Note on Significant Issues re ADHD Care in Scotland

23 February 2026

Key Takeaways

- STAND is deeply concerned by the issue of many GP practices issuing blanket bans on entering into Shared Care Agreements (SCAs) with private providers for the prescription of ADHD medication following initiation and titration of that medication by the private provider.
- We have had no explanation from the GP practices in question, or the Scottish Government, regarding why ADHD medication is singled out as "unfunded" or outwith the scope of the GP contract following private diagnosis, but not when the patient has been diagnosed on the NHS.
- The refusal of GP practices to trust providers regulated by Healthcare Improvement Scotland (HIS), and prescribers regulated by the GMC or other relevant regulators, implies a fundamental lack of confidence in the national regulatory frameworks for all healthcare.
- It is somebody's responsibility to provide ADHD children with the treatment they need. If it isn't the GP practices, then whose is it? It is either the Scottish Government or the health boards.

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Introduction

During her evidence to the Equality, Human Rights and Civil Justice Committee on Tuesday 17 February 2026, Dani Cosgrove highlighted the struggles of neurodivergent children and their families in Scotland.

These struggles are particularly apparent within the education system, and this is exacerbated by the lack of NHS assessment and treatment pathways for ADHD.

Dr Jason Lang, in his evidence to the Committee on 10 February 2026, highlighted the stark reality for unmedicated children within the current education system, stating that the "*only way to pass exams is to sit for two or three hours in a hall, concentrating on one thing"* and that "*somebody with ADHD cannot attain success in that system without medicating themselves or doing something that makes them more neurotypical.*" This is just one example of the huge impact on a child's education as a result of not getting the medication they need.

Many children have ADHD but remain unmedicated due to a lack of NHS provision and a refusal on the part of their GP to enter into shared care arrangements with a private healthcare provider. In many cases, a child will receive an NHS diagnosis but then be put on yet another waiting list for treatment, forcing them to obtain medication via private prescription in any case.

This note draws attention to the key aspects of our concerns. We have also provided Committee Clerks with our previous correspondence on this matter with the Health, Social Care and Sport Committee and the letter STAND sent to the Cabinet Secretary for Health in September 2025.

Regulation of ADHD assessments

A recurring justification for the "blanket ban" on shared care is the assertion that GPs cannot reassure themselves as to whether a private provider is "safe" because they are not properly regulated. This is a surprising assertion from our perspective. It takes very little time to verify a provider's status via HIS or CQC. Furthermore, the clinicians initiating medication are necessarily registered with the GMC (for doctors), the GPhC (for pharmacist independent prescribers), or the NMC (for nurse independent prescribers).

Therefore, a prescription issued by a private ADHD specialist is doubly regulated: once by the professional body of the prescriber and once by the statutory regulator of the service.

Healthcare Improvement Scotland's Remit

HIS are tasked with the regulation of independent health care services under Part 1 of the National Health Service (Scotland) Act 1978. In 2024, this was explicitly expanded to include "independent medical agencies" to ensure it covered online providers.

HIS already conducts regular, published inspections of clinics frequently used by families, such as ADHD Direct and Diverse Diagnostics. These reports, which review clinical governance and safety, are publicly available and easily searchable.

Care Quality Commission's Remit

The CQC regulates independent and digital providers. Much like HIS, the CQC is responsible for registering and inspecting private providers who prescribe ADHD medication. The English system also includes the "Right to Choose" (RTC) mechanism, which allows patients to select a private provider for ADHD assessment and titration if that provider holds an NHS contract. To be a "qualified provider" under RTC, a provider must be registered with the CQC and meet the same safety and quality standards as NHS providers. Therefore, if a patient in Scotland has been diagnosed and had treatment initiated and titrated by a provider who is a "qualified provider" under RTC, it is difficult to see why a GP in Scotland would have concerns about that if they would not have the same concerns about an NHS provider.

