Report of the independent ADHD Taskforce: Part 1

April 2025

Contents

Abbreviated summary

ADHD, when unsupported, is a potent route into educational failure, long-term unemployment, crime, substance misuse, suicide, mental and physical illness[1–5]. Economic costs to individuals and the government of at least £17 billion[6] are avoidable as, when appropriately supported, people with ADHD can thrive and fully engage in a working life. This is a brief summary of our key recommendations.

1. There is robust evidence that **ADHD is not the remit of health alone**. Policies, budgets, spending, service plans and the collection of routine data need to span departments and agencies across all levels from government to locality.

2. **Support for ADHD and neurodivergence should begin early.** This should be needs-led, begin in preschool or school and not rely on or require clinician provided diagnosis.

3. **An entirely specialist, single diagnosis model is not sustainable or evidence informed.** In England, clinician-defined ADHD is under-recognised, under-diagnosed and under-treated[7–9], although we recognise that may not be the case in some parts of the world. ADHD frequently co-occurs with autism and neurodevelopmental disorders[10] and mental health disorders[5] and is common, with a population prevalence of 3–5%[11,12]. Given the established adverse outcomes and costs of unsupported ADHD, there is an urgent need to address early determinants of adverse outcomes and reduce waiting times in cost-effective, evidence-supported ways. ADHD NHS waiting times will continue to escalate, so cannot be ignored. We recommend a holistic, stepped, joined-up, generalist approach, with adequately-resourced primary care and secondary health care, local authorities and the voluntary/community sector to enable both initial needs-led holistic support and the fast-tracking of those with severe ADHD or whose functioning does not improve with first-line non-pharmacological intervention[13] to high-quality clinical diagnostic assessment and medication.

4. **ADHD services need to be digitised and data improved.** We urge government to include ADHD health services in its 10 year plan for digitisation to make processes efficient. Data need to be systematically gathered across sectors to inform service planning and monitor quality (under and over-diagnosis). We also recommend that NICE (National Institute for Health and Care Excellence) prioritise rapid assessment of digital products for clinical effectiveness and value.

Executive summary

The independent ADHD Taskforce was commissioned by NHS England in 2024. This was due to serious concerns about access to timely support, the impacts, risks (e.g. suicide, crime) and avoidable costs of unsupported ADHD (e.g. welfare, benefits, long-term unemployment)[14]. It was tasked with (1) considering how services and support across health, education, justice and the whole of society need to be transformed to ensure those with ADHD are able to access timely, appropriate, effective and high-quality support beyond health alone, and live to their full potential, as well as (2) making recommendations on a whole system approach to managing ADHD. Societal changes in attitude and the provision of appropriate support can enable people with ADHD to engage successfully in education and work and participate fully in society.

Given the urgency for action, and the need for recommendations to be considered in the 2025 Spending Review, we provide Part 1 of our report. This report provides initial evidence-informed recommendations to be addressed now and in the longer term. These align with the government's three key health priorities (from hospital to community, prevention and digitalisation) and wider missions. We have shared our work with the Department for Education's (DfE) Neurodivergence Task and Finish Group and the Department for Work and Pensions' (DWP) Academic Panel on Neurodivergence, who will consider issues relating to education and employment policy in more detail.

1. **ADHD impacts are seen across sectors.** ADHD is not solely the remit of the NHS and other health-care providers. Education is a vital sector in terms of identifying and meeting needs at an early stage, and education policy may be a driver for demand on the NHS, as it has been evidenced to be in parts of the USA. Other sectors involved include the workplace, job centres, higher education and vocational training and social services (e.g. looked after children). It also includes the criminal justice sector that includes very high rates of young people and adults with ADHD and other types of neurodivergence, as both offenders and victims. ADHD is commonly misunderstood or not recognised, contributing to inequalities across all sectors. Staff in different sectors may not have received training on early recognition and support of ADHD and neurodivergence. Different sectors frequently work in isolation from each other, typically with separate funding streams.

   We need cross-agency and cross-government department working focused on the whole person.

2. **ADHD is a potent, early route into multiple adverse and costly outcomes across different sectors.** It thus represents an important early prevention target. ADHD is associated with higher risks of educational failure, not in education, employment or training (NEET), long-term unemployment, welfare costs, early entry into the criminal justice system, family breakdown, chronic mental health problems, self-harm, suicide, substance misuse, obesity, chronic physical illnesses (e.g. cardiovascular disease) and premature mortality[15,16]. With early, needs-led support in childhood and timely clinical intervention, when required, many of these impacts and costs can be successfully avoided[e.g.17,18].

