THE COLLAPSE OF ADHD CARE IN THE UK & IRELAND

The Quiet Collapse of ADHD Care — And What It Reveals About the UK

I am a doctor working in adult ADHD services in the UK. I also have ADHD myself. That dual perspective means I spend my days navigating the system both professionally and personally. Increasingly, what I see is difficult to reconcile with what the system is supposed to be.

We are not simply dealing with pressure on services. We are watching a system quietly fail.

ADHD affects around 3–5% of adults. It is not rare. It is not emerging. It is not controversial in the scientific sense. It is a well-characterised neurodevelopmental condition with robust evidence for treatment, particularly pharmacological treatment. And yet, across large parts of the UK, access to that treatment is inconsistent, delayed, or entirely absent.

The gap between need and provision is no longer subtle. It is structural.

On paper, the UK model is sound. Patients are assessed by specialists, stabilised on treatment, and then transferred into primary care under shared care agreements. This allows ongoing prescribing and monitoring to occur within the NHS, preserving specialist capacity and ensuring continuity of care. It is a rational system, endorsed by NHS England and embedded in national guidance.

But the system depends on one critical assumption: that shared care actually functions.

Increasingly, it does not.

Across England, shared care has become variable and unreliable. In some areas, it works well. In many others, it is breaking down. General practitioners are declining to prescribe, particularly where diagnoses have been made privately. The reasons are understandable — concerns about clinical responsibility, controlled medication, and variability in diagnostic standards — but the outcome is not.

Patients who have been appropriately diagnosed and stabilised are being told, often bluntly, that their treatment will not continue within the NHS.

And so the burden shifts. Not to another service, but to the patient.

And this is where the reality becomes impossible to ignore.

On the NHS, ADHD medication costs **£9.90 per month — or nothing at all if exempt**.

Privately, that same medication costs **£50 to £150 per month**, sometimes more depending on drug and dose. That is not a marginal difference. It is a complete transfer of cost from system to patient.

What was designed as a publicly funded, lifelong treatment pathway is quietly becoming a pay-per-month condition.

The surge in private ADHD diagnosis is often framed as the problem. It is not. It is a predictable response to a system that cannot meet demand.

Referrals into NHS services have risen dramatically over recent years. Waiting lists now extend into years, and in some cases, close to a decade. Faced with that, patients are doing exactly what we would expect them to do: seeking help elsewhere.

Private providers have stepped in to meet that demand. Assessment volumes have increased exponentially. In some regions, a substantial proportion — in places, the majority — of new ADHD diagnoses now originate outside the NHS.

This is not an aberration. It is a release valve. The real problem is what happens next.

Shared care was supposed to integrate these pathways. Instead, it has become the point at which the system fractures. When GPs decline to engage, patients are left in a position that is clinically precarious and financially burdensome. A chronic condition requiring long-term treatment becomes contingent on ongoing private payment. At that point, we are no longer operating a universally accessible healthcare system.

What is perhaps most striking, however, is how this compares to other Western European countries.

Across much of Western Europe — countries such as France, Germany, and the Netherlands — ADHD care is more consistently embedded within public healthcare systems. Access is not perfect, but there is a clearer expectation that diagnosis and ongoing treatment are state responsibilities. The idea that large numbers of patients would be diagnosed and then effectively excluded from publicly funded prescribing is far less common.

The UK, by contrast, appears to be drifting into a uniquely fragmented position: a formally universal system that increasingly relies on private provision to function.

And then there is Ireland.

Ireland presents a different, and in some ways more stark, picture. Public adult ADHD services are extremely limited. In many areas, they are effectively absent. The private sector is not simply an overflow mechanism — it is the primary route to care.

What is striking is how normalised this absence has become.

Where the UK still operates under the assumption that ADHD care should exist within a public system, Ireland often operates without that assumption at all. The result is a system where diagnosis and treatment are, in practice, private by default.

The contrast is uncomfortable.

In the UK, we have built a system that was meant to provide care, but is increasingly failing to deliver it consistently. In Ireland, the system has not been built to deliver that care at scale in the first place. In Western Europe, there is generally greater alignment between need and provision.

We now sit somewhere in between — and that ambiguity is where the problem lies.

From a clinical perspective, this matters.

ADHD is not episodic. It is not optional. It requires sustained treatment. When medication is withdrawn or inaccessible, patients deteriorate — in work, in relationships, in mental health. The consequences are not abstract. They are lived.

From a professional perspective, it is increasingly difficult to justify.

I find myself explaining to patients why a system that has diagnosed them may not treat them, why geography determines access, and why their ability to pay now dictates whether they remain stable on medication.

These are not explanations that sit comfortably within the ethos of the NHS.

And yet, they are becoming routine.

Perhaps the most concerning aspect of all this is how quietly it is happening. There has been no single decision, no formal redesign. Just a gradual erosion of shared care, a surge in demand, and a parallel expansion of private provision.

Individually, each step is understandable. Collectively, they amount to transformation.

We are moving, without saying so, from a universal healthcare model to a hybrid one — where ADHD is treated publicly in theory, but privately in practice.

The question is whether we are prepared to acknowledge that.

Because if ADHD care is to remain part of a genuinely universal healthcare system, then shared care cannot remain optional, specialist capacity cannot remain static, and patients cannot continue to absorb the financial consequences of systemic failure.

If not, then we should at least be honest about what the system has become.

Because right now, the reality is simple.

For ADHD in the UK, the difference between stability and struggle may be nothing more than whether you can afford £100 a month.

Dr Alan Cross (9th April 2026)