Cross-border regulation

There are existing Memorandums of Understanding between HIS, CQC and other UK regulators. Therefore, a provider registered and regulated by the CQC is part of a unified network of regulators. We are unsure why a GP in Scotland would refuse to recognise CQC regulation as a sufficient safeguard, unless they are effectively dismissing the reliability of the healthcare regulator for England.

Trust in Regulators

The current situation presents a serious regulatory contradiction. If GP practices publicly state they cannot trust the safety of a HIS-regulated or CQC-regulated provider or a clinician registered with the

GMC, GPhC, or NMC, they are effectively expressing a "no confidence" vote in the national regulatory infrastructure.

HIS aims to ensure *"every person in Scotland receives high-quality, safe, and effective care,"* irrespective of the provider's status as public or private. All inspections follow standardised processes and utilise a quality framework that aligns with the National Health and Social Care Standards (which are published by the Scottish Ministers under the National Health Service (Scotland) Act 1978). Many GP practices and Local Medical Committees argue that HIS-regulated private providers cannot be trusted, but we interpret this as a challenge to the validity of the very assurance mechanism used to monitor the NHS itself. If the Scottish Government accepts the narrative that these regulators are insufficient to guarantee safety for ADHD care, then we wonder why the public should trust these bodies in any other area of healthcare, including in relation to the inspection of NHS services?

Clinical Standards

Single Condition Assessments

A common objection we hear from GP practices in Scotland concerns the nature of "single condition" assessments. The concern is that private providers may focus exclusively on ADHD, potentially missing comorbid conditions such as autism, depression, or anxiety.

We accept that there are legitimate reasons why single condition assessments are less than ideal, and we note the Royal College of Psychiatrists recommendations for comprehensive, holistic mental health assessments. However, the reality is that current NHS provision often mirrors the very "single condition" model for which the private sector is criticised. Children's NHS pathways for ADHD and autism are frequently separate, with different referral criteria and waiting lists. We often hear of children who have waited years on a waiting list for an autism assessment, been diagnosed as autistic, but are then put on yet another waiting list to be assessed years later for ADHD. The ongoing consideration of whether single condition assessments are appropriate is not, therefore, particular to the private sector and therefore we struggle to see the relevance to the question of whether blanket bans on shared care with private providers are justified.

NICE and SIGN Guidelines

STAND surveyed neurodivergent children and their families to find out what private providers they were using, and the ones that were noted in the survey responses, including ADHD Direct and Diverse Diagnostics, explicitly state that their clinicians follow NICE (National Institute for Health and Care Excellence) and SIGN (Scottish Intercollegiate Guidelines Network) guidelines (where applicable). While it might be the case that some psychiatrists consider that the NICE guidelines for ADHD require to be updated, that does not apply only to the private sector. Therefore, again we struggle to see the relevance to the question of whether blanket bans on shared care with private providers are justified.

The GMC

GPs are regulated by the GMC. We are concerned that the approach of some GP practices is not consistent with the requirements of their registration.

Prescribing Practice

Paragraph 73 of the GMC's Good Practice in proposing, providing and managing medicines and devices states:

"*Decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on convenience or the cost of the medicine and associated monitoring or follow-up."*

We are unsure how this guidance is reconcilable with the position of those GP practices which cite resourcing issues as a reason for their blanket policies. We are also unsure how the blanket policies, which by their nature do not consider the best interests of an individual patient, are compatible with this guidance.

Good Medical Practice

Paragraph 23 of the GMC Good Medical Practice Guidance states that doctors should be "*willing to explain [their] reasons for the options you offer (and the options [they] don't) and any recommendations [they] make".*

The defensive approach of all but one of the GP practices that we (or the families we support) have engaged with manifests in a complete unwillingness to meaningfully explain their reasons for not entering into the shared care arrangements. In many cases they give internally contradictory statements, or change their reasoning when challenged. For example, one GP practice told us that their justification for a blanket ban included their opinion that it would exacerbate socio-economic inequalities, only to retract this statement when we pointed out how inappropriate it was to make clinical decisions on that basis.