3. **ADHD can be viewed as lying along a spectrum (neurodivergence) as well as a clinical diagnosis (disorder)**. A clinical diagnosis of ADHD via the NHS/health is required for certain clinical decisions (e.g. medication) in health-care settings but **not** for characterising early needs and informing appropriate support in other settings[19]. This includes those who fall just below or near the diagnostic threshold.

   We need timely recognition and early support of suspected ADHD and neurodivergence across all settings. This is especially important in schools and the early years, to prevent adverse impacts and costly outcomes in the future. This should be **needs-led** and not require a clinical diagnosis.

For those who require clinical intervention (e.g. high-risk, medication likely needed), the backlog of those waiting needs to be cleared urgently to avoid increased unnecessary costs elsewhere (e.g. repeated A&E use, prisons, long-term sick, unemployment, clearing even longer wait lists in the future): an invest to save model.

4. **ADHD is common and treatable but costly when unsupported.** ADHD, defined using diagnostic criteria (e.g. DSM-5), after a high-quality assessment, affects 3–5% of the population[11,12]. Although it originates in childhood, the impacts of ADHD are observed across the individual's lifespan[5]. Despite the effectiveness of treatment for those who meet diagnostic criteria[13] (psychoeducation, environmental adaptations for all; pharmacological treatments when impairment remains) and consistency of robust scientific evidence on its impacts and costs, ADHD can be downplayed and is prone to misinformation. Currently, the estimated economic costs of not treating ADHD are around £17 billion to the UK economy[6] (e.g. less tax contributions, in receipt of more state benefits, more likely to be not in education, employment or training (NEET) or long-term unemployed and higher costs for health, social care and criminal justice). English population data show that among young people who are NEET, 20–34% are likely to have ADHD, most of whom will not be diagnosed[3,20]. Many of these costs are avoidable, as with appropriate, early support, people with ADHD can thrive.

5. **ADHD under or over-diagnosis in the UK?** England and the rest of the UK have much lower service recognition and treatment rates of ADHD diagnosis compared with other European countries (e.g. Norway, Denmark, Spain)[7–9]. Recent data show a very high level of under-recognition and under-treatment of strictly diagnosed ADHD, with significant inequalities in access to care (e.g. minority groups). For example, for those who meet strict diagnostic criteria for ADHD, fewer than one-third of children have contact with any type of mental health service[7], and only 15–25% of adults and children obtain pharmacological treatment[9]. This means that demand on services is very likely to continue to rise. There is also concern by some about potential over-medicalisation and over-diagnosis and a lack of regulation of ADHD service providers as this has been reported in some parts of the world. Some also raise concerns about ADHD self-diagnosis based on information from social media. However, currently there is no good evidence on what percentage of those waiting to see a clinician have self-diagnosed ADHD using social media and eventually meet or do not meet ADHD diagnostic criteria after a high-quality assessment. We only know currently that in England, recognised rates of ADHD are lower than the expected prevalence of ADHD. Early needs-led support that is uncoupled from clinician diagnosis, provision of non-pharmacological support, strict regulation of ADHD clinical service providers and high-quality data to enable monitoring of diagnosis and treatment rates across all services will be important for allaying such concerns.

6. **Waiting times for NHS ADHD services have escalated and are unacceptably long.** Significant research gaps exist in determining ADHD prevalence and incidence nationally and internationally; the reasons for increased demand for ADHD assessments in

England, which has been replicated across most Western countries, are unclear and complex. In England, it is likely due to multiple factors, including greater awareness, changes in DSM-5 and ICD-11 diagnostic criteria that are reflected in changes to NICE guidelines (e.g. co-diagnosis with autism is now allowed), previous missed or misdiagnosis, especially among females[21], impacts of the Covid-19 pandemic[22,23], the perceived requirement for a diagnosis to access support (e.g. education) and more recent scientific evidence that ADHD is not restricted to childhood, but often persists across adult life[24]. This means adults who were missed as children are now presenting to services. Waiting times for NHS services are increasing (up to 4+ years for children, up to 8+ years for adults) and demand outstrips the capacity of services. These services require modernisation to improve efficiencies, as well as join-up with other sectors, as not all support needs to be provided by health care.

