services have discussed the possibility of training an existing nurse to issue prescriptions, however, this has yet to be determined.	An update is now available in the response below.

	Findings	Comments
4	ADHD medication is not on the Prescribed List of Medications due to global shortages and is not currently eligible for subsidy from the Health Insurance Fund (HIF).	ADHD medication is not on the Prescribed List. An application for medicines for ADHD to be added to the Prescribed List is under review by PBAC but, to date, inclusion has not received endorsement from primary care providers who have raised concerns about issues including ongoing medicines shortages, the Share Care Agreement, and the role of community Pharmacy.
5	In addition to the one on Island consultant psychiatrist being authorised to issue repeat prescriptions for ADHD medication provided under Health and Community Services, they are also the only person who can provide an ADHD diagnosis.	This is not entirely correct. Other practitioners are able to provide a diagnosis, but only when they feel appropriately trained and experienced in this specific area to do so. In adult services, very few of the practitioners have the necessary training and experience currently.
6	A nurse from the Health and Community Services Department's education team has been seconded to assist with the ADHD waiting list who is also qualified to assess for ADHD diagnosis. The secondment of the nurse is due to be reviewed with a discussion as to how to use the services of the nurse going forward.	Noted
7	The current waiting list from referral to a diagnosis of ADHD is 3 and a half years. The number of adults on the waiting list is currently at 778, a reduction from 817 in June of this year. The Panel was informed that this was due to the work undertaken by a nurse who had been seconded to work on the waiting list.	The current waiting list has now reached 924 people (January 2025).
8	The lengthy waiting list was having a negative impact on the wellbeing of those waiting to be assessed/diagnosed.	Noted
9	Lack of communication from Health and Community Services whilst on the waiting list was having an impact on the wellbeing of those waiting for an assessment/diagnosis.	Noted
10	The hospital pharmacy opening hours are Monday to Friday, 9am to 5pm and	Noted

	Findings	Comments
	the Panel learned from members of the public that at times, these impact on the working day. The Panel also learned from members of the public that the waiting area for collection of ADHD medication within the hospital is inadequate for those with who are neurodiverse and/or with neurological illnesses, with reference to poor lighting, the lack of seating and loud Tannoy announcements.	
11	The waiting list for assessment and diagnosis of ADHD is arranged in chronological order and is not prioritised for those who may be in need of a diagnosis more than others. In addition, it is possible that some people on the waiting list could be suffering from a different neurological condition other than ADHD.	Noted
12	The Panel learned that there was a global shortage of medication, as a consequence prescriptions for ADHD medication were being issued for one month as opposed to 6 weeks/3 months.	Noted
13	The Panel learned that there was a danger that due to the global shortage of medication, patients may have to go without their standard medication and substitute it for another product with the same characteristics. Although this had not happened in Jersey, it had happened in other jurisdictions.	Noted
14	Should ADHD medication be included on the Prescribed List of Medications, the cost per annum would be an additional £800,000 which would need to be subsidised by the Health Insurance Fund.	Accurately estimating the cost impact to the HIF of including medicines for ADHD is problematic due to uncertainties around service model, capacity, the rate at which newly diagnosed patients are started on treatment and the transfer of patients currently accessing supplies of medicines through private prescription. Additional costs comprise · increased cost of the medicine · Dispensing fees · HIF subsidy (£55.28 adult) and four consultations per year

	Findings	Comments
		ADHD medicines procured via community pharmacy tend to be 40% more expensive that secured through General Hospital arrangements. A figure of £800,000 pa was estimated for drug costs alone based on likely total prevalence/uptake figures previously provided by the adult and CAMHS services. With current volumes, drug cost would be in the region of £450k pa.
15	The Minister for Social Security informed the Panel that she has reliance on the expert advice from the Pharmaceutical Benefit Advisory Committee (PBAC) and informed the Panel that any decisions could not be made without that expert advice.	Noted
16	The Pharmaceutical Benefits Advisory Committee (PBAC) meet quarterly and provide recommendations to the Minister for Social Security on medications which should be included/excluded on the Prescribed List of Medication. This list qualifies medicine to be subsidised under the Health Insurance Fund (HIF).	Noted
17	The Panel understands that a Shared Care Pathway is in discussion with both the Minister for Health and Social Services and the Minister for Social Security. The discussions involve the Shared Care Pathway allowing a referral to be made by a GP and moved onto secondary care to for diagnosis and treatment, following which it would be moved back to the GP for ongoing monitoring. Until the Shared Care Pathway protocols are agreed, it is difficult to see how primary care will form part of the overall management of patients with ADHD.	Noted
18	The Panel understands that some GPs from small practices are reluctant to sign up to the Shared Care Pathway due to the responsibility of prescribing ADHD medication on a day-today	Noted

