Adult ADHD IN THE UK

2025

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Adult ADHD Care in the UK: An Urgent Case for Systemic Reform

Summary: A Hidden Crisis in Plain Sight

Adult attention-deficit/hyperactivity disorder (ADHD) has emerged as one of the most under-recognised, underfunded, and underserved public health issues in the UK today. While scientific understanding of ADHD has advanced significantly over the past two decades, health service provision has lagged far behind—particularly for adults. Tens of thousands of adults now seek ADHD assessments each year, often after a lifetime of undiagnosed symptoms that have impaired their mental health, careers, relationships, and overall well-being. Yet the majority encounter a fragmented, overstretched system in which even the most basic care is routinely delayed for years.

As of 2025, this crisis is no longer hidden. Over 131,000 people are on ADHD assessment waiting lists across the UK—90,000 of them adults. Some NHS services report waits exceeding ten years. Others have ceased accepting new referrals altogether. The 2012 Right to Choose policy briefly gave patients a way to circumvent delays, but proposed changes by NHS England in 2025 now threaten to eliminate that vital pathway. Without urgent reform, the UK risks regressing into a two-tier system, where only those with private means can access timely ADHD care.

Meanwhile, the costs of neglect are mounting. Untreated ADHD is linked with greater rates of unemployment, substance misuse, criminal justice involvement, and long-term physical and mental illness. The estimated economic burden of untreated ADHD is in the billions, far exceeding the cost of providing adequate services. Despite this, there is no national ADHD strategy, no standardised wait-time target, and—until recently—no coordinated data on who is being assessed, treated, or turned away.

This review provides the first full-scope overview of the UK adult ADHD crisis in 2025. It draws on extensive FOI data, policy documents, published research, and new developments from the NHS ADHD Taskforce. We compare child and adult services, assess the impact of recent media narratives and drug shortages, and highlight critical issues around shared care and prescribing reluctance. The article concludes with evidence-based recommendations for redesigning ADHD services through a mainstream, integrated care model suitable for chronic neurodevelopmental conditions.

The findings demand attention—not just from clinicians, but from policymakers, commissioners, and NHS leaders. The time for incremental change has passed. With political will and modest investment, the UK could transform adult ADHD care into a model of effective, equitable, and person-centred neurodevelopmental support.

Adult ADHD in the UK – The Crisis at a Glance (2025)

- ⚖️ **131,000+** people on ADHD assessment waiting lists in the UK
  - 90,000 adults
  - Waits up to **10+ years** reported
- ❌ **Some NHS services** no longer accepting adult ADHD referrals
- ✅ **Right to Choose** offered NHS-funded private assessments
  - **Now under threat** due to NHS Payment Scheme changes
- 💷 **Economic cost of untreated ADHD:**
  - Estimated **£6.5 to £11.2 billion** over 10 years
- ⚠️ **Medication shortages (2023–24):**
  - 27% of patients without meds for months
- ❎ **No national ADHD strategy**
  - No wait-time targets
  - Only 21% of ICBs could provide waitlist data (2023)
- 📄 **Panorama (2023)** sparked concern over private diagnoses
  - But missed NHS under-provision context
- 🏛️ **NHS ADHD Taskforce (2023–25)** aims to reform services
  - Final recommendations expected this year.

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a common neurodevelopmental disorder characterized by persistent inattention and/or hyperactivity-impulsivity with childhood onset. Once thought of mainly as a paediatric condition, it is now clear that ADHD frequently persists into adulthood in a substantial proportion of cases theguardian.compmc.ncbi.nlm.nih.gov. Worldwide prevalence estimates are about 5–7% in children and roughly 2–4% in adultsadhdfoundation.org.uk. In the UK, this suggests well over 1 million adults are affected, yet historically only a small fraction received a diagnosis or treatment. Untreated adult ADHD is associated with a wide range of adverse outcomes: higher rates of accidental injuries and traffic accidents, more frequent psychiatric comorbidities (especially anxiety, depression, and substance misuse), and even a significantly elevated mortality risk pmc.ncbi.nlm.nih.gov. Notably, one UK study found men with ADHD die on average 7 years earlier than peers without ADHD (with a still substantial gap for women), and other estimates suggest a reduction in life expectancy of around 11 years. Chronic health problems such as obesity and type 2 diabetes are more common in those with ADHD news.ki.se, and ADHD is associated with a five-fold increased risk of suicide attempts in women according to patient advocacy reports adhdworks.info. These figures underscore that adult ADHD is a serious health condition – *at least* as impactful as many better-recognized chronic illnesses – and that effective management has major implications for public health and patient well-being.

Fortunately, evidence-based treatments for ADHD can substantially improve symptoms and functional outcomes. Stimulant medications (e.g. methylphenidate or lisdexamfetamine) have among the largest effect sizes in psychiatrypmc.ncbi.nlm.nih.gov and are generally well-tolerated, leading to improvements in concentration, impulsivity and related impairmentspmc.ncbi.nlm.nih.gov. Effective treatment is associated with reductions in injuries, improved educational and occupational attainment, and better mental healthpmc.ncbi.nlm.nih.gov. Psychological interventions (psychoeducation, coaching, and cognitive-behavioural strategies) also play a role, often combined with medication for best resultsnews.ki.se. Thus, identifying and treating ADHD in adults is not only beneficial for patients – enabling many to “understand themselves and thrive in a way they haven’t before”theguardian.com – but also yields broader societal benefits by reducing downstream health, social care, and criminal justice costspmc.ncbi.nlm.nih.gov.

In recent years, the UK has witnessed a surge of awareness and demand for adult ADHD assessment. The ADHD Foundation reported a **400% increase** in adults seeking an ADHD diagnosis since 2020theguardian.com. This rising tide of adults – many of whom were never diagnosed in childhood due to lesser awareness in past decades – has exposed long-standing shortcomings in the healthcare system’s ability to meet their needs. Services have not expanded commensurately, resulting in

extreme waiting times and forcing many patients to seek alternative pathways. This article examines the current state of adult ADHD care in the UK, including the policy context and recent developments (as of 2025), NHS service provision and gaps, the role of the private sector and shared-care challenges, and the economic implications of the status quo. We also critique prevailing media narratives and highlight ongoing issues such as medication shortages. Finally, we propose evidence-based recommendations and models of care to reform and enhance adult ADHD services, in line with emerging national initiatives.

Current Policy and Legislative Context

Right to Choose and NHS Reforms: A pivotal policy in recent years has been the NHS **"Right to Choose"**, which gives patients in England the legal right to choose the provider for their first outpatient appointment for a specialist-led service, as long as the provider is NHS-commissionedpmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov. This framework, grounded in 2012 NHS regulations and the NHS Constitution, has been highly relevant to ADHD. With local NHS clinics overwhelmed, many adults have used Right to Choose to access assessments from independent providers (such as telepsychiatry services) that hold NHS contractspmc.ncbi.nlm.nih.gov. This effectively opened a pressure valve: thousands obtained NHS-funded ADHD assessments outside their local area, often much faster than waiting for the local clinic. Psychiatry-UK, for example, became a well-known provider via this route. While this increase in capacity has been a lifeline for patients facing multi-year waits, it also introduced challenges of care continuity and quality oversight (discussed later)pmc.ncbi.nlm.nih.gov.

However, as of 2024–2025, Right to Choose in its current form is under threat. In late 2023, NHS England quietly proposed changes in the NHS Payment Scheme that would *"mean the end of Right to Choose as we know it."*adhduk.co.uk In this plan – which was put to consultation with minimal public awareness – local Integrated Care Boards (ICBs) would gain new powers to restrict out-of-area referrals and funding for elective mental health careadhduk.co.uk. Essentially, ICBs could refuse to pay for patients to be seen sooner via Right to Choose providers, instead keeping them on local waiting lists. ADHD advocacy groups like ADHD UK have vociferously opposed these changes, arguing that using a "backdoor" technical consultation to remove a patient right granted by Parliament lacks transparency and due scrutinyadhduk.co.uk. They warn that if implemented, **assessment waits could "jump almost immediately from months to multiple years"** for those who would have used Right to Chooseadhduk.co.uk. At time of writing, the consultation has closed and the outcome is pending, but patients and clinicians are anxiously watching what would be a fundamental policy shift. If Right to Choose is curtailed without alternative capacity in place, tens of thousands of adults could be forced back into the already overstretched regional queues.

NICE Guidelines and Legal Recognition: The National Institute for Health and Care Excellence (NICE) issued its first guideline on ADHD in 2008 (updated 2018), which for the first time explicitly included adults and recommended service models for transition from child services. NICE recognises ADHD as a lifelong condition in many cases and emphasizes that adults should have access to assessment and treatment by specialists, with shared care arrangements for routine prescribing in primary care once stable. Despite this guidance, implementation has been uneven. ADHD is legally considered a disability under the Equality Act 2010 if it has a substantial impact on daily activities, which means adults with ADHD are entitled to

workplace accommodations and protection from discrimination. In practice, however, the legislative recognition of ADHD has not translated into parity of healthcare provision.