ADHD assessment and treatment in England, as recommended by the National Institute for Health and Care Excellence (NICE)[13], are provided by highly specialised, secondary care clinicians (super-specialists). Inability to access NHS services has led to a significant growth in the use of private providers that are not regulated, resulting in two-tier access to services, diagnosis and treatment; one for those who can pay and another for those who cannot. This drives health inequalities and links to disproportionate impacts and outcomes in the education and justice systems, employment and health.

> We need to shift rapidly to accessible, regulated and generalist models of care in the community, including primary care and other sectors outside the NHS.

7. **ADHD rarely presents in isolation.** ADHD frequently co-occurs with other types of neurodivergence/neurodevelopmental disorders that onset in childhood, e.g. autism (disorder is the terminology used in current diagnostic systems)[10]. However, ADHD, autism and other neurodevelopmental services in England are often separated and siloed by diagnosis type and by age, so are not person-centric. ADHD co-occurrence with common and rare mental health problems (e.g. anxiety, depression, bipolar disorder) is also extremely frequent[15].

> We need to breakdown diagnostic silos that create inefficiencies so there is a single front door for holistic support and, where needed, for clinical assessment and intervention for ADHD, co-occurring neurodevelopmental disorders/neurodivergence and associated mental health co-morbidities.

8. **NHS ADHD services could benefit by harnessing technology**. Many services remain paper-based (e.g. prescribing, questionnaire and outcome measures) and rely on expensive clinicians spending time on lengthy administrative tasks. Administrative data on ADHD in England are limited, poor quality and do not link across systems. This leads to duplication or multiplication of the same tasks for clinicians and patients. We support the recommendation in the Darzi review[25] to harness technology to simplify and speed up clinical processes and systematically gather data on ADHD across England. This will reduce the burden on clinicians and free their time to focus on what matters – clinical care as well as enable evidence-informed planning and costing of services.

We need to harness digital technologies and data to streamline and modernise our services.

Recommendations

Our recommendations for immediate action align with the government's priorities set out in its NHS, opportunity, growth and safer streets missions.

Cross-agency and government department working

1. **Data capture: government and its relevant departments (specifically DHSC, MoJ, DfE and DWP)** need to work together to improve data capture digitally and join up of datasets. This is to understand where people with ADHD or neurodivergence are in public services, the disproportionalities that exist, and to capture impacts and outcomes.

2. **The Office for National Statistics** should routinely collect and analyse data relating to ADHD in health, education, the workforce and the justice system.

3. **Spending review plans: government and its relevant departments (specifically DHSC, DfE, DWP and MoJ)** need to work together on radical and holistic spending review plans. These plans should consider the work of the Taskforce, the DWP academic panel on neurodivergence and the DfE Task and Finish group on neurodivergence. We recommend an invest to save model that includes ADHD and neurodivergence training and awareness building across all different sectors as well as evidence-based, holistic models of care (that will be described in the final report).

Prevention

4. **Needs-led support that is uncoupled from diagnosis: DHSC/NHS England, DfE and MoJ** must work together to prioritise early years support that is based on needs not diagnosis to break the school to prison, school to adult unemployment and school to ill-health pipelines. Examples of very early, structured support that have worked include evidence-based parenting interventions and early years support, embedded in Sure Start areas. For school age children, another step is to ensure that rollout of outreach mental health support teams in schools (MHSTs; Mental Health Support Teams) is completed and enhanced by the inclusion of staff with neurodivergence expertise in every school. These teams need to be linked up with integrated neurodevelopmental and Children and Adolescent Mental Health Services (CAMHS) teams.

5. **Urgently address escalating NHS ADHD waiting times: DHSC and HMT** must act quickly to address the growing backlogs across both children's and adult services to avoid wasted expenditure on the adverse outcomes of untreated ADHD (e.g. repeated A&E use, chronic mental and physical health problems, prison, unemployment) and identify those at highest risk. The government should ensure that local systems bring down ADHD waiting times for children's and adult services in line with its commitments on reducing waiting for diagnosis and treatment for physical health conditions. This can be achieved in cost-effective ways that meet quality standards, are accessible and build

for the future (e.g. by nurse-led triage, by task-shifting so that senior medical time is primarily utilised for consultation, supervision and the most complex cases).