Paragraph 89 of the same Guidance states as follows:

“You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:

- *you must take reasonable steps to check the information is accurate*
- *you must not deliberately leave out relevant information*
- *you must not minimise or trivialise risks of harm*
- *you must not present opinion as established fact.”*

We are concerned that the terms of paragraph 89 may not have been complied with in some cases. By way of example, we have seen statements made by some Edinburgh based GP practices to their patients that *all* other Lothian GP practices are following the same blanket policy, when this is categorically untrue. This has led to a common misconception amongst the ADHD community that there is no point asking a GP to enter into shared care arrangements, when in reality there are GP practices that are willing to do so.

Clinical Discretion

We acknowledge that a GP must only prescribe within the limits of their clinical competence, and must exercise "clinical discretion” when doing so. However, clinical discretion relates to the discretion of a doctor regarding an individual patient's care. Clinical discretion is not an accurate characterisation of the implementation of a blanket policy to refuse all requests for shared care arrangements with private providers. Rather, a blanket ban is a systemic decision to exclude a specific class of disabled patients from their right to health care regardless of whether it is in a particular patient’s best interests or not.

Equalities and Human Rights Considerations

The blanket refusal to enter into Shared Care Agreements for ADHD medication following private diagnosis raises equality and human rights issues.

Equality Act 2010

STAND has been making FOI requests to GP practices for evidence of equality impact assessments but, so far, have not been provided with any. This is despite the fact that blanket bans on shared care with private providers can disproportionately and significantly disadvantage people with ADHD - a group protected under the Equality Act 2010 by virtue of disability. We are concerned that such policies constitute discrimination and a breach of the public sector equality duty.

We know that GP practices prescribe medication following private diagnosis in other contexts. For example, we have seen evidence of GP practice prescribing medication for bipolar disorder following a private assessment based simply on an email from a psychiatrist, without the comfort of a formal shared care agreement. This suggests that the barriers applied to ADHD could be based on stigma and negative attitudes about the nature of the disability itself rather than clinical safety. Evidence of this stigma is found in the "***ADHD sigh***" email obtained by STAND via FOISA, which illustrates a culture of prejudice that directly impacts clinical decision-making (more details in STAND's written submissions to the ADHD and Autism Inquiry).

UNCRC

These barriers directly infringe upon the rights of children in Scotland under the UNCRC, specifically the right to the highest attainable standard of health. Article 24 of the UNCRC protects a child's right to the highest attainable standard of health and prohibits the state from depriving them of healthcare. The Children and Young People's Commissioner Scotland has noted that a child's right to health is not altered by the parent's choice to seek private diagnosis:

"We are aware that some families make the choice to seek a private diagnosis for their child and that this is not always accepted by schools as the basis for requesting adjustments or additional support. Any decision whether or not to accept a diagnosis made by an appropriate medical practitioner should be

evidence based and consider the individual child's rights and best interests. It is not appropriate to have a blanket ban in place, particularly in the context of the lack (or at least effective lack) of access to diagnosis via the NHS."

Given the recent incorporation of the UNCRC into domestic law, it is disappointing that the clear advice of the Children and Young People's Commissioner is being routinely and blatantly ignored.

Further, by forcing children who have already been diagnosed by a regulated specialist onto multi-year waiting lists for "re-assessment" as a prerequisite for NHS medication, children with ADHD are substantially disadvantaged - both because some children have to undergo a second, unnecessary assessment, and because the other children who are behind them on the NHS waiting list could have been assessed sooner if that unnecessary assessment did not take place.