Recent Government Attention: Amid growing public attention (and some controversy, as discussed later), national bodies have begun to respond. In early 2023, NHS England – in collaboration with government – launched a **special ADHD Service Review Taskforce** to examine the state of ADHD services. The taskforce brings together experts from health, education, and justice sectors, and is charged with **"assessing ADHD service provision, identifying causes of increased demand, and addressing challenges spanning wider society."** Findings and recommendations are expected to be published in 2024static1.squarespace.com. NHS England's Chief Executive has publicly acknowledged the need for timely diagnosis and comprehensive support for ADHDstatic1.squarespace.com. The Royal College of Psychiatrists has also thrown its weight behind this effort, stressing the urgency of a **"proactive approach to service provision"** given soaring demand, and highlighting the need for better data and increased investment in workforce and servicesstatic1.squarespace.comstatic1.squarespace.com. These developments – a taskforce, high-level statements, and mooted policy changes – set the stage for what could be a significant inflection point in how adult ADHD care is organized and funded in the UK. The following sections examine why such systemic attention is not only welcome but long overdue.

NHS Service Access, Waiting Times and Regional Disparities

Access to ADHD assessment and care through the NHS has become a postcode lottery for adults in the UKadhdworks.info. While some areas established dedicated adult ADHD clinics following NICE's 2008 guidance, many others still have minimal or no provision. Patients are subject to extraordinarily long waits in much of the country, far exceeding the NHS's own performance targets for other conditions. A recent comprehensive Freedom of Information (FOI) investigation by ADHD UK (covering 2023) starkly illustrated the scale of the problem. **Waiting times for an adult ADHD assessment ranged from 12 weeks in the best-case scenario to an astounding 550 weeks (over 10 years) in the worst case**adhduk.co.uk. For example, at Dorset Healthcare University NHS Trust the average wait was around 3 months, whereas at Herefordshire & Worcestershire Health and Care Trust it was over 10 yearsadhduk.co.uk. The longest-waiting individual identified in the FOI data had been waiting **443 weeks (8.5 years)** and was under a Welsh health boardadhduk.co.uk. Such figures are almost unheard of in modern NHS practice – by comparison, waits for elective surgical procedures rarely exceed 1–2 years even after the COVID-19 backlog. Indeed, many adult ADHD patients added to "routine" waiting lists today are effectively being told they will not be seen for *five to ten years* unless additional capacity is foundpmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov. This far outstrips the NHS's Elective Recovery Plan goals (which aimed to eliminate waits over 2 years by 2022 and over 1 year by 2025)pmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov – yet those goals notably **excluded mental health** services, highlighting how conditions like ADHD have slipped through the cracks of performance managementpmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov.

Geography plays a huge role in access. In some regions (e.g. parts of Yorkshire and the North), adult ADHD services have been so overwhelmed that they effectively stopped accepting new routine referrals. In York and North Yorkshire, it was reported that people are **"simply refused assessments unless they are in crisis, and even then may not be seen "**adhdworks.info. Some trusts have provided the alarming answer that they have *no service at all* for adult ADHD, meaning a referral would lead nowhereadhdworks.info. In these areas, patients' only routes are to seek private assessment or rely on the Right to Choose to find an out-of-area provider. Even within a single region, the disparity can be great: one 2018 survey found CCGs (predecessors to ICBs) quoting waits from 4 weeks up to nearly 4 yearspmc.ncbi.nlm.nih.gov, and we now know the upper end of waits has since grown even longer. Such variation reflects differences in historical commissioning priorities – some areas invested early in adult ADHD teams, others did not allocate any dedicated resources, leaving general psychiatry teams to cope or (more often) leaving adults unserved entirely.

A notable and concerning practice that has emerged is **screening or triaging out referrals** to manage demand. Approximately 15% of NHS organizations in the ADHD UK FOI admitted they use additional screening questionnaires or criteria to decide which referred patients will even be offered a full assessmentadhduk.co.ukadhduk.co.uk. In theory, screening might prioritize those with the highest clinical need; in practice, it has often meant excluding large proportions of referrals without ever meeting them, as a blunt rationing tool. For instance, Sheffield's adult ADHD service removed **97% of referrals** in 2022–2023 via an online screening form, reducing 1,093 referrals down to only 33 assessments completedadhduk.co.uk. Women were slightly more likely to be screened out than men (98% vs 96% removed in Sheffield)adhduk.co.uk, which is deeply ironic given NICE's explicit warning that ADHD in girls and women is underdiagnosed and requires vigilanceadhduk.co.uk. In areas like York (which piloted an online triage tool), only **15% of those who filled an initial questionnaire were deemed eligible for formal referral**theguardian.com. And even those who "pass" the screening in such systems face further internal waits – in the York pilot, accepted cases went to a second-stage clinical triage with a 12–15 month queuetheguardian.com, and only after that would they join the regular **2.5-year waiting list** for assessmenttheguardian.com. In effect, many individuals are left in indefinite limbo, denied an assessment unless their condition is considered an extreme crisis. Patient advocates have decried these practices as an *"unlawful denial of patient rights"*theguardian.com, noting that since GP referrals for ADHD already require clinical judgment, additional screening layers lack any national mandate and risk excluding genuine casesadhduk.co.ukadhduk.co.uk. Notably, **NICE has no recommendation for using screening tools to refuse assessments**adhduk.co.uk – this is a local invention born purely out of service pressure.

The lack of **national data and targets** has allowed this situation to deteriorate with relatively little oversight. Unlike some conditions (e.g. autism, where data on waiting times is now collected nationally under NHS targets), adult ADHD services until recently had no required reporting of waiting times or outcomespmc.ncbi.nlm.nih.gov. The ADHD UK FOI found that only **21% of Integrated Care Boards could even state how many people were waiting** for ADHD assessment in their areaadhduk.co.ukadhduk.co.uk. By extrapolating from those that did respond, the charity estimated **around 90,000 adults and 42,000 children** were stuck on waiting lists across the UK as of late 2023adhduk.co.ukadhduk.co.uk. That is roughly **131,000 people waiting**, which is about 5% of the estimated total UK ADHD populationadhduk.co.ukadhduk.co.uk. In other words, a significant subset of all people with ADHD are actively seeking diagnosis/support at any time, but the system's capacity is so misaligned that many will not be seen for years, if ever, unless they pursue alternatives. This is not a transient surge that will abate; it reflects a persistent under-resourcing given the true prevalence of ADHD (which has not changed dramatically over decades, even as recognition has improved). Without a strategic expansion, waiting lists of this

magnitude will be a permanent feature. The newly formed NHS ADHD Taskforce will need to start by **collecting robust data on service demand and waits** – a step that has been recommended by experts and charities alikeadhdworks.infoadhdworks.info – to underpin any effective plan. It is impossible to manage what is not measured.

To illustrate the regional inequality in access, **Table 1** presents examples of adult ADHD waiting times from selected NHS providers, highlighting the best- and worst-case scenarios and national estimates:

NHS Provider / Region	Reported Wait for Adult ADHD Assessment	Source
Dorset HealthCare (England)	**12 weeks** (3 months) – among shortest waits	NHS FOI dataadhduk.co.uk
Belfast HSC Trust (N. Ireland)	~1.5 years (median ~80 weeks)	NHS FOI dataadhduk.co.uk
Greater Manchester Mental Health (Eng)	~2–3 years (estimated 100–150 weeks)	Local reports (2023)
Herefordshire & Worcestershire (Eng)	**550 weeks** (10.5 years) – longest reported	NHS FOI dataadhduk.co.uk
Hywel Dda Health Board (Wales)	Individual waited 443 weeks (8.5 years)	NHS FOI dataadhduk.co.uk
National (England) – estimated total	~90,000 adults waiting (average wait ~2–3 years; many much longer)	ADHD UK analysis

*Table 1: Examples of adult ADHD assessment waiting times in UK regions (2023 data). Where official wait times are extremely long, they often reflect capacity limits rather than true queue length (e.g. some services closed to new referrals).*adhduk.co.ukadhduk.co.uk

In summary, NHS provision for adult ADHD is **characterized by extreme and unacceptable delays, and marked inconsistency across the country**. Such delays directly contravene patients' rights to timely care – it is telling that **no other mental health condition** in the NHS has comparable waits. Depression or anxiety patients, for instance, can usually access some form of treatment within weeks or months (e.g. via IAPT services), and even autism diagnostic services – which face their own backlog – are now subject to improvement targets far shorter than the ADHD waits described. The neglect of ADHD services has reached a critical point, manifesting as a silent crisis. Adults with ADHD often languish without support during the prime of their working lives, incurring heavy personal and social costs during the waiting period. For children and adolescents, lengthy waits can derail education and development; and as discussed next, even those diagnosed in childhood frequently lose support when they transition to adulthood, compounding the gaps in care.