6. **Improve support to those on waiting lists: health care providers/Integrated Care Boards (ICBs)** must ensure support for those waiting and provide clear signposting to local organisations that can provide information and support. Health care providers/ICBs to consider screening of wait lists to identify the most severe ADHD, co-morbidities and risks (e.g. suicidal) for prioritisation using evidence-based clinical screening tools (different to profiling tools) but not on their own, as such tools can over and under-identify ADHD.

From hospital to community

7. **A generalist model: NICE** should reconsider its stance and interpretation that ADHD always requires a highly specialised, secondary care workforce (ADHD super-specialists) for diagnosis, treatment initiation, follow-up and other types of support. It should clearly define the meaning of specialist to enable greater involvement of primary care (with training and remuneration), with secondary care support as well as generalist secondary care. This approach would align ADHD management with the way other common conditions, such as diabetes, are managed. A clear definition of ADHD specialist and monitoring of NICE adherence is also important to regulate non-NHS providers and allay concerns raised by some about the quality of diagnosis or over-diagnosis by some providers.

8. **A single, accessible front door: Integrated Care Systems (ICSs)/Neighbourhood Health Services** need to work with other local services to modernise ADHD pathways to join up professional expertise across different types of neurodivergence/ neurodevelopmental disorders. Furthermore, there needs to be an explicit link up with mental health services. Such pathways need to operate across all age groups and involve different settings of care and intensity of support (inclusive of primary and secondary care, local authority, VCSE (voluntary, community and social enterprise) and, where needed, private providers). One potential model that has been adopted in Canada and some other countries is the community-based Integrated Youth Service (IYS) for youth aged 12 to 25 years. These provide an evidence-based ‘one-stop shop’ that include support for neurodivergence, mental health and substance use, physical health, peer support, education, employment and social services. The emphasis is on needs, goals and strengths rather than diagnostic siloes and, in Canada, these have led to more rapid access to support and cost savings (to be described in Part 2 of our report).

9. **Stepped care: Integrated Care Systems (ICSs)/Neighbourhood Health Services** should adopt ‘test and learn approaches’ to a stepped care model that involves providing support of different intensities for ‘possible ADHD’ and high-quality ‘clinical diagnosis of ADHD’. This should involve primary and secondary care, local authority, VCSE and private providers. The NIHR should fund formal evaluation of these models.

Digitalisation

10. **Introduce NHS digitalisation into ADHD services now:** the DHSC through its 10-year plan should prioritise the digitalisation of ADHD services. Digitalisation can speed up routine administrative tasks (e.g. questionnaire measures, height, weight, blood pressure centiles, generating reports), help screen waiting lists and, where evidence based, improve efficiencies (e.g. Quantitative Behaviour test[26]). These do not substitute for clinical care and clinical measures should be evidence based.

11. **Improve evidence base: NICE** should scope an early value assessment (EVA) of digital products delivering improved outcomes and efficiencies for ADHD management and treatment across the pathway and settings of care.

12. **Improve data quality: NHS England/DHSC** must prioritise its data improvement work. Currently, data on ADHD waiting lists, referrals, outcomes, local and regional ADHD diagnosis and treatment rates and on clinical standards of all providers are of poor quality.

Background

Why and how was the Taskforce set up

The ADHD taskforce was commissioned by NHS England, with the support of government, after a rapid review of challenges in the health care system found that ADHD service provision and interrelated policies needed a joined-up approach across health, care, education and the justice system. The Taskforce was tasked with gaining a better understanding of the challenges affecting those with ADHD and to make recommendations for change. The taskforce has explicitly taken a whole-person, evidence-based perspective to ADHD and is focusing across health, education, employment and justice. A joined-up approach across sectors is necessary as appropriate recommendations cannot be made by health focused work alone.

The central principle of the Taskforce is co-development. The terms of reference and decisions on the membership of the ADHD taskforce were informed by those with lived experience via a deliberative public engagement event organised and conducted by Healthwatch England. Our Taskforce members include those with lived experience and our report was supported by written and oral feedback from the experts by experience working group to ensure discussions are centred around lived experience.