Fairer Scotland Duty

We have also noticed a socio-economic dimension. As the Committee will be extremely familiar with due to its remit, under Part 1 of the Equality Act 2010 (the Fairer Scotland Duty), public bodies must have due regard to the need to reduce inequalities of outcome caused by socio-economic disadvantage. GP practices in areas of higher deprivation are less likely to agree to shared care than those in affluent areas. This creates a "postcode lottery" that punishes families who may have scraped together funds for a one-off private assessment to escape a 5-year wait, only to be denied the NHS prescriptions they should be entitled to. Of course, there are many families who could not even afford the initial assessment, but there is a significant cohort of families (some of which are part of our case studies at STAND) who could get the money together for the initial assessment, but not be able to afford the ongoing private prescription costs. It is difficult to see how the refusal to prescribe to that cohort of families does anything to help the cohort that are stuck on an even longer waiting list as a result of socio-economic disadvantage.

The GP Contract and "Essential Services"

Under the NHS (General Medical Services Contracts) (Scotland) Regulations 2018, "essential services" include the management of patients suffering from chronic disease. ADHD is a chronic condition (ICD-10). We have yet to receive a formal explanation as to why ADHD management, specifically issuing a repeat prescription for a stable patient who is being monitored by a private specialist, is

considered "outwith scope" solely because the titration was, and ongoing monitoring is, carried out privately.

Scottish Government Engagement

STAND wrote to the Cabinet Secretary in September 2025 asking for further explanation. In December, officials promised a reply "ASAP." As of late February 2026, we have had no response.

Complexity of SCAs

We also submitted an FOI request in relation to a statement made by the Minister for Social Care and Mental Wellbeing to the Health, Social Care and Sport Committee as part of the ADHD and Autism Inquiry. The statement was that *“shared care agreements are specific and often complex”*. We have seen examples of the shared care agreements that have been proposed to, and rejected by, GP practices in Scotland by private providers and, in our view, they are not complex. The ones we have seen provide for all ongoing monitoring to be carried out by the private provider, with only the prescribing falling to the GP. The reply explained that the reference to the agreements was simply taken from NAIT Guidance published in April 2022 in relation to the prescription of ADHD to adults. The reply also included an email received by the Scottish Government from the Royal College of GPs in April 2025.

The Royal College Email

The email referred to above is an example of why we lack faith in the assertions made by some GP practices about the issue of private providers and shared care. We have set out an explanation of this below.

Remote Consultations

The email from the Royal College made the following points about remote assessments from private providers:

“It is currently the case that some private providers offer assessments 'from the comfort of your home'.”

”It is possible that the patient may not have been offered or advised to travel to in-person assessments with a specialist, or indeed that the patient may have chosen a specialist based far away having anticipated remote assessment may suffice.”

However, NHS services for neurodevelopmental conditions often take place remotely, and the Royal College of Psychiatrists clarified during the ADHD and Autism Inquiry that remote assessment was not necessarily a problem.

The role of HIS

The email goes on to make the following comments about assurances provided by HIS:

"Furthermore, Healthcare Improvement Scotland (HIS) does not provide any specific assurances around private services offering ADHD assessment and diagnosis. As such, it is understandable that some GPs lack assurance that private providers offer high quality diagnostic services."

We do not understand this statement, and find it concerning. Why would HIS be expected to provide specific assurance over and above their normal functions in relation to independent health care providers? We do not think it is understandable that GPs lack assurance about diagnostic services from private providers unless they lack assurance in relation to HIS, CQC and the GMC more generally. The email also states:

"The Scottish Government could address barriers to entering into voluntary agreements by commissioning HIS to inspect private providers of ADHD diagnostics to provide assurance of their qualifications, assessments, and treatment recommendations."

As noted previously, HIS already conducts regular, published inspections of registered independent clinics, including those frequently used for private ADHD assessments by families in Scotland such as ADHD Direct and Diverse Diagnostics. These reports are publicly available and therefore it is not clear what the Royal College suggests is missing.

Additional Responsibilities

The email then moves on to speak about "additional responsibilities" of GPs:

"Ultimately, shared care agreements result in general practice taking on additional responsibilities at a time when the profession is under significant pressure."