Child and Adolescent Services vs Adult Services: The Transition Gap

ADHD is typically first diagnosed in childhood, and specialist child & adolescent mental health services (CAMHS or community paediatrics) handle most paediatric ADHD cases. In theory, when an ADHD patient outgrows CAMHS (usually at 18, sometimes at 16 in some services), there should be a planned **transition to adult mental health services** if ongoing treatment is needed. NICE guidelines recommend a structured transition process: a meeting between child and adult services, a handover of care, and an overlap period if possiblepmc.ncbi.nlm.nih.gov. In practice, however, transitions for ADHD are often poorly executed or entirely absent. A national surveillance study published in 2019 found that only **15% of young people on ADHD medication who required continued care actually had a successful transition to adult services**pmc.ncbi.nlm.nih.gov. The vast majority were lost to follow-up. Some drop off before 18 due to service policies (e.g. being discharged if they miss appointments or if they seem stable) and then never reconnect with adult services. Others are referred to adult psychiatry but find that no adult ADHD team exists in their area, or the referral is not accepted.

Many CAMHS teams, facing their own high caseloads, prioritize severe mood, anxiety, or eating disorders, and may have limited capacity for ADHD beyond age 16. Consequently, it's not uncommon for adolescents with ADHD – especially if they also have autism or other neurodevelopmental conditions – to fall into a "transition black hole." A striking pattern is that **if a youth on the CAMHS waiting list has not been seen by age 17–18, they often have to start over on the adult waiting list** from scratchadhdworks.info. This can add years more of delay just due to crossing an age boundary. As noted earlier, children nearing adulthood are sometimes simply discharged without adult follow-up if the local adult service won't accept the referral. The result is that many individuals only receive an ADHD diagnosis as an adult, even if symptoms were present in childhood – either because they were never assessed as children, or because the transition failed. Studies suggest about 65% of children with ADHD continue to have impairing symptoms in adulthoodtheguardian.compmc.ncbi.nlm.nih.gov, yet only a small fraction of those currently have continuous care through the transition.

The differences in service structure also create gaps. CAMHS may offer multimodal support for ADHD (including parent training, school liaison, etc.), whereas adult mental health services are largely medication-focused for ADHD, with far less routine involvement of psychology or social work for ADHD patients. There is also a cultural gap: adult psychiatry historically did not consider ADHD a core part of its remit, given that ADHD as an adult diagnosis only entered ICD/DSM criteria in the late 20th century. Many general adult psychiatrists were not trained in recognizing or managing ADHD. So even where adult services exist, young adults often describe

the transition as abrupt and difficult – going from a child service that involved parents and teachers, to an adult service where they are expected to self-manage and navigate prescription renewals and appointments independently (which, ironically, can be challenging for someone whose condition impacts organization and executive function).

Another vulnerable point is early adulthood (18–25 years), where those without a prior diagnosis may first seek help. If a young adult presents to primary care with concentration problems or comorbid depression/anxiety, GPs might not always think of ADHD – especially if the patient did relatively well in school or if they are female (hence masking symptoms). There is a risk that without robust services and training, young adults get misdiagnosed or shuffled into generic diagnoses. Indeed, a lack of smooth transition can lead to *"avoidable co-occurring problems arising out of no diagnosis or support"*, such as youths ending up treated for depression or anxiety while the underlying ADHD is missed.

Strengthening the interface between CAMHS and adult services is thus crucial. Proposals have included having **dedicated transition clinics** for ages ~17–20, jointly run by child and adult psychiatrists, to ensure no one falls through the gap. Another model is to extend CAMHS coverage to age 25 for neurodevelopmental disorders – reflecting the modern understanding that adolescence extends into the mid-20s for brain development. Until something changes, however, thousands of young people each year will "age out" of children's services and find an absence of support waiting on the other side. This discontinuity means lost opportunities for early intervention in late adolescence and young adulthood – a period where many life trajectories (higher education, entering the workforce, forming relationships) are shaped. It also means that many adults in their 30s, 40s, or beyond are only now being identified after struggling for years, sometimes decades, without a name for their challenges. The unmet needs carried forward from childhood are a significant part of the adult ADHD care backlog today.

Bridging this child-adult divide requires both removing the artificial barriers at age 18 and scaling up adult service capacity to meet latent demand from prior underdiagnosis. Encouragingly, the ongoing NHS England ADHD Taskforce has indicated it will look at **"challenges spanning wider society"** and involve education and justice sectorsstatic1.squarespace.comstatic1.squarespace.com – this suggests recognition that transitions (e.g. from school to adult life, or youth justice to adult justice systems) are a key issue. Any comprehensive solution must include a plan for those moving from CAMHS to adult services, to ensure continuity of care, as well as better identification of those missed in childhood.

Private Sector Involvement and Shared Care Challenges

In response to the severe constraints of NHS ADHD services, a substantial private sector ecosystem has developed for ADHD assessment and treatment. This ranges from large providers (e.g. Psychiatry-UK, Clinical Partners) offering diagnostic assessments via video consultation, to individual consultant psychiatrists and clinics seeing patients for out-of-pocket fees. Over roughly the past 5 years, **more than half of new adult ADHD diagnoses in the UK have been made by private providers** rather than NHS clinics. Many of these diagnoses are ultimately NHS-funded through the Right to Choose pathway, while others are self-funded by patients who can afford it. This two-tier system raises equity concerns: those with means or knowledge can circumvent waits, whereas others are left in the queue. It also underscores an uncomfortable truth – the NHS's failure to build capacity has effectively outsourced a large portion of ADHD care to the private sector by default.

Private assessments have undoubtedly helped thousands of individuals get a timely diagnosis and treatment plan. However, they have also brought new challenges. One major issue is the **lack of integration and "shared care" arrangements between private specialists and NHS GPs**. In the UK, ADHD medication (being mostly controlled drugs) is ideally initiated by a specialist, but ongoing prescriptions can be provided by the GP under a shared care agreement – a formal understanding that the GP will take over day-to-day prescribing once the patient is stable, while the specialist remains available for advice and annual review. Many Clinical Commissioning Groups/ICBs have shared care *protocols* for ADHD medication. However, some GPs have been reluctant to prescribe medication that was initiated by a private ADHD assessment, especially if the assessing doctor is not known to them or if they have concerns about the diagnosis accuracy. The General Medical Council's guidance states doctors should prescribe only where they have sufficient knowledge of the patient and believe the treatment is in the patient's best interestpmc.ncbi.nlm.nih.gov. Following a high-profile investigative report by BBC Panorama in 2023 (discussed in the next section) that questioned the reliability of certain private ADHD clinics, a number of GPs and NHS commissioners became even more wary of accepting private diagnoses and prescriptions.

As a result, **many patients diagnosed privately have been left in limbo without medication, because their GP would not prescribe and the private provider's initial prescription supply ran out**pmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov. Some patients resort to paying privately for medication (which can cost hundreds of pounds per month for stimulant drugs not available as generic), while others simply go untreated despite having a diagnosis. This represents a serious breakdown in care continuity. From the patient's perspective, it can feel punitive: they did what they were told (got a specialist evaluation), but are then denied treatment because of

administrative barriers. Some NHS mental health trusts also have policies refusing to "recognise" diagnoses made outside the NHS, or requiring an NHS re-assessment before accepting a patient into care – leading to duplication and waste of resourcespmc.ncbi.nlm.nih.govpmc.ncbi.nlm.nih.gov.

The independent sector boom has also created **quality variability**. While many private clinicians adhere to NICE guidelines and best practices, the lack of systematic oversight means there is potential for inconsistent diagnostic thresholds or suboptimal assessment processes. The BBC **Panorama** episode "Private ADHD Clinics Exposed" (aired May 2023) sent undercover reporters to three private providers and alleged that they were diagnosed with ADHD after only brief video consultations, with minimal examination of their history – in contrast, a NHS assessment they underwent did not diagnose ADHD. The programme suggested it was "too easy" to get an ADHD diagnosis privately, raising spectres of overdiagnosis or even stimulant misuse. This broadcast drew heavy criticism from patients and clinicians for oversimplifying the issue. Charities like the ADHD Foundation noted that **Panorama failed to adequately acknowledge the historic *under*-diagnosis and inequality of access that drove people to private clinics in the first place**. They pointed out that **NHS failures had forced patients to seek help elsewhere**, with *"more than half of new adult diagnoses"* being via private route and **"over 50% of these diagnoses in women"**, who have been especially under-served by NHS services. In other words, the private sector was filling a void left by the NHS; focusing on a few possibly lenient diagnostic practices risked discrediting the very real needs of thousands who sought private care after being unable to access NHS support.

Nonetheless, the Panorama program did spur action: it caught the attention of policymakers and likely was one impetus for NHS England establishing the ADHD taskforce to review service provision. It also prompted the Care Quality Commission (CQC) to inspect and, in some cases, sanction certain private providers. The situation thus presents a paradox: the NHS depends on private providers to handle overflow (especially via Right to Choose), yet there is no uniform system to ensure those providers meet quality standards or to smoothly incorporate their assessments into NHS care. The **fragmentation** is costly and confusing for patients and GPs alikepmc.ncbi.nlm.nih.gov.