	Findings	Comments
	basis and not having the flow of patients to gain the experience required.	
19	Following the written submissions from members of the public, the Panel learned that to have GPs prescribe repeat medication would be of benefit and may ease the existing pressure on the one psychiatrist	Noted
20	The Department of Health and Community Services is currently discussing with GPs the possibility of them undertaking special interest sessions in some services – one being ADHD. If a GP was particularly interested in an area and wanted to develop some expertise, the GP could work in that area and receive supervision from the specialist which would increase capacity and help with the service.	This is still in discussion.
21	Shared Care Pathways are used successfully in Jersey, however, do not cover mental health issues. In the UK, they successfully cover areas such as mental health, cancer and chronic conditions such as diabetes. The benefits of Shared Care Pathways include patient satisfaction, efficiency and cost savings and better health outcomes	Noted
22	The Minister for Health and Social Services and the Minister for Social Security hold different roles with regards to the health service. It is uncertain which Minister would have responsibility for the Shared Care Pathway, or if the role would be shared.	The Minister for Health and Social Services holds responsibility for Shared Care Pathways but recognises the role played by the minister for Social Security where HIF funding is required or impacted.
23	The Minister for Social Security informed the Panel that one Minister with sole responsibility for the Shared Care Pathway is not something that she would be opposed to.	Noted

	Findings	Comments
24	Awareness of ADHD is not as prominent as it should be. The Panel was informed that this was due to it being an evolving situation and areas needed to be resolved prior to undertaking raising awareness.	Noted

RECOMMENDATIONS

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
1	The Minister for Health and Social Services should implement a training programme for nurses to provide them authorisation to issue repeat prescriptions for ADHD medication to ultimately establish a clinic or hub for ADHD patients to pick up medication and receive advice. A costed update should be provided to the Panel within 3 months of publication of this report.	MH SS	Partially accept	The need to increase prescribing capacity within the service is accepted. Training is available for nurses to become prescribers (there are currently 2 nurses from within adult mental health services undertaking this course); this is a formal, approved training programme within the UK that is delivered by health faculties within universities. However, even if nurses are trained to be prescribers, they will need to want to work in this specialist area and will need significant supervision and support during the training. The 2 nurses that are undertaking the training currently do not work within the ADHD service, and to redeploy them into the service (should they wish to do so) will require an additional financial investment and the need to replace them within their current services. Further to the completion of the Scrutiny review, the service has successfully recruited a senior nurse who has speciality training and experience in this area, and is a prescriber. This will increase capacity when she takes up post. Discussions are	

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				also ongoing to potentially develop GP input into the service. The service will therefore review the capacity and delivery of the service when the new post holder is in place, and will also review the roles of the nurses that have been trained to prescribe once they are near to completion of their training.	
2	The Minister for Health and Social Services must consider the allocation of duties to the nurse to enable assessments and diagnosis to alleviate the pressure on the one on Island psychiatrist. This should be implemented following review of the secondment, due to take place imminently.	MH SS	Accept	The secondment arrangement has now been completed. As described above, the service has now recruited a full-time specialist nurse into the service (yet to take up post) and continues to review the capacity and operating arrangements of the service on a regular basis.	
3	The Minister for Health and Social Services should ensure there is clarity on the status of the waiting list for those currently waiting for an assessment/diagnosis. In addition, clear lines of communication must be available to those who have been referred. This should be implemented within 3 months of the presentation of this report.	MH SS	Accept	The service is currently in the process of reviewing the waiting list again, and developing a potential model for prioritisation. All people on the waiting list will be contacted again by the service by the end of March 2025 with an updated position. The service is also exploring how to publish current waiting times on a regular basis.	Mar 2025
4	The Minister for Health and Social Services should, in conjunction the Minister for Infrastructure, should ensure a modified waiting area be included	MH SS	Reject	All waiting areas within the Acute facility are designed to be inclusive for all users and are in line with recognised best practice. A number of key elements such as materials, colour, lighting, acoustics, furniture and textures have been considered during the design process to ensure	

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	as part of the new hospital. This should be in line with best practice for waiting areas for those with neurological conditions.			accommodation of all users. As part of the ongoing design development, consultation will take place with a range of stakeholders to confirm the interior design is suitable & accessible for all. In particular, the proposed NHF Jersey Waiting Areas are designed to accommodate users with a range of conditions. Detailed below are the considerations for the key elements that reflect the best practice in this area. By incorporating these elements, the proposed design provides a supportive and inclusive environment for individuals with a wide range of neurological and neurodiverse conditions: **Use of Natural Materials (i.e. Timber-Effect Laminate):** Natural materials promote a calming environment and reduce sensory overload, which is beneficial for people with conditions like autism spectrum disorder (ASD), anxiety disorders or ADHD. **Neutral Colour Palette:** Neutral tones help minimise visual stimulation and create a sense of tranquillity. This is particularly helpful for individuals with sensory sensitivities or neurological conditions. **Colour-Coded Wayfinding:** Muted, distinct colours aid in orientation and navigation, especially for people with cognitive impairments, dementia, or ADHD. Keeping the colours muted ensures they are not overstimulating. **Consistency Across Floors:** A consistent design theme and cohesive materials palette with varying accent	