Who is involved in the Taskforce

The ADHD taskforce was established by NHS England in April 2024 and first met in November 2024. It is led by an independent chair, Professor Anita Thapar, a scientist, child and adolescent psychiatrist, Professor at Cardiff University and co-chair of the Welsh Government Neurodivergence Ministerial Advisory Group. Anita brings with her experience of investment and transformation around ADHD and neurodivergence in Wales over the last decade. Taskforce members also bring lived experience and expertise from the health, education, justice and employment sectors and include the voices of children, young people and parents.

We are supported by information provided by our experts by experience and experts in evidence working groups as well as the NHS England ADHD Clinical Reference Group. Membership of the taskforce and our working groups are available here.

We are working closely with the DfE's neurodivergence task and finish group and DWP's neurodiversity academic panel to ensure an integrated, aligned direction of travel.

Taskforce timeline and outcomes

Part 1 of the report outlines immediate priorities identified by the taskforce, is evidence based and describes initial steps that the government and public sector bodies should urgently take to address growing challenges around ADHD across England. Part 2 of our report, due to be written at the conclusion of our work in summer 2025, will provide further detailed recommendations that include evidence relevant to implementation.

Our recommendations have deliberately been set to align with the government's three key health priorities that will be outlined in the 10 Year Health Plan (from hospital to community, prevention and digitisation).

The Taskforce does not have power to implement solutions. It is for government, cross-sector partner organisations and public sector bodies to consider for implementation and monitor progress.

What we mean by ADHD

Introduction and views of experts by experience: we recognise that the language around ADHD can be confusing and have a stigmatising impact on individuals. Furthermore, the failure to consider scientific evidence and recognise the serious and costly impacts of ADHD can lead to misunderstanding ADHD. Experts by experience highlight the emotional toll of undiagnosed ADHD. While many individuals with ADHD thrive and are fully engaged in working life, those with under-supported ADHD often experience significant inequalities – especially where systems and processes do not recognise or accommodate neurodevelopmental differences and where there is inequality in access to support. People with ADHD often refer to the 'ADHD tax', a combination of income inequality, un/underemployment and lack of access to education – alongside impulsive spending, vulnerability to fraud and other challenges.

ADHD clinical diagnosis: ADHD is a clinical diagnostic term. A clinical diagnosis of ADHD requires a full and thorough clinical assessment and cannot be defined on the basis of questionnaires alone. Diagnostic criteria are set using contemporary scientific evidence and by expert consensus. Thus, diagnostic criteria have changed and will continue to do so over time. For example, ADHD can now be diagnosed in those with autism as the strong co-occurrence is now recognised.

Two different diagnostic systems are used currently: (1) the American Psychiatric Association DSM-5, used by US clinical services and for much global research; and (2) the

World Health Organization ICD-11, used more widely in Europe and the rest of the world. Both systems are used in England. While there are many similarities (e.g. a persistent pattern of hyperactive-impulsive and inattention symptoms, the types of symptoms, symptoms present across multiple settings, early onset and interference with functioning), the criteria are not identical. Both systems group ADHD as a neurodevelopmental disorder. This grouping includes autism, communication disorders, specific learning disorders, motor disorders, intellectual disabilities and (for DSM-5) tic disorders that originate early in development.

Suspected ADHD describes people who suspect they have ADHD, or where others suspect they have ADHD, and have chosen not to or have not received an ADHD diagnosis.

Possible ADHD refers to people who score above a cut-point on a validated ADHD screening questionnaire (screen positive). As is the case for all screening, there will be false positives (not everyone who scores high will have a diagnosis of ADHD) and false negatives (some with clinical ADHD will not score above the questionnaire threshold).

ADHD spectrum: ADHD symptoms behave as a spectrum or continuum in the population (like blood pressure) so many people may display some symptoms but do not meet diagnostic criteria or may choose not to seek diagnosis. While a clinical diagnosis is needed for certain clinical decisions such as prescribing medication, because ADHD, like blood pressure, that is subthreshold can lead to adverse outcomes, non-pharmacological (e.g. self-management, lifestyle) and other types of support (e.g. education) should be based on needs rather than diagnosis.

Neurodivergence: ADHD, like other neurodevelopmental disorders, can be viewed as differences rather than as purely a deficit, and the term neurodivergence is preferred by many with lived experience. We use the term neurodivergence in this report to align with the ongoing focus of the DfE’s neurodivergence task and finish group and when referring to ADHD outside clinical settings.

Next steps

Our next steps for the final report are to identify mechanisms for implementation of our interim recommendations, including holistic models of care, accountability and follow-up, