Erratum: This article has been corrected to address an error relating to the requirements for prescribing Schedule 8 psychostimulants in Tasmania.

Balancing care with compliance: Medicolegal issues for general practitioners treating attention deficit hyperactivity disorder



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Background
As demand for attention deficit hyperactivity disorder (ADHD) treatments increases, Australian governments are relaxing the requirements for general practitioners (GPs) to prescribe Schedule 8 psychostimulants. Depending on state or territory legislation, GPs will likely increase their involvement in the assessment and management of children and adults with ADHD.

Objective
This article summarises the medicolegal issues that might affect GPs when initiating, continuing and monitoring ADHD medications in children and/or adults.

Discussion
Psychostimulants are restricted medications that carry risks of misuse and dependence. GPs must comply with state and territory prescribing laws and the requirements of the Pharmaceutical Benefits Scheme (PBS). Patients must be carefully assessed and warned of risks. Treatment via telehealth can raise medicolegal issues, given inherent limitations of the online environment, the requirement to verify patients' identity and to ensure that a genuine therapeutic need exists. Treatment in children can be especially complex when separated parents disagree. GPs need to understand how to manage these challenging and emotive situations.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) is a neurodevelopmental condition characterised by both strengths and challenges with attention, concentration, hyperactivity and/or impulsivity.[1] ADHD can negatively affect a person's learning, work and relationships. It often begins in childhood and might continue into adulthood.[2] It affects over 1 million Australians and is estimated to cost the Australian economy over $20 billion per annum.[3]

The past 20 years has seen a global increase in diagnosis and treatment rates for ADHD.[4] Data from the Australian Institute of Health and Welfare shows that the number of people treated climbed 11-fold from 2 patients per 1000 population in 2004–05, to 8 per 1000 population in 2018–19, to 22 per 1000 in 2024–25.[5] These increases might reflect an increase in the number of ADHD medications available on the Pharmaceutical Benefits Scheme (PBS),[6] expanded PBS listings for existing medications, and greater community awareness of the symptoms and impact of ADHD.[7]

Psychostimulants have high misuse and dependency potential and long-term health consequences, with some psychiatrists concerned they are being overprescribed.[8] However, delays in access to ADHD treatment can adversely impact academic and social progress in children and psychosocial functioning in adults.[9] In response to growing awareness of the symptoms and impact of ADHD and community demand for timely and affordable assessment and treatment, state and territory governments are relaxing psychostimulant prescribing requirements for general practitioners (GPs). This shift in the treatment of ADHD towards primary care will increasingly mean GPs are diagnosing ADHD and initiating and monitoring ADHD treatment. Therefore, they will need to understand and comply with a complex web of legal, regulatory and professional obligations.

Therapeutic Goods Administration licensing and scheduling of ADHD treatments in Australia

Three psychostimulants are currently approved by the Therapeutic Goods Administration (TGA) for use in Australia: dexamphetamine (International Nonproprietary Name [INN]: dexamfetamine), methylphenidate and lisdexamphetamine (INN: lisdexamfetamine). All are classified as Schedule 8 (S8) under the Standard for the Uniform Scheduling of Medicines and Poisons[10] and are strictly regulated because of their high risk of misuse and/or physical and psychological dependence. While other psychostimulants,

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such as amphetamine (INN: amfetamine) mixture and methamphetamine (INN: metamfetamine), are approved for use by the Food and Drug Administration (FDA) in the US,[11] they are not currently approved for use in Australia.

Non-psychostimulant medications commonly used to treat ADHD are classified as Schedule 4 (S4). They include atomoxetine, guanfacine and clonidine. Atomoxetine and guanfacine are approved for use in ADHD treatment. Clonidine is not. Table 1 summarises the classifications of medications used to treat ADHD in Australia.

State and territory prescribing laws and regulations

If an ADHD treatment is approved for use in Australia, GPs must then ensure that they are legally authorised to prescribe it in their state or territory. While there are no requirements for GPs to obtain a permit or approval before prescribing S4 medications used to treat ADHD, there are strict requirements in relation to the prescribing of the S8 psychostimulants (dexamphetamine, methylphenidate and lisdexamphetamine) that can differ substantially across Australian jurisdictions, making it confusing for GPs working across state or territory borders.

In Queensland, the requirements for GPs to prescribe S8 psychostimulants are least restrictive.[12] GPs may lawfully initiate and continue S8 psychostimulant treatment for children and adults with ADHD, provided that certain criteria are met (Table 2). GPs can prescribe without having to apply for an approval/permit/authorisation. In addition, they are not required to undertake further education or to be co-managing the patient with a relevant non-GP specialist (eg paediatrician or psychiatrist).

In Western Australia (WA), GPs may continue (but not initiate) prescribing an S8 psychostimulant under a shared care model without authorisation, provided certain criteria are met[13] (Table 2).

In New South Wales (NSW) and the Australian Capital Territory (ACT), GPs who have undertaken endorsed education may continue prescribing S8 psychostimulants that were commenced by a relevant non-GP specialist without applying for an approval/permit/authorisation for each individual patient and without ongoing non-GP specialist review, but must check the relevant real-time prescription monitoring database in that jurisdiction (Table 3).[14,15] GPs who have not undertaken endorsed training in those jurisdictions must apply for an approval/permit/authorisation for each individual patient before prescribing. In NSW (and planned for the ACT), GPs who undertake additional training will also be able to initiate S8 psychostimulant prescribing.

In South Australia (SA) and Tasmania, GPs who complete additional training may diagnose and make the initial application for an authority to prescribe S8 psychostimulants.[16,17] In SA and Tasmania, GPs who have not completed training must apply for an authority and comply with other requirements (Table 2).

In Victoria and the Northern Territory (NT), the requirements for S8 psychostimulant prescribing remain the most onerous.[18,19] GPs must obtain an approval/permit/authorisation prior to prescribing for each patient. An approval/permit/authorisation will generally only be issued where there is evidence of paediatrician or psychiatrist involvement. Victoria is rolling out education for GPs, allowing them to diagnose ADHD and initiate treatment without the need for non-GP specialist involvement.[20] NT has not proposed any changes to S8 psychostimulant prescribing rules for GPs. Table 2 summarises the salient features of S8 psychostimulant prescribing in each Australian jurisdiction. The Australasian ADHD Professionals Association (AADPA) also has a useful guide.[21] This is a rapidly changing area, and GPs would be advised to check current requirements in their state or territory.

If GPs are legally authorised to prescribe an S8 ADHD treatment in their jurisdiction, the details on the prescription must also comply with further legal requirements to be valid. These include the name and address of the patient and prescriber, the name, strength, quantity and number of repeats of the medication, directions for use, and the prescriber's signature. The Australian Digital Health Agency has produced a useful quick reference guide that sets out these requirements.[22]

Table 1. Licensing and scheduling of ADHD medications in Australia

Medication	Can be lawfully supplied in Australia	Approved by TGA for use in ADHD	Schedule 4	Schedule 8
Methylphenidate	✓	✓		✓
Dexamphetamine	✓	✓		✓
Lisdexamphetamine	✓	✓		✓
Guanfacine	✓	✓	✓	
Atomoxetine	✓	✓	✓	
Clonidine	✓	✗	✓	
Melatonin	✓	✗	✓	
Amphetamine mixture[A]	✗	✗		✓
Methamphetamine[A]	✗	✗		✓

The TGA licenses dexamphetamine for patients aged between 3 and 17 years, immediate release methylphenidate between 6 and 17 years, lisdexamphetamine between 6 and 55 years, long-acting methylphenidate (Ritalin LA) between 6 and 60 years, methylphenidate (Concerta) between 6 and 65 years, guanfacine between 6 and 17 years and atomoxetine between 6 and 65 years. Prescribing outside these age ranges is also considered 'off label'.

[A] Amphetamine and methamphetamine are not licensed for use in Australia.

ADHD, attention deficit hyperactivity disorder; TGA, Therapeutic Goods Administration.

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Table 2. Legal requirements for general practitioners prescribing Schedule 8 psychostimulants for ADHD in Australian states and territories as at June 2026

Jurisdiction	When can GPs lawfully prescribe Schedule 8 psychostimulants for ADHD?
Australian Capital Territory (ACT)[15]	GPs who complete specified training and who notify the ACT CHO can continue prescribing S8 psychostimulants that were commenced by a non-GP specialist, without requiring a CHO approval for each patient and without ongoing specialist review. This is limited to patients who are stable, aged 6 years and over, have an existing ADHD diagnosis from a specialist, and stimulant doses are within dosing limits specified below. GPs must register for and check Canberra Script to be eligible. Later in 2026, GPs who complete additional training can initiate medication in non-complex patients, over the age of 6 years, who are not drug dependent. They will be required to apply for a CHO approval for each individual patient. GPs who have not undertaken additional training must apply to the ACT CHO to continue an established treatment dose. This application must be accompanied by letter of support from the treating specialist (paediatrician, psychiatrist or neurologist). Patients must be over the age of 4 years. The approval lasts up to 2 years. Prescribing must not exceed the following maximum doses: • 40 mg daily of dexamphetamine • 70 mg daily of lisdexamphetamine • 72 mg daily of controlled release methylphenidate • 60 mg daily of conventional methylphenidate.
New South Wales (NSW)[14]	Since 1 September 2025, GPs may apply to the Ministry of Health for a 'continuation prescriber' authority number to prescribe for non-drug dependent patients aged 6 years and older who have already been diagnosed with ADHD and are stabilised on treatment commenced by a specialist, without the need for an individual patient approval. To be granted a continuation prescriber authority number, the GP must: • complete endorsed training (details available on the Ministry website and includes RACGP modules) • have an established ongoing therapeutic relationship with the patient for >12 months • prescribe no more than a maximum daily dose of dexamphetamine 50 mg (0.75 mg/kg/day in children), lisdexamphetamine 70 mg (1 mg/kg/day in children) or methylphenidate 108 mg (2 mg/kg/day in children) • check SafeScript NSW before prescribing. From March 2026, approximately 300 GPs were invited to complete additional training that would allow them to commence psychostimulant prescribing. This is still being rolled out at the time of writing. GPs who are not approved continuation prescribers or who wish to prescribe outside the above restrictions must apply to prescribe dexamphetamine, methylphenidate or lisdexamphetamine. There must be a co-management arrangement with a psychiatrist or paediatrician. Checking SafeScript is not mandatory in these circumstances.
Northern Territory (NT)[19]	• GPs must apply to the NT CHO once an S8 psychostimulant has been initiated by, or on the recommendation of, a specialist paediatrician neurologist/psychiatrist/physician or registrar-in-training in those specialties and is co-managing the patient with such a specialist or registrar-in-training who reviews the patient at least every 2 years. • A second specialist opinion is needed for patients aged under 4 years.
Queensland[12]	Since 1 December 2025, GPs do not need to apply for approval for the treatment of ADHD for anyone aged 4 years or older, provided that the maximum daily dose is no more than: • 40 mg of dexamphetamine • 70 mg of lisdexamphetamine • 80 mg of methylphenidate. In all other situations, GPs must obtain a prescribing approval from the CEO of Queensland Health before prescribing and must have support from a psychiatrist.
South Australia (SA)[16]	From 28 February 2026, GPs who have completed ADHD-specific training through the RACGP may diagnose and apply for an initial authority to prescribe without needing to refer to a paediatrician or psychiatrist. GPs who have not completed training must apply for an authority, which will usually only be granted where: • there is explicit written support from a relevant specialist medical practitioner, and • the diagnosis and treatment have been established, and/or • for individual patients with special needs (including those living in regional areas) where there is ongoing specialist oversight. A specialist must review the patient at least every 5 years.
Tasmania[17]	Tasmanian GPs are required to undertake additional clinical training to be considered appropriately trained to diagnose ADHD and initiate treatment with S8 psychostimulants. A GP who is trained in their practising jurisdiction to diagnose ADHD is also considered appropriately trained to diagnose ADHD and initiate treatment with S8 psychostimulants to Tasmanian patients. GPs who have not completed additional training must apply for an authority, which will usually only be granted where an application is accompanied by a clinical report from a specialist who has assessed and diagnosed the patient and recommended treatment with a psychostimulant. Authorities may be granted for up to 3 years.