The GP practices that have responded to us usually concede that they would prescribe the ADHD medication to the patient if the patient had been diagnosed by the NHS. However, if the NHS services

were to keep up with the level of need that exists, then the level of "*additional responsibility"* could potentially increase. Not everyone that should be entitled to NHS assessment and treatment will be able to afford a private assessment, and therefore it could well be the case that their workload would be even higher if the health boards were actually fulfilling their duties, as the GP practices think they should be.

Local Guidance

Lastly, there is a confusing statement about local Scottish guidance:

"We fear that multiple private providers will not be familiar with good practice guidance in Scotland and may lack the ability to arrange any necessary follow up checks locally."

The prescribers for the private providers must be registered with the relevant professional body in the UK. If a prescriber was not familiar with the relevant guidelines, and prescribed regardless, then it is likely that they would be in breach of the requirements of the relevant professional body.

Further, the national standards which HIS use to assess the private providers state that they must follow current recognised clinical guidelines.

Our Frustration

We give the examples above to demonstrate why we are getting increasingly frustrated by the general acceptance of a narrative about the safety of private providers that is propagated by bodies or organisations which are either unwilling or unable to provide or publish empirical data or objective evidence of the potential risks resulting from assessment and treatment of ADHD by a private provider rather than an NHS service.

GP Practices and Accountability

Many GP practices do enter into shared care for ADHD with private providers. However, the ones that refuse are often defensive and uncooperative.

For example, we made an FOI request to one GP practice in Ayrshire and received a reply saying that they would not reply before the statutory deadline because their office manager was on annual leave, and it would be more reasonable for them to reply the following month. Another Edinburgh based GP practice refused to reply for months, citing that they were awaiting sign-off from their lawyers before

complying. We have also seen correspondence obtained via a subject access request that made reference to FOI requests for details of blanket bans as being “threatening”. One practice agreed to a meeting between a STAND volunteer and a patient to discuss the issues, and then cancelled it at short notice because they had only then (after months of correspondence about the implications of their policy in the context of the Equality Act 2010) decided to seek legal advice instead. They never rearranged the meeting after that, nor answered the patient’s questions.

One Edinburgh-based practice did reflect on their blanket ban after it was raised with them as potentially discriminatory, and subsequently apologised and reversed the decision. This is admirable, and consistent with the principles of the duty of candour in a way which gave us hope that, eventually, maybe other GP practices would follow suit. Unfortunately, that has not yet happened.

In light of the examples above, we welcome the recommendation of the Health, Social Care and Sport Committee, as set out in their report following the ADHD and Autism Inquiry, which called about GPs to work with the Scottish Government, HIS and health boards to address the problems with shared care agreements.

Scottish Government and Health Board Duties

It is not just GP practices that have relevant duties in relation to the issue of ADHD treatment in Scotland. The Scottish Ministers and health boards have a range of functions and duties, and it is important that we recognise their responsibility to solve the problem and ensure disabled children in Scotland get the treatment they need.

Scottish Ministers

The Scottish Ministers have duties and powers under the National Health Service (Scotland) Act 1978 to promote a comprehensive and integrated health service, and to promote the improvement of the physical and mental health of the people of Scotland.

Health Boards & Equal Opportunities

Under section 2D of the 1978 Act, health boards must discharge their functions in a manner that **encourages equal opportunities and in particular the observance of the equal opportunity**

requirements. This includes their primary health care functions, which ordinarily they outsource under the GP Contract.

Patients Rights (Scotland) Act 2011

The Patients Rights (Scotland) Act 2011 places an obligation on NHS bodies to uphold the health care principles when performing their functions, and ensure that any person with whom it enters into a contract (i.e. GP practices) do so too. The health care principles are set out in the Schedule to the 2011 Act, and it is clear that they are not currently being upheld. In particular, the opaque, confusing and inconsistent messages that neurodivergent children and their families (which we have witnessed at STAND) contradicts several of those principles, for example that "*communication about general services and processes and decisions is clear, accessible and understood*" and "*patients are treated with dignity and respect"*. Similarly, the patients' rights under the 2011 Act are being routinely breached. For example the importance of being provided with such information and support as is necessary to enable the patient to participate as fully as possible in decisions relating to their health and wellbeing, and the right for health care to be *"patient focused"* and *"take into account the patient's needs"*.

It should go without saying because of the legal obligations in this area, but the Patients Charter of Rights and Responsibilities, published by the Scottish Government under the 2011 Act, makes clear that access to health care should not be refused on the basis of a person's disability. However, this is the case when it comes to CAMHS services - if a child is "just" neurodivergent, as opposed to having a separate mental health condition, their right to ADHD treatment is either non-existent or extremely sub-standard. Further, the Charter includes the "Treatment Time Guarantee", staying explicity that:

Mental health waiting times

If you have a mental health problem that requires support through specialist services, your health board should provide you with treatment within the following timescales:

- 90% of those referred to Child and Adolescent Mental Health Services (CAMHS) should begin treatment within 18 weeks
- 90% of people referred for psychological therapies should begin treatment within 18 weeks

This Treatment Time Guarantee is not anywhere near close to being met for children with ADHD. We often hear that “CAMHS is not the right service”, however that is not an excuse. The mental health of children with ADHD is being sacrificed by decision-makers, and the name of the service from whom they should receive support is irrelevant to them.

Whose responsibility is it?

If the Scottish Government and Health Boards do not share the concerns expressed by the Royal College regarding the safety of private providers, they must take proactive steps to ensure that GP practices fulfill their contractual and professional obligations to prescribe this medication. Conversely, if they do share these concerns, they are effectively admitting that the NHS assessment pathways are so inadequate that they are forcing families into a private sector which is regulated by a regulator that also has responsibilities in relation to NHS care.

In either case, the duties mentioned above remain with the Scottish Government and health boards: **they must either make arrangements to direct GPs to prescribe or provide the service directly themselves**. Otherwise, the protections under the Equality Act 2010, the UNCRC (Incorporation) (Scotland) Act 2024, the NHS (Scotland) Act 1978, the Patients Rights (Scotland) Act 2011, the Patients’ Charter of Rights and Responsibilities, and many other protections are rendered useless in respect of children with ADHD. What does this tell us about the way that society views neurodivergent children?

The Cost of Inaction

The Public Purse

This Inquiry, and the ADHD and Autism Inquiry, has heard evidence about the huge costs of untreated and unmanaged ADHD. This cost is borne by our prison systems, health systems, and the education sector. By failing to solve the issues mentioned in this note, the public sector is not saving money; they are simply shifting a much larger financial burden onto public services while causing avoidable harm to children.

Harm to the Patient

A significant and often overlooked form of harm is that which arises from the failure to treat ADHD due to protracted waiting lists or GP refusals to prescribe. Both Inquiries have heard evidence of these harms, including from the Royal College of Psychiatrists so we have not narrated them here.

This means that when GP surgeries implement blanket bans on private shared care, they may be exposing patients to these severe, measurable risks while citing vague "safety" concerns about the private sector that they are unwilling or unable to evidence within any degree of detail.

STAND's Message

The current approach to ADHD shared care is a textbook example of systemic stigma. We urge the Committee to recommend that the Scottish Government:

1. clarifies whether ADHD management falls within "essential services" in the GMS contract (subject to the GP having the clinical competence to prescribe the medication in question). If it does not fall within scope of the GMS contract, we would welcome their view as to whose responsibility it is to provide the service;
2. issues guidance that blanket bans on shared care are incompatible with the Public Sector Equality Duty, UNCRC obligations and the Patient Rights (Scotland) Act 2011;
3. affirms confidence in HIS, CQC, and professional regulators (GMC, GPhC, NMC).