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				colours maintains familiarity and reduces cognitive load for patients and visitors, which is crucial for those with memory or processing difficulties. **Lighting**: The lighting design ensures the use of LED lights and a backlit feature ceiling over the Waiting Area provides even illumination to prevent glare or flickering, as these can trigger migraines or sensory issues. Where possible Waiting Areas have been positioned adjacent to natural light as it helps regulate mood and supports circadian rhythms. **Acoustics**: For individuals with hyperacusis or sensory sensitivities ambient noise can be unpredictable and distressing in busy spaces, particularly open plan layouts containing mixed function zones. To mitigate the noise levels perforated acoustic panels finished in timber-effect laminate have been proposed above the larger Waiting Areas. In addition, all corridors incorporate perforated metal ceiling tiles with an acoustic backing. **Furniture Layout:** The layout ensures clear and uncluttered pathways to enhance accessibility and reduce confusion. Within the larger waiting zones a diverse range of seating is provided. **Texture and Pattern:** Simple textures have been incorporated to avoid overly busy patterns in flooring or upholstery, as these can be visually overstimulating.	
5	The Minister for Social Security should consult further with	MSS	Accept	PBAC will review the application for medicines for ADHD (adults and young people) to be added to the Prescribed List	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
	Pharmaceutical Benefits Advisory Committee (PBAC) regarding the inclusion of ADHD medication on the Prescribed List of Medications. Due to the rising number of adults requiring ADHD medication, costings should be provided for the next 5 years to ensure its affordability. Discussion on this should be without delay with possible inclusion on the prescribed list by the end of Q2 2025.			at its next meeting. This will include an update on potential numbers/costs with the MH/CAMHS teams invited to provide updates to the meeting. Including ADHD medicines on the prescribed list will require additional HIF funding in terms of drug costs, dispensing costs and GP costs	
6	The Minister for Health and Social Services, together with the Minister for Social Security must continue its discussions with the Primary Care Board to find a solution to additional medical professionals being authorised to prescribe medication. Should this not come to fruition, both Ministers should implement an alternative plan to offer training to existing medical professionals to qualify for prescribing.	MHSS/ MSS	Accept	Discussions with the Primary Care Board (and individual GP practices) are ongoing. MHSS continues to believe that an effective shared care model - whereby primary care clinicians can access specialist support if required and a regular specialist review is undertaken – remains the most appropriate method to implement this.	
7	The Minister for Health and Social Services should explore the option of funding GPs to undertake special interest sessions in ADHD, where they would receive training and	MHSS	Accept	Discussions continue with potentially interested GPs, as part of the ongoing work reviewing capacity and delivery models of the service. One GP practice has been identified as having a specific interest to date. This will require additional funding for the service.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
	supervision from the ADHD specialist, helping to increase capacity and alleviate pressure on the waiting list for assessment/diagnosis. This should be carried out by Q2 2025 with an update provided to the Panel of its progress within 3 months of the presentation of this report.				
8	The Minister for Health and Social Services, together with the Minister for Social Security, should discuss roles and responsibilities with a view to one Minister (or Assistant Minister) having sole responsibility for the Shared Care Pathway. These discussions should take place in line with the timeline for the implementation of the Shared Care Pathway with an update provided to the Panel within 3 months of presentation of this report.	MHSS/ MSS	Reject	The responsibility for developing a Care Pathway sits with MHSS. But in cases where this pathway is deployed across Secondary and Primary care, and seeks to use HIF funding, or increase costs to the HIF, (for example by increasing the volume of General Practice appointments which received HIF funding) there needs to be engagement and agreement from both Ministries. The Ministers work closely together and do not consider that it is necessary to provide for an Assistant Minister with responsibility for this specific area.	
9	The Minister for Health and Social Services, together with the Minister for Social Security, must consider a programme of activity to support ADHD Awareness Month 2025. This should be carried out within ample time for preparation for the next	MHSS/ MSS	Partially Accept	Before Attention-Deficit / Hyperactivity Disorder (ADHD) Awareness Month in October the publication of the Neuroinclusive Jersey strategy in 2025 will include a significant focus on ADHD awareness and education. The strategy will be implemented by a steering group – inclusive of a number of individuals with ADHD and representing the third sector – and the group will agree an approach to	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
	ADHD awareness month.			education and awareness raising, including any plans for ADHD awareness month.	
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CONCLUSION

We are grateful to the Scrutiny Panel for their review. Many of the recommendations reflect work that has already been very much underway in relation to developing capacity within the service to meet greatly increased demand. As recognised by the review, these are international problems faced in many jurisdictions. The Panel heard about the efforts that have already been made to develop a shared care pathway, increase clinical capacity within the service, and manage the specific challenges faced as a result of reduced availability of medicines for those people already receiving this. These recommendations build upon this work, and we will continue to seek solutions to address the assessment, diagnostic, treatment and waiting challenges faced by those within the service, and those waiting to be seen – including, for example, the recent introduction of psychological support sessions for people who are waiting an assessment.