Addressing this requires establishing **clear shared-care pathways** and mutual recognition. One recommendation is that **NHS England develop a national protocol for accepting externally-made ADHD diagnoses** – perhaps a standard template for private psychiatrists to communicate diagnosis details and treatment plans to GPs, and a requirement for ICBs to facilitate shared care if the private provider meets certain criteria (e.g. CQC-registered, using evidence-based assessment). Another approach is to harness the independent sector in a more coordinated way: for example, short-term contracts to outsource a portion of waiting

list cases to vetted providers, with the NHS retaining oversight (similar to how surgical waitlist initiatives use private hospitals). This could ensure quality control while using all available capacity to reduce waits.

From a workforce perspective, the shortage of NHS psychiatrists with expertise in adult ADHD is a bottleneck. Training more specialists will take time; in the interim, better use of other professionals could help. Specialist ADHD nurses or nurse prescribers can manage follow-ups, and GPs with extended roles (GPwERs) in ADHD could help manage stable patients. Integrating ADHD care into primary care for long-term management – analogous to how depression or diabetes are largely managed by GPs after initial specialist input – is a model worth exploring. But that will require upskilling and addressing GPs' reluctance. As it stands, many GPs feel ADHD is a "specialist-only" area, which is unsustainable given the prevalence of the condition. Overcoming the trust gap between NHS and private sector will be key to any solution: patients need a seamless pathway, not a turf battle. Shared care agreements, if uniformly adopted, would allow most patients to receive their ongoing prescriptions via their GP (improving convenience and cost), with periodic specialist reviews to adjust treatment as needed. This distributed care model can only work if specialists (NHS or private) and GPs operate as partners rather than in silos.

In summary, the rise of the private sector in adult ADHD care is a symptom of NHS undercapacity. It has increased access for some, but at the expense of coherence. Going forward, **a hybrid model** may be necessary – leveraging independent providers to meet demand *while* establishing national standards and ensuring that the NHS remains accountable for the patient's continuum of care. The Royal College of Psychiatrists has emphasized collaboration between sectors, noting the need to **"streamline communication and monitoring to support better outcomes for people with ADHD"**static1.squarespace.com. Breaking down barriers to shared care and ensuring every diagnosis (whoever makes it) can translate into treatment is vital to avoid wasting the opportunities created when patients finally get that long-awaited diagnosis.

Economic Impact of Untreated vs Treated ADHD in Adults

The personal stories of those navigating years without support illustrate profound individual costs – loss of employment, debt, relationship breakdowns, mental health crises, and sometimes conflict with the law. These individual threads add up to a significant economic and societal burden of adult ADHD that has been historically underestimated. Conversely, effective treatment and support for ADHD can yield substantial economic benefits by improving productivity and reducing strain on public services. Here we examine what is known about the cost of *not* addressing adult ADHD, and how this compares to the investments made in other chronic conditions.

Multiple analyses have found that **untreated ADHD imposes costs running into the billions**. A 2018 report by the think tank Demos concluded that for a country the size of the UK, the annual cost of ADHD is "likely to run into billions of pounds," with the **majority of costs stemming from adults** rather than childrendemos.co.uk. This might seem surprising until one considers that adults with ADHD often experience reduced income and productivity. Many are under-employed or unemployed: research shows adults with ADHD are significantly less likely to hold full-time jobs and tend to earn lower wages than those without ADHDdemos.co.uk. They also may rely more on welfare benefits. A detailed population study using Swedish and Danish registry data (comparing adults with ADHD to their non-ADHD siblings) quantified this economic gap: **adults with ADHD had on average €20,000 (~£17,000) higher costs per year** when considering lost income, extra health and social care utilization, and criminal justice expensespubmed.ncbi.nlm.nih.gov. They paid less tax and drew more from public resourcespubmed.ncbi.nlm.nih.gov. Similarly, a Danish study estimated the **average cost to society for an individual with ADHD at ~€16,000 per year**, rising to €23,000 if social benefits are includednews.ki.senews.ki.se. These figures are comparable to or exceed the per-person costs of many physical health conditions. For instance, **type 2 diabetes** – very common in adults – is estimated to cost the UK about £10 billion in direct NHS costs annuallyyork.ac.uk, roughly £2,000–£3,000 per patient per year on average. ADHD's costs, by contrast, are largely outside the NHS budget (in lost productivity, policing, etc.), but they accumulate to a similarly large order of magnitude. Put another way, failing to treat ADHD is expensive – the bill is just paid through prisons, welfare, and missed economic growth rather than through NHS invoices.

There is also evidence that untreated ADHD contributes to costs in the healthcare system indirectly, via comorbid conditions and complications. Adults with ADHD have higher rates of substance misuse disorders, which carry healthcare and societal costs (treating hepatitis C from IV drug use, accidents from alcohol misuse, etc.). They also have higher rates of smoking, and as noted, higher risk of obesity and related illnessesnews.ki.se – all of which can drive chronic illness expenditures

(e.g. cardiovascular disease). ADHD is over-represented among certain costly populations, such as inmates: one UK estimate put the extra cost burden of medical and behavioural issues in prisoners with ADHD at ~£11.7 million per yearbmcpsychiatry.biomedcentral.com. While that is a small slice, it highlights how the condition shows up in expensive public services when left unmanaged.

On the flip side, **effective treatment of ADHD in adults can be seen as an investment** that pays off. Studies have found that when adults with ADHD receive medications, they have fewer accidents and injuriespmc.ncbi.nlm.nih.gov, improved work performance, and reduced rates of comorbid depression and anxiety over timepmc.ncbi.nlm.nih.gov. A Swedish registry study famously showed that medicated ADHD patients had significantly lower rates of traffic accidents compared to when they were off medication, effectively closing the risk gap with the general population. Another study indicated that treating ADHD could markedly reduce criminality rates – for instance, one large trial saw criminal acts drop by 32–41% in medicated patients. These improvements translate to economic gain: fewer emergency visits, less burden on mental health crisis teams, more consistent employment and tax contributions.

It is also instructive to compare how the system treats ADHD versus other chronic conditions. **Depression**, for example, is similarly prevalent, and when untreated it exacts massive costs (the overall cost of mental ill-health in England is estimated at over £100 billion annually)lse.ac.uklse.ac.uk. The NHS response has been to invest in services like IAPT such that most patients can get at least some therapy quickly. In **hypertension** (high blood pressure) – another chronic condition often without immediately visible consequences – the healthcare system takes a proactive approach: GPs screen for it, monitor it long-term, and treat it to prevent strokes and heart attacks decades later. ADHD, by contrast, affects a few percent of adults and significantly elevates risk for various poor outcomes, yet it has not been managed in the same proactive fashion. There are no routine screenings or health checks for ADHD in adults (some have argued perhaps there should be, in high-risk groups). And rather than empowering primary care to manage it (as with hypertension or diabetes), the system has cordoned ADHD off into under-resourced specialist silos. The result is that we incur greater downstream costs when unrecognized ADHD leads to preventable job loss, addiction, or health problems.

From an economic perspective, **investing in adult ADHD services and treatment likely has a high benefit-to-cost ratio**. Treatment need not be terribly expensive: ADHD medications are mostly generic (methylphenidate has been generic for years; atomoxetine is generic; only lisdexamfetamine remains on-patent in the UK, discussed below) and GP follow-up for prescriptions is relatively low-cost. Non-medication supports (e.g. coaching or CBT-based group interventions) are also cost-effective in helping with employment skills and coping strategies. The main “cost” is the upfront expense of assessments and initiating treatment – but given the long-

term nature of ADHD, that cost is quickly offset by improvements in function. One analysis summarized it well: **"the human and financial costs of untreated ADHD represent a compelling case for investment, considering that effective long-term management benefits both the individual and the wider economy."**pmc.ncbi.nlm.nih.gov It is rare in healthcare to find an area where a modest investment (a few clinic visits and some pills) might return someone to productive employment or prevent years of mental health and social care utilization. Adult ADHD could be one of those high-yield areas, analogous to how providing insulin for type 1 diabetes prevents catastrophic complications – except here the "insulin" is methylphenidate and the complications are incarceration or chronic unemployment.

In planning services, policymakers should note that **the costs of scaling up ADHD care are far outweighed by the costs of leaving ADHD untreated**. Every year that tens of thousands go undiagnosed is another year of avoidable detriments adding to the nation's welfare bill and lost output. Especially in an era where the UK is striving to improve workforce participation and productivity, addressing adult ADHD could unlock potential in a segment of the population currently underutilized. Many adults with ADHD, once treated, describe it as transformative – they can maintain steady jobs, pursue further education, or simply manage daily tasks that were once constantly derailed. The aggregate economic gain from those individual transformations is hard to measure precisely, but likely substantial. As a point of comparison, consider that **mental illness overall costs the UK economy ~£118 billion per year** (Mental Health Foundation/LSE report, 2022)lse.ac.uk; ADHD is a piece of that pie that until recently was largely neglected.

In conclusion, the economic argument aligns with the moral and clinical one: **invest in diagnosing and treating adult ADHD, and the returns will be seen in healthier, more productive lives and reduced strain on public resources**. It requires short-term spending (on clinics, staffing, etc.), but much of this spending simply replaces what patients are currently forced to pay out-of-pocket privately, and it prevents larger expenditures elsewhere. Given the data at hand, adult ADHD should be viewed as a public health priority – similar to how we approach chronic physical illnesses – rather than a niche sub-specialty. Bringing it into the mainstream of NHS planning is both prudent and just.

Media Narratives and Public Perception

Public and media narratives about adult ADHD have oscillated between sympathy and scepticism, and these narratives have a powerful influence on policy and funding priorities. For many years, ADHD in general was subject to misunderstandings and stigma – often portrayed as an "American" over diagnosed condition or simply misbehaviour/laziness. In the UK media, stories about rising ADHD medication use or the role of pharmaceutical companies sometimes carried an undertone that ADHD might be a fad. This began to change as more high-profile figures shared their adult ADHD diagnoses and as investigative journalism shone light on the *under*-provision of services. But the tension between an **overdiagnosis narrative** and an **underdiagnosis/crisis narrative** remains evident.

The BBC *Panorama* program in May 2023, *"Private ADHD Clinics Exposed,"* was a watershed moment in recent discourse. By alleging that it was alarmingly easy to get an ADHD diagnosis privately (citing cases of possibly rushed assessments resulting in diagnosis), it tapped into public concerns about diagnostic inflation and stimulant medication misuse. The fallout was immediate: it prompted NHS England to announce its review of ADHD services, essentially acknowledging that something was amiss – either with the diagnoses or, as many pointed out, with the system that drove people en masse to private clinics. **Patient advocacy groups reacted strongly against the Panorama narrative**, arguing it presented a one-sided view that could harm genuine patients. The ADHD Foundation, for example, released a detailed rebuttal noting that Panorama failed to engage with patient-led groups and ignored the context of overwhelming NHS waiting lists. They emphasized that the **"historic inequality of access"** in NHS ADHD services has left **"1 in 20 children and adults"** living with ADHD without adequate care, fuelling a desperate resort to private options. In short, they argued the real scandal was not overdiagnosis, but the systemic neglect that made quick private diagnoses both necessary and, in a few cases, perhaps too superficial.

Media narratives have consequences. After the Panorama episode, there were anecdotal reports of GPs becoming more hesitant to accept any ADHD diagnosis (fearing it could be "wrong"), and some patients felt increased stigma – worried that friends or employers might think their diagnosis was not real. On the other hand, the program also inadvertently raised awareness; the ensuing conversation in newspapers and social media underscored how many people were struggling to get diagnosed at all. Publications like *The Guardian* ran pieces highlighting the massive waiting lists and the human toll of underdiagnosisadhdworks.infotheguardian.com. For instance, an investigation in *The Observer* (Oct 2023) revealed the controversial Yorkshire screening pilot that blocked 85% of ADHD referrals, framing it as the NHS "blocking" legitimate assessment requeststheguardian.com. Such coverage has

helped shift the narrative towards recognizing adult ADHD as a “real” condition with real unmet needs, countering earlier tropes of it being an overhyped label.

Another media theme has been scepticism about ADHD medications, especially stimulants. Periodically, headlines appear about record numbers of adults taking ADHD medication, sometimes with an implication of alarm. Indeed, the most recent NHS prescribing data showed **record-high dispensing of ADHD medications in England** (with adult prescriptions growing fastest) as of 2024. While this could be spun negatively, it actually reflects that more people are finally getting treatment they long went without. Some reports, however, raise the spectre of students abusing stimulants or diversion of meds – issues that are valid to monitor, but should be kept in proportion. The evidence so far in the UK does not indicate a large-scale problem of stimulant misuse via medical ADHD treatment; most medication is closely monitored, and the greater concern is that those who need it can’t get it.

The media also loves human interest angles – for ADHD, that has meant celebrity diagnoses or personal stories. Documentaries and interviews with figures like Mel Sykes, Johnny Vegas, and others discussing their late ADHD diagnoses have added a relatable face to the conditiontheguardian.comtheguardian.com. This tends to generate public empathy and normalize ADHD in adults as something that can affect anyone, not just hyperactive schoolboys (the old stereotype). Such narratives have likely contributed to more people coming forward to seek assessment, recognizing themselves in those stories.

We must also mention the role of **social media**, which the user question hints at through “media narratives.” Platforms like TikTok and Instagram have large ADHD communities. In fact, in 2023 #ADHD was reportedly one of the top health-related hashtags globallystatic1.squarespace.com. This has been a double-edged sword: on one hand, it’s been a source of peer support and disseminated information (sometimes accurate, sometimes not). On the other, there have been concerns about self-diagnosis and the spread of misinformation about ADHD online. NHS England’s taskforce noted the impact of social media in driving awarenessstatic1.squarespace.com, implicitly acknowledging that platforms have outpaced traditional healthcare in reaching people with ADHD-like symptoms. Some media articles have picked up on the “TikTok ADHD” trend, questioning if people are pathologizing normal distractibility. However, surveys suggest that most who seek an ADHD evaluation do meet criteria – the backlog is real illness, not a wave of the “worried well.”

Lastly, the media coverage of **medication shortages** (next section) has portrayed ADHD patients as victims of supply chain issues and even targets of unscrupulous supplement companies. A December 2023 *Guardian* article, for instance, highlighted how UK firms were exploiting the ADHD medication shortage by marketing unproven “smart supplements” to desperate patientstheguardian.comtheguardian.com. This

kind of coverage casts ADHD patients in a sympathetic light – people with a legitimate medical need, being failed by system shortages and even preyed upon. Such framing can help galvanize support for fixing issues like drug supply and counteract any notion that patients are simply drug-seekers.

In conclusion, public perception of adult ADHD in the UK is at a crossroads. Greater awareness and open discussion (including through media) have reduced stigma to a degree – it's far more common now to hear ADHD talked about as a genuine condition affecting adults. Yet, lingering scepticism and the periodic overdiagnosis alarms can influence decision-makers. Policymakers need to base decisions on evidence: and the evidence, as we have reviewed, indicates under-diagnosis and under-treatment are the predominant problems, not overdiagnosis. Media narratives should be actively corrected when they misinform. For example, after the Panorama programme, experts published responses and articles (in *The Guardian*, *BMJ*, and elsewhere) explaining the context and urging that we not "throw the baby out with the bathwater" by denying ADHD diagnoses to those in need. Continued advocacy and factual public communication are needed to maintain support for expanding services. A well-informed public that understands ADHD as a real, treatable neurodevelopmental disorder – one that society has long overlooked – will be more likely to back the necessary investments for improvement.

Ongoing Issues: Medication Shortages and Delayed Access to Generics

A pressing practical issue impacting adult ADHD care in the UK over 2023–2025 has been **severe medication shortages**. In late 2023, patients and clinicians across the country began reporting difficulties obtaining common ADHD medications from pharmacies. By October 2023, it was evident that a national shortage was underway, affecting both stimulant and non-stimulant medications. The Department of Health and Social Care confirmed supply problems with **methylphenidate prolonged-release preparations and some lisdexamfetamine products** from September 2023 onwardscheshireandmerseyside.nhs.ukcheshireandmerseyside.nhs.uk. The causes were twofold: an *increase in global demand* for ADHD meds (reflecting rising diagnosis rates in many countries) coupled with manufacturing constraintscheshireandmerseyside.nhs.uk. In plain terms, the production of these specialized medications had not kept pace with the exploding number of prescriptions.

The impact on patients has been substantial. By the end of 2023, **27% of UK patients in one survey had received no medication at all since September** (due to stockouts), and a further one-third experienced "long gaps" in treatment continuitytheguardian.comtheguardian.com. Patients who were stable on a particular medication often had to suddenly switch to whatever alternative was available – for example, someone on an extended-release methylphenidate brand might be given a shorter-acting version or an alternative stimulant, which can lead to suboptimal symptom control or new side effects. Others had to ration their remaining pills or take "drug holidays" not by choice but by necessity. NHS advisories even suggested that those who could safely do so should consider pausing medication on weekends or holidays to stretch supplycheshireandmerseyside.nhs.uk. For those on atomoxetine liquid (often children) or guanfacine, specific warnings were issued because abrupt stopping could be unsafecheshireandmerseyside.nhs.ukcheshireandmerseyside.nhs.uk.

Frontline providers found themselves scrambling – writing different prescriptions, hunting down stock at various pharmacies, and managing withdrawal symptoms or relapse of ADHD symptoms in patients who went without medication. This shortage has been a source of enormous anxiety for patients; many describe the return of debilitating symptoms when their medication lapses, impacting their work and family life. The knock-on effects include increased need for sick leave, and in some cases, mental health crises as people lose the stability that medication provided. The situation also created a ripe market for dubious solutions: as mentioned, supplement sellers started aggressively advertising "natural alternatives" to ADHD meds to parents and adults, a practice that NHS England leadership condemned as **"exploitative" and "irresponsible"**theguardian.comtheguardian.com.