Table continued on the next page

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Table 2. Legal requirements for general practitioners prescribing Schedule 8 psychostimulants for ADHD in Australian states and territories as at June 2026 (cont'd)

Jurisdiction	When can GPs lawfully prescribe Schedule 8 psychostimulants for ADHD?
Victoria[18]	GPs must apply for a permit, which will usually only be issued where there is evidence of a specialist diagnosis and that a specialist review has taken place within a specified period. GPs do not need to apply for a permit if treating patients in prisons, residential aged care facilities or hospital inpatients (including day procedure centres). The Victorian Government will commence training an initial 150 GPs in June 2026 to allow them to diagnose and treat ADHD.
Western Australia (WA)[13]	GPs do not need to apply for an authority to prescribe if: • prescribing was commenced by a paediatrician, neurologist or psychiatrist, and the GP is continuing treatment under a shared care model with that paediatrician, neurologist or psychiatrist; and • the patient is aged: – 6 years or older when prescribed lisdexamphetamine; or – 4 years or older when prescribed methylphenidate or dexamphetamine; and • the patient does not have a history of: – stimulant induced psychosis; or – psychosis or bipolar disorder; or – substance abuse, diversion, or misuse of drugs of addiction within the previous 5 years; or – does not have a record of drug dependence or oversupply; or – opioid substitution therapy; and • the daily dose does not exceed: – 1 mg/kg of dexamphetamine for patients aged under 18 years or 60 mg in patients aged 18 years and older; or – 2 mg/kg of methylphenidate for patients aged under 18 years or 120 mg in patients aged 18 years and older; or – 30 mg of lisdexamphetamine (commencing) for patients aged over 6 years up to a maximum of 70 mg; and • the patient has been reviewed: – annually by a psychiatrist or paediatrician if the patient is aged under 18 years; or – at least every 3 years by a psychiatrist if the patient is aged over 18 years. GPs are not permitted to: • initiate treatment; • alter a psychostimulant dose, type or formulation without written authority of the paediatrician or psychiatrist; • prescribe an S8 psychostimulant medicine for a patient that has an authority displayed on ScriptCheckWA. Where these criteria are not met (or cease to be met during treatment), then GPs must apply to the CEO of the WA Department of Health for authorisation to prescribe.

ADHD, attention deficit hyperactivity disorder; CEO, Chief Executive Officer; CHO, Chief Health Officer; GP, general practitioner; RACGP, The Royal Australian College of General Practitioners; S8, Schedule 8.

Table 3. Requirements to check real time prescription monitoring databases across Australian states and territories

Jurisdiction	Name of database	Mandatory to register	Mandatory to check
Australian Capital Territory (ACT)[A]	Canberra Script	✗	✗
New South Wales (NSW)[A]	SafeScript NSW	✗	✗
Northern Territory	NTScript	✓	✓
Queensland	QScript	✓	✓
South Australia	ScriptCheckSA	✓	✓
Tasmania	TasScript	✓	✓
Victoria	SafeScript	✓	✓
Western Australia	ScriptCheckWA	✓	✓

[A] Recent changes to prescribing requirements in NSW and proposed changes in the ACT mean that general practitioners who wish to initiate psychostimulants and prescribe for multiple patients without applying for an authority for individual patients must check SafeScript NSW or Canberra Script before prescribing a Schedule 8 psychostimulant. In other circumstances, there is no obligation in NSW or ACT to check SafeScript NSW or Canberra Script before prescribing a Schedule 8 medication. More information is provided in Table 2.

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Pharmaceutical Benefits Scheme requirements

Aside from the legal requirements for prescribing ADHD treatments, GPs must also comply with additional PBS requirements if they want the cost of the medication to be subsidised. GPs can prescribe dexamphetamine, methylphenidate and lisdexamphetamine as Authority Required medicines under the PBS and must meet and document specific criteria before supply can be subsidised. These criteria are available on the PBS website[23] and are summarised in Table 4. Essentially, prescribers must comply with restrictions based on dose, maximum amount, maximum repeat, dosage frequencies, and age of the patient at the time of diagnosis and treatment. Non-stimulants (guanfacine or atomoxetine) cannot be initiated by GPs under the PBS, but can be continued where a paediatrician or psychiatrist has commenced PBS-subsidised treatment: (1) as an adjunct to the maximum tolerable dose of a psychostimulant; or (2) where there is a contraindication to, or severe medical risk with, the use of a psychostimulant; or (3) where there has been a severe adverse reaction to, or worsening of a comorbid mood disorder from, the use of a psychostimulant.

Prescribing in accordance with appropriate standards

As ADHD prescribing might be new for many GPs, it is critical for GPs to be familiar with clinical guidelines and to refer to relevant non-GP specialists for review or second opinions when in doubt. Civil liability laws in Australia are clear that the standard of care expected of GPs will be that of a reasonable professional peer.[24] The Royal Australian College of General Practitioners (RACGP)[25] and AADPA[26] have recently released a position statement and clinical guideline. Some of the potential medicolegal risks for GPs might include: providing repeat prescriptions without adequate review; failing to adequately assess treatment response, adverse effects or functional outcomes; and failing to reassess the ongoing clinical need for psychostimulants.

In addition, clonidine is sometimes used 'off label' for ADHD treatment. Off label uses are not approved by the TGA. The Australian Health Practitioner Regulation Agency (Ahpra) recommends that prescribers only consider prescribing medicines for unregistered indications when an approved medicine is unavailable or inappropriate, and there is adequate information available to support use and the potential benefits and risks have been identified, evaluated and documented.[27] This includes obtaining and documenting informed consent and ensuring the patient understands that intended use is unapproved as well as the associated risks and benefits. The reason for the unapproved use should be documented in the patient's medical record. More broadly, GPs must ensure patients are properly informed about the intended benefits of treatment, any risks (cardiovascular, psychiatric or dependency) and any alternatives.

Dealing with fraudulent or stolen prescriptions

Another commonly encountered issue in general practice is dealing with suspected forged or stolen prescriptions for S8 medicines, including psychostimulants. It is an offence for an individual to make or use a false or stolen prescription to unlawfully obtain restricted medicines.[28] Examples of forged prescriptions might include computer-generated prescriptions with manual alterations, computer-generated prescriptions with fraudulent phone numbers, and prescriptions of obviously excessive quantities.[29] Suppliers (but not prescribers) of S8 medicines can face penalties for failing to take reasonable steps to verify the identity of a prescriber of a suspected false prescription or failing to report a suspected false prescription.[30] For GPs, Australian privacy laws could permit voluntary disclosure of limited information about a suspected fraudulent prescription to a law enforcement agency if they reasonably suspect that unlawful activity has occurred and that disclosure is necessary for law enforcement activities.[31] In addition, GPs might be contacted by pharmacists seeking

Table 4. Pharmaceutical Benefits Scheme criteria for psychostimulant prescribing

Medication	Strengths	Maximum daily dose	Duration of required coverage	Age of diagnosis
Dexamphetamine	5 mg	–	–	–
Methylphenidate tablet	10 mg		–	–
Methylphenidate modified release[A] tablet	18 mg, 27 mg, 36 mg or 54 mg	72 mg	12 hours	6–18 years
Methylphenidate modified release[A] capsule	10 mg, 20 mg, 30 mg, 40 mg or 60 mg	80 mg	8 hours	6–17 years or retrospective diagnosis[B]
Lisdexamphetamine capsule	20 mg, 30 mg, 40 mg, 50 mg, 60 mg or 70 mg	70 mg	12 hours	6–17 years or retrospective diagnosis[B]

[A] For all modified release forms, patients must have responded to immediate release forms without adverse reaction.

[B] If treatment is commencing after age 18 years, a retrospective diagnosis of attention deficit hyperactivity disorder for the purposes of administering this restriction means: (i) the presence of pre-existing childhood symptoms of attention deficit hyperactivity disorder (onset during the developmental period, typically early to mid-childhood); and (ii) documentation in the patient's medical records that an in-depth clinical interview with, or, obtainment of evidence from, either a: (a) parent; (b) teacher; (c) sibling; or (d) third party has occurred and which supports point (i) above.

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confirmation about the details of suspected fraudulent psychostimulant prescriptions. Australian privacy laws may also permit disclosure of information without patient consent if directly related to the primary purpose for which the information was collected (ie it is reasonably necessary for the ongoing treatment of a patient),[32] or to lessen or prevent a serious risk to public health or safety.[33]

Telehealth prescribing

The use of telehealth has been shown to improve the access, assessment, outcomes and experiences of some children with ADHD and their parents,[34] and for adults with ADHD.[35] However, prescribing via telehealth raises additional medicolegal considerations. First, the Medical Board of Australia's telehealth guidelines[36] recommend that practitioners carefully consider in each clinical situation whether the lack of in-person assessment and physical examination will allow the practitioner to meet the appropriate standard of care. The guidelines also discourage 'asynchronous requests for medication communicated by text, email, live-chat or online that do not take place in the context of a real-time continuous consultation and are based on the patient completing a health questionnaire, when the practitioner has never spoken with the patient'.

Second, GPs prescribing psychostimulants via telehealth need to be satisfied that this medium facilitates adequate verification of the patient's identity and assessment of the therapeutic need for and risks of psychostimulant prescribing. For example, in Victoria[37] and WA,[38] GPs must verify the identity of the patient before prescribing an S8 medication. This might be more difficult online, where there is no prior in-person therapeutic relationship. Moreover, because of the potential for misuse, dependence and diversion, most jurisdictions prevent S8 psychostimulant prescribing to patients who are drug-dependent (Table 2). Therefore, GPs need to consider whether a brief virtual assessment is sufficient to obtain any collateral history and understand a patient's mental and substance use history, and the concomitant risks of dependence, misuse or diversion. The Medical Board of Australia is currently focusing regulatory attention on emerging models of telehealth-based prescribing.[39]

Third, GPs physically located in one Australian jurisdiction but prescribing for patients located in another Australian jurisdiction may have to comply with the requirements for prescribing in their jurisdiction, the patient's jurisdiction, or both. For example, in Queensland, GPs outside Queensland who write prescriptions must be authorised to prescribe in their home jurisdictions and must comply with any legislative requirements of that jurisdiction. Additionally, for a prescription to be dispensed in Queensland, a prescriber (whether inside or outside Queensland) must ensure that the prescription meets the requirements of a lawful prescription under Queensland law.[40] The situation might be different for other combinations of jurisdictions and GPs are urged to contact their medical defence organisation for advice.

Fitness to drive

ADHD can be associated with higher rates of impaired driving, traffic violations, licence revocations[41] and collisions.[42] While some studies have found that prescribed psychostimulants have negative effects on driving, most studies show a reduction in driving risks.[43] Assessing fitness to drive in patients with ADHD who are taking psychostimulants is complex. However, ADHD and/or the use of psychostimulants only requires reporting to driver licensing authorities if they result in impairment of behaviour, cognitive ability or perception, or any impairment of insight into the above, which are required for safe driving. While GPs only have mandatory legal obligations to report impaired drivers in SA[44] and the NT[45] (or for heavy vehicle licence holders in the ACT),[46] they might have ethical and professional obligations elsewhere. As mentioned above, privacy laws across Australian jurisdictions permit this type of disclosure without consent if reasonably necessary to lessen or prevent a serious risk to the life, health or safety of any individual or to public health or safety, which is a clinical question for the GP to assess. It is recommended that if a driver is being assessed for fitness to drive, their use of prescribed psychostimulants for treating ADHD be documented in any report provided to the driver licensing authority, irrespective of the outcome of the fitness assessment.[47]

Dealing with parental disagreement

The final issue for GPs to consider is how to manage parental disagreement about the treatment of children with ADHD. This issue has been addressed in a previous article in *AJGP*.[48] In summary, GPs should first consider whether the child is 'Gillick competent' and has capacity to make their own decision about treatment. In Australia, the common law allows individuals aged under 18 years to consent to medical treatment if they have 'sufficient understanding and intelligence' to enable them to 'fully understand' what is proposed.[49] South Australian law allows children aged over 16 years to consent to treatment, but children aged under 16 years may only consent if two medical practitioners agree that the child understands the nature, consequences and risks of treatment that is in the best interests of the child's health and wellbeing.[50] The level of maturity required to provide consent will vary with the nature, complexity and risks of the proposed medical treatment. Where a child's Gillick competence is being relied on to determine the outcome of a parental dispute about treatment, it would be prudent to obtain a specialist psychiatric opinion about the child's capacity to consent.

Where a child is deemed not to be Gillick competent, Australian Family Law[51] presumes that both parents (whether married, cohabiting, separated or divorced) are entitled to consent to treatment. Either parent can consent. Consent is not required from both parents. Where treatment is commenced with the consent of one parent and the GP later learns that the other parent no longer consents, treatment may still be lawfully provided with the consent of only one parent. However, this situation could prompt a complaint from the non-consenting parent. Requests from one parent to cease treatment that has commenced is also challenging and decisions should ultimately be made that are in the best interests of the child. It is prudent for GPs to seek advice from their medical defence organisation.

Where a parent has engaged in family violence or abuse of that child[52] or where parenting orders remove parental

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responsibility from one parent, that parent may not be permitted to consent to treatment on behalf of their child.[53] These situations can be complex and emotionally challenging for all involved. If the parents are unable to reach an agreement, then courts might intervene and order a particular course of action.[54] If this occurs, or if parenting orders exist, the GP should request and file a copy in the child's medical record and, again, seek advice from their medical defence organisation about how best to give effect to them.

Conclusion

As ADHD management and prescribing increasingly extends into primary care, GPs will need to understand and navigate complex and changing legal, regulatory and ethical issues. While many GPs believe GP-led care is the best approach to improving ADHD diagnosis and management,[55] sufficient resources need to be invested in general practice education, training, support and guidelines to ensure GPs have the tools to safely and effectively diagnose and manage ADHD. In addition, the RACGP has called for nationally consistent legislation through amendment and harmonisation of state and territory laws to enable GPs to initiate, modify and continue psychostimulant medications for adults and children with ADHD across all jurisdictions.[56] In response, Australia's health ministers recently announced the National Advisory Group on Drugs and Poisons Legislation Reform to plot a path towards consistent medicines laws.[57] GPs will need to keep abreast of legal requirements and emerging clinical evidence in this evolving field.

Key points

- GPs must comply with rapidly changing state and territory requirements before they can lawfully prescribe S8 psychostimulants. These requirements can differ substantially between Australian jurisdictions and are separate and additional to the requirements for a valid prescription and PBS subsidisation.
- GPs new to ADHD prescribing should follow available clinical guidelines and involve relevant non-GP specialists in the care of patients as required.
- Ideally, GPs should only prescribe TGA-unapproved ADHD medicines when an approved medicine is unavailable or inappropriate, and the use of the unapproved medicine is evidence-based – patients should be informed that the medicine is unapproved.
- Before prescribing psychostimulants via telehealth, GPs should consider whether an online consultation is sufficient to assess the patient's identity, any prescribing risks and whether the medication is clinically justified.
- Where parents disagree about ADHD treatment, the first step is to consider the best interests of the child and whether the child is Gillick competent and can decide for themselves. Where a child is not Gillick competent, the law presumes that both parents have equal say about their child's treatment, unless there is a court or parenting order to the contrary, or if there are reasonable grounds for suspecting that a parent has engaged in family violence or abuse of that child.
- Additional legal issues can arise when assessing fitness to drive or if GPs believe that patients have forged or stolen S8 prescriptions.
- The medicolegal issues surrounding ADHD treatment can be complex and GPs should contact their medical defence organisation when in doubt.

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Competing interests: None.

Funding: None.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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