By early 2024, the supply issues began to ease for some products, but **intermittent shortages are expected to be an ongoing risk** given the global pressures. As of April 2025, NHS England bulletins still noted a “national shortage of some ADHD medications” and variable availability across regionscheshireandmerseyside.nhs.uk. Ensuring a resilient supply chain for these drugs is now an urgent task. Possible measures include working with manufacturers to increase UK stock, allowing regulated importation of equivalent products from abroad during shortages, and encouraging new market entrants.

One structural factor in the UK is the patent status of key drugs. The **stimulant lisdexamfetamine** (brand name Elvanse in UK, Vyvanse in US) is a first-line medication for adult ADHD and has seen sharply increased use. In the US, generic versions of lisdexamfetamine started to appear after the patent expiry around 2023.

Takeda Pharmaceuticals' patent for lisdexamfetamine (marketed as Elvanse in the UK and EU) expired on June 1, 2024, in the European Union. This expiration has allowed for the introduction of generic versions of the medication in several EU countries, including Germany, where generics became available in autumn 2024 .

In the UK, while the patent also expired in 2024, there have been discussions about potential extensions or exclusivity rights that might delay the availability of generics until 2028 . However, the exact timeline for generic availability in the UK remains uncertain and may be influenced by regulatory decisions and market authorisations.Reddit

For context, in the United States, the patent for Vyvanse (the brand name for lisdexamfetamine) expired on February 24, 2023, with paediatric exclusivity extending until August 24, 2023 .

However, in Europe, the manufacturer (Takeda) has **extended its exclusivity in certain countries including the UK until 2028**reddit.com. This means no generic competition for Elvanse in the UK for several more years. The absence of generics matters for two reasons: cost and supply. A single supplier (Takeda) currently provides all lisdexamfetamine – any production hiccup or quota issue there directly translates to UK patients having no alternative source. With generics, supply tends to be more diversified. Moreover, generics typically reduce costs significantly. Lisdexamfetamine is one of the costliest ADHD drugs; having to rely on the brand until 2028 keeps prices high for the NHS. (By contrast, generic methylphenidate is relatively cheap and multiple companies produce it, which likely helped that supply recover faster.)

Thus, the **“delay in generic access”** to lisdexamfetamine is a policy and advocacy point. It appears that patent extensions were granted, which may have been to reward the development of the drug for binge eating disorder or other indications.

Regardless, the effect is that UK patients wait longer for affordable alternatives. Ideally, NHS could negotiate with the manufacturer to ensure better supply in exchange for that market exclusivity. The shortage has demonstrated the vulnerability of relying on a single source; going forward, the government might consider stockpiling critical medications or incentivizing local production for essential medicines like ADHD stimulants.

In addition to stimulants, the non-stimulant atomoxetine has had formulation-specific shortages (e.g. liquid form)cheshireandmerseyside.nhs.uk. Guanfacine (used more in children) also saw sporadic supply issues. The **pharmacy and wholesale system** sometimes exacerbated the problem, with uneven distribution (some pharmacies had excess stock, others none). NHS England did issue Medicine Supply Notifications and guidance to prescribers about switching and generic dispensingcpe.org.ukreddit.com. One positive change from the crisis has been encouraging prescribers to **write prescriptions generically** (e.g. “lisdexamfetamine capsules” rather than “Elvanse”), which allows pharmacists to dispense any available equivalent product, including imported ones, rather than the exact brandreddit.com. In one case, in mid-2024, a memo indicated that if there is a shortage of UK brand, a generic prescription could allow supply of an alternate product (though in practice the generic product might be an imported identical drug from another country)reddit.com.

Medication shortages not only harm patients but can undermine trust in the healthcare system. It is hard to convince the public that ADHD is being taken seriously when those who are already diagnosed and stable cannot reliably get the pills that keep them well. The government and NHS have been somewhat reactive on this front; moving forward, a proactive strategy is needed. This could involve closer monitoring of ADHD prescribing trends and working with drug regulators to adjust production quotas (notably, in the US, the DEA sets amphetamine production quotas which affected Vyvanse supply – they later raised the quota when shortages hitusnews.com). In the UK, consultations with industry might identify pinch points early.

From a patient perspective, transparency is key. During the shortage, many patients reported getting little information on when their medication might be back, or whether it was a local pharmacy issue or national problem. Publishing timely updates (as some NHS regional teams did on websites by late 2024) is helpfulberkshirehealthcare.nhs.uk. Also, ensuring clinicians have clear guidance on how to manage treatment during shortages – including which alternative medications to consider – can reduce unsafe or ad-hoc practices.

One silver lining is that the medication shortage brought the ADHD community together to amplify their voice. Surveys by ADHD UK on the impact of the shortage gained media tractiontheguardian.com, and even MPs have raised questions about medicine supply security. It underscored that ADHD medication is not a luxury or

convenience – for many, it is as essential as insulin for a diabetic. The hope is that by 2025, the worst of the shortages will be behind us, but vigilance remains necessary.

In summary, the recent ADHD medication shortages have highlighted systemic issues in pharmaceutical supply and the need for contingency planning. They have also added a layer of strain on patients and clinicians already battling service shortfalls. Addressing adult ADHD care must include ensuring that when a patient is finally diagnosed and given a treatment that works, something as basic as a supply chain problem does not then derail their progress. **Guaranteeing reliable access to prescribed medications** is a fundamental component of quality care, and the NHS – perhaps in partnership with the Department of Health and regulators – should treat stimulant medication supply as a priority area to safeguard, just as it would for medications treating other long-term conditions.

The NHS ADHD Taskforce and Institutional Efforts

Recognizing the multifaceted challenges outlined above, various institutions have begun concerted efforts to reform ADHD care. Chief among them is the **NHS England ADHD Taskforce**, established in 2023. This taskforce represents the first national review of ADHD services in England, indicating a top-level acknowledgement that the status quo is untenable. Led by senior NHS officials (including an ADHD Programme Director) and including clinicians, academics, and patient representatives, the taskforce has set out broad objectives: **to evaluate current service provision, understand the drivers behind increased demand, and develop recommendations to improve access and outcomes**static1.squarespace.com. Importantly, it is adopting a cross-sector lens – engaging not just healthcare providers, but also education, social care, and justice system stakeholdersstatic1.squarespace.comstatic1.squarespace.com. This approach aligns with the understanding that ADHD's impact transcends health alone and that solutions may involve schools (early identification), employers (workplace support), and even policing and criminal justice (diversion and treatment programs).

By March 2024, the taskforce had conducted evidence gathering and heard testimony from experts and patient groups. Interim communications highlighted some key points: ADHD had become the **second most-viewed health condition on the NHS website in 2023 (after COVID-19)**static1.squarespace.com, reflecting the explosion of public interest. Social media trends (like #ADHD on TikTok) were acknowledged as part of the phenomenonstatic1.squarespace.com. The taskforce emphasized the urgency of improving data collection – the NHS's chief delivery officer admitted that understanding the "scale of the challenge" requires better metrics and trackingstatic1.squarespace.comstatic1.squarespace.com. We can expect the taskforce's final report to call for a comprehensive strategy akin to a "national ADHD action plan."

Concurrently, the **Royal College of Psychiatrists (RCPsych)** has been active in this space. The RCPsych's Faculty of Neurodevelopmental Psychiatry (established in 2021) provides guidance and training on adult ADHD and related conditions. Dr. Ulrich Müller-Sedgwick, an RCPsych spokesperson, welcomed the NHS taskforce and stressed the need for **data-driven decision making and a national ADHD data improvement plan**static1.squarespace.com. He also highlighted the critical role of psychiatrists in developing effective care pathways and the importance of investing in **workforce development** to meet ADHD needsstatic1.squarespace.comstatic1.squarespace.com. The College appears committed to collaborating with NHS England and government on implementing the taskforce's forthcoming recommendationsstatic1.squarespace.com. This is notable, as historically not all psychiatrists welcomed the expansion of ADHD services (some saw it as diverting resources from "serious mental illness"). The current RCPsych

stance is clearly that ADHD must be part of core business and that enhancing care will “fundamentally reshape the landscape of ADHD care” for the betterstatic1.squarespace.com.

Other institutional efforts include work by the **National Institute for Health and Care Excellence (NICE)** – while the ADHD guideline was last updated in 2018, there are calls for another update to address emerging issues (e.g. the guideline does not currently cover how to manage transitions from private to NHS care, or what to do in medication shortages)adhdworks.infoadhdworks.info. Some have recommended NICE produce more detailed standards for what constitutes a quality ADHD assessment and treatment plan, which could help unify approaches across providersadhdworks.infoadhdworks.info. For example, ensuring every patient gets a comprehensive treatment plan (as NICE already suggests) should be audited in practiceadhdworks.info. The NICE guideline does mention providing psychoeducation and considering comorbidities, but implementation is spotty.

The **All-Party Parliamentary Group (APPG) for ADHD** (and Neurodiversity) has also been a forum for raising issues. This informal group of MPs and Lords has hosted discussions on ADHD in education, police training for neurodiversity, and the need for research. While APPGs have no formal power, they signal political interest. It is worth noting that in 2022, the Parliamentary Health Service Ombudsman published a case report highlighting failures in an adult ADHD referral that led to years of delay and distress, recommending service improvements – so even ombudsman bodies are aware of the issues.

Moreover, independent charities and patient advocacy organizations have been crucial. **ADHD UK**, **ADHD Foundation**, and **ADDISS** have collected data, produced reports (like the waiting list FOI study cited earlier), and engaged with the media and policymakers. These groups often act as a voice for patients in institutional discussions. For instance, ADHD UK was involved in consultations around the NHS Payment Scheme changes threatening Right to Choose, ensuring patient objections were heardadhduk.co.ukadhduk.co.uk.

One specific output to watch for is the taskforce’s recommendation on **data infrastructure**. Given only 21% of ICBs could supply waiting list data, it is likely the taskforce will push for systematic data reporting for ADHD (e.g. require ICBs to regularly report number of referrals, waits, outcomes). This alone would be a game-changer for accountability, much as published waiting times have kept pressure on elective surgical services. The taskforce is also expected to address **medication supply** – stakeholders have urged it to review the causes of the 2023 shortages and how to prevent recurrencesadhdworks.info.

The timeline for change may hinge on political will. Mental health has been a campaign topic, and neurodiversity in particular has gained political salience (e.g.

debates on whether to screen for ADHD in prisons, or provide more SEND support in schools). If the taskforce delivers a strong report, the government could adopt it as part of an NHS improvement plan.

In the devolved nations (Scotland, Wales, Northern Ireland), similar issues exist. Scotland, for example, commissioned a report in 2022 on neurodevelopmental services and is exploring a unified approach. There is a Scottish ADHD Coalition pushing for better adult services. Wales has an “Neurodevelopmental Service” approach that combines autism/ADHD in some health boards, but long waits are reported there too. These regions will likely look to England’s taskforce as a model or warning, depending on outcomes.

In summary, after decades of neglect, **adult ADHD is finally on the radar of NHS leadership and policymakers**. The ongoing taskforce and related institutional efforts represent a chance to design a more rational, fair system. It is a complex endeavour: aligning NHS bureaucracy, clinical practice, and patient expectations will require reconciling the needs and constraints of multiple sectors. But the very existence of these efforts is a positive sign. As one might say, “the first step to solving a problem is recognizing there is one” – and the UK has, at last, officially recognized that adult ADHD care is a problem in need of solving.

Recommendations and Proposed Models of Care

The analysis above lays bare a stark reality: while scientific understanding and public awareness of adult ADHD have advanced, the healthcare system has lagged far behind in translating that into accessible care. To close this gap, a multi-pronged reform is necessary. Here we present key recommendations and potential models of care, informed by the evidence and issues discussed, aiming to guide policymakers, NHS leaders, and clinicians in building a system that can meet the needs of adults with ADHD. The overriding principle is that ADHD, as a common and impactful disorder, must be **"mainstreamed" into routine healthcare pathways** rather than treated as an orphan condition. This will require bold changes in commissioning, workforce training, and service design.

1. Establish a National ADHD Strategy with Targets: A comprehensive **England-wide (or UK-wide) Adult ADHD strategy** should be developed, akin to existing strategies for cancer or diabetes. This should set clear targets: for example, a maximum waiting time standard for ADHD assessments (e.g. no one waits more than 12 months by 2026, moving to 18 weeks in line with NHS standards eventually). It should mandate routine data collection on referrals, waiting times, and outcomes for ADHD servicespmc.ncbi.nlm.nih.gov. Key performance indicators can drive investment – what gets measured gets done. Without explicit targets, ADHD will continue to be deprioritized. The strategy should also address regional inequities by requiring each ICB to have an adequate ADHD service provision (whether in-house or via commissioned partners) so that **no area is left with "no service"** as is currently the caseadhdworks.info. This might involve pooled budgets or resource-sharing for smaller regions.

2. Increase Dedicated Funding and Workforce Expansion: Meeting any targets will require **investment in capacity**. The NHS must allocate ring-fenced funding to significantly expand adult ADHD assessment and treatment slots. This could take the form of establishing new specialist clinics or bolstering existing ones with additional staff (psychiatrists, ADHD nurse specialists, psychologists, occupational therapists). Given the workforce constraints in psychiatry, innovative staffing models are needed – for instance, training more **nurse practitioners or clinical psychologists to conduct ADHD assessments** under supervision, freeing psychiatrists to oversee and manage complex cases. Incentives (like training bursaries or retention bonuses) could encourage more clinicians to subspecialize in ADHD. Moreover, involving **primary care** is crucial: a cadre of GPs with extended roles in ADHD could be developed, who receive extra training and can manage straightforward cases or follow-ups in the community. This mirrors how some GPs handle things like substance misuse or dermatology. Over time, as competence increases, much of ADHD management (especially follow-up of stable patients) could occur in primary care, with specialists focusing on new diagnoses or

complicated cases – similar to a chronic disease model where specialists guide and GPs treat day-to-day.

3. Integrated Care Pathways and "Hub-and-Spoke" Model: We recommend an integrated care pathway that connects primary care, specialist services, and other supports. One model to consider is a **"hub-and-spoke" system**: each region (hub) has a core multidisciplinary ADHD team (psychiatrist, psychologist, nurse, social worker) that does initial assessments and formulates care plans. They then work with spokes – e.g. local GPs or mental health practitioners – who deliver ongoing care closer to the patient. Telehealth can be leveraged to extend specialist reach to remote areas (something learned during the pandemic and by Right to Choose providers). Importantly, **transition from CAMHS** should be formally built into this pathway: e.g. joint clinics for 17-year-olds, or an overlapping age range clinic (16–25) that bridges youth and adult mental health services. No young person should be discharged from CAMHS without either being confirmed as not needing further care or having a secured adult service appointment (a standard that could be audited).

4. Preserve Patient Choice while Ensuring Quality: If the NHS England changes remove the current Right to Choose, alternative means of expediting care are needed. One solution is to **centrally commission a cohort of independent providers to help clear the waiting list**, rather than leaving it to individual patient choice. For instance, a national procurement could allow vetted private clinics to take on, say, 20,000 NHS patients for assessment over the next year, paid by the NHS. This would be analogous to how private hospitals have been used to clear surgical backlogs. However, to ensure quality and consistency, those providers should follow standardized assessment protocols, use shared electronic record systems if possible, and communicate results to NHS GPs in a structured format. The goal is to integrate them as an extension of the NHS, not a separate silo. In parallel, the NHS should strengthen its **quality requirements**: perhaps develop an accreditation for ADHD service providers (NHS or private) that meet criteria in diagnosis and management. Patients should still have some choice – choice can drive competition and quality – but it should be an *informed* choice among quality-assured options.

5. Improve Shared Care and GP Involvement: To address the GP prescribing reluctance issue, a national template for **shared care agreements** for ADHD medication should be adopted across all ICBs. GPs need reassurance and support to take on prescribing. This could include training sessions on adult ADHD for GPs, an advice hotline or email where GPs can quickly get consultant input on ADHD medication issues, and clarity that if a private diagnosis meets accepted standards, it is not outside their remit to prescribe (perhaps backed by guidance from NHS England or the GMC). Some areas have employed **"shared care facilitators"** – nurses or pharmacists who liaise between specialist and GP to ensure smooth handover. This could be implemented widely. Ultimately, taking ADHD prescribing into primary care (once the patient is stable) will benefit everyone: it normalizes

ADHD as a chronic condition managed like others, and it frees specialist time for new patients. Commissioners should also ensure that **private providers arrange shared care** – maybe making NHS funding contingent on them providing the GP with necessary info and support for prescribing, to avoid dumping patients back onto waiting lists.

6. Address Medication Supply Proactively: The NHS, possibly together with MHRA and the Department of Health, should develop a **risk mitigation plan for ADHD medication supply**. Concretely, this could involve maintaining a strategic reserve of key medications (especially stimulants) that can be deployed to areas facing shortages. Authorities should engage with manufacturers: for example, requesting that the sole supplier of lisdexamfetamine provide regular reports on supply status, and consider secondary suppliers or early introduction of generics via license agreements if shortages persist. By 2028, when generics for lisdexamfetamine are expected, the NHS should encourage multiple entrants to prevent monopolies. Pharmacists should be given more flexibility to substitute equivalent products (as was guided during the shortage) without bureaucratic hurdles. Lessons from 2023 should be compiled into an action list (the taskforce can incorporate this) so that if demand spikes again, response is swift. Fundamentally, medication treatment is central to ADHD care; guaranteeing its availability is as important as the diagnostic services.

7. Holistic Post-Diagnostic Support: Diagnosis and medication are not the whole story. A robust model of care would also include **psychoeducation and psychosocial support** for adults with ADHD. Many NHS clinics currently struggle to provide anything beyond diagnosis and drug titration due to resource constraints. We recommend commissioning **post-diagnostic ADHD groups or workshops** (these could be delivered once a month in each area, potentially by third-sector organizations with NHS support). Topics should include understanding ADHD, strategies for organization and time management, managing emotional dysregulation, etc. Additionally, facilitating access to **coaching or peer mentoring** could greatly help patients translate treatment into functional gains. Employers and educators could be engaged by providing them guidance on adjustments for people with ADHD. While these might seem outside “medical” care, they pay dividends in outcomes – for instance, helping someone maintain a job will improve their mental health and reduce relapse into depression or anxiety.

8. Research and Innovation: As part of reform, it’s worth investing in **implementation research** to find the best approaches. The NHS could pilot different models (e.g. a primary-care-led ADHD clinic in one region vs. a specialist-led in another) and compare outcomes like wait time reduction, symptom improvement, and patient satisfaction. Also, studying the cost-effectiveness of interventions (does

spending X on clearing waiting lists yield Y savings in other areas?) will help build the business case for sustained funding. Technological solutions could be explored: could some of the assessment process be streamlined with digital tools (without resorting to crude “screening out”, but maybe using online history-taking questionnaires to aid clinicians)? Could smartphone apps help patients with medication reminders or symptom tracking, feeding back data to clinicians for review during check-ups? Embracing innovation could improve efficiency and patient engagement.

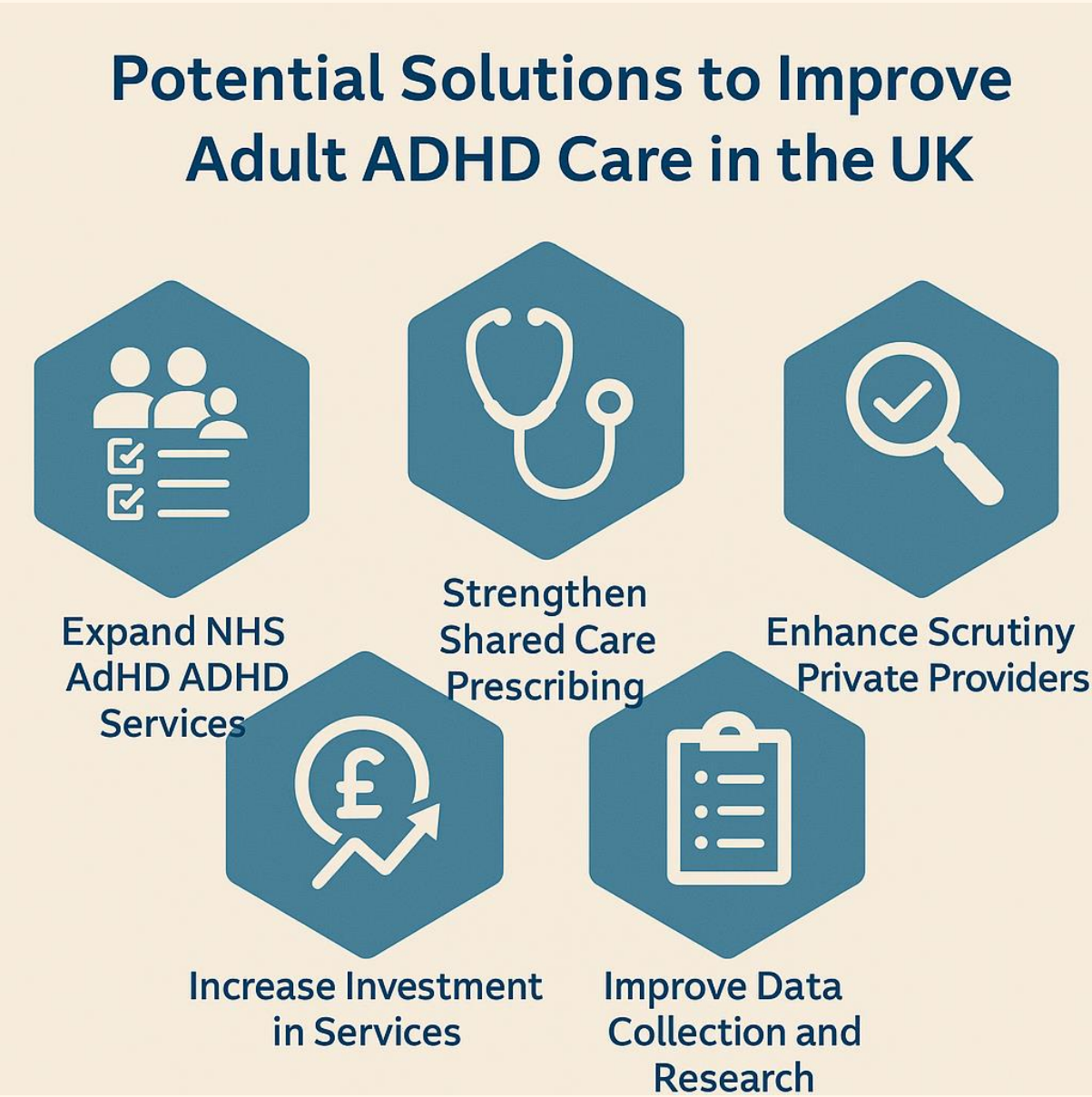
9. Public and Professional Education: To underpin all this, an **awareness campaign** is needed – not to create more demand (demand is already high) but to improve understanding and reduce stigma. The Demos report in 2018 called for a government awareness campaign for adult ADHDtheguardian.comtheguardian.com. This could involve updated NHS website content (the taskforce noted the NHS ADHD webpage was outdated and due for reviewadhdworks.info), leaflets in GP surgeries about adult ADHD, and media messaging that balances the narrative (highlighting the risks of non-treatment as much as any risks of overdiagnosis). Within the NHS, training modules on adult ADHD for GPs, mental health practitioners, and even psychiatrists in training should be bolstered. A cultural shift is needed so that an adult presenting with classic ADHD symptoms in primary care is identified early and referred appropriately, rather than bouncing between services with misdiagnoses. Improved professional education can also guard against the pendulum swinging too far in the direction of overdiagnosis – by emphasizing careful, criterion-based assessment including gathering collateral history (so that those without ADHD are correctly reassured or directed to alternate help).

10. Monitoring and Continuous Improvement: Finally, any new measures must be continuously audited and refined. The NHS ADHD Taskforce should not dissolve after publishing a report; it or a successor body should steer implementation and check progress. There could be an **annual report on ADHD services** to Parliament or at least to NHS boards, tracking key metrics (wait times, number treated, patient outcomes such as employment status or quality of life changes). Engaging patients in co-production of services can ensure they remain responsive to needs – for example, patient panels at the ICB level could review plans for ADHD services and give feedback. As services improve, it will also be important to communicate that success: demonstrating stories of lives changed when systems work can reinforce the commitment to see this through.

In conclusion, these recommendations aim for a **future state where adult ADHD care in the UK is timely, evidence-based, and equitable**. Imagine a scenario five years from now: an adult who suspects they have ADHD can see their GP and be taken seriously; if criteria are met, they are referred and seen within a few months by a specialist team. They receive a thorough assessment, a diagnosis, and a holistic treatment plan. Medication is initiated and titrated to good effect. Their GP, under a

shared care plan, continues prescriptions and monitors their progress, with specialist backup as needed. The patient has access to support groups or coaching that help them with practical life strategies. They do not face undue bureaucratic hurdles, and their condition is respected just like any other medical condition. Meanwhile, fewer people are reaching breaking point before getting help; young people transitioning to university or work have continuity of care. Such a vision is ambitious but achievable – it mirrors what countries like Sweden or some parts of Canada provide, and indeed what the NHS already provides for other conditions.

The moral case is clear: adults with ADHD deserve the same standard of care as those with depression, diabetes, or hypertension. The economic case is convincing: invest now to save later, unlocking human potential that is currently wasted. The pieces (policy focus, expert consensus, patient advocacy, and growing awareness) are coming together in 2025. What is needed next is the political will and managerial drive to implement these changes. The NHS has a proud history of rising to meet public health challenges; with concerted effort, adult ADHD could transform from a “Cinderella service” into a exemplar of modern, integrated care for a neurodevelopmental condition. It is time to act decisively – the thousands of individuals and families affected by adult ADHD have waited long enough. pmc.ncbi.nlm.nih.govdemos.co.uk


Potential Solutions to Improve Adult ADHD Care in the UK
Expand NHS AdHD ADHD Services
Strengthen Shared Care Prescribing
Enhance Scrutiny Private Providers
Increase Investment in Services
Improve Data Collection and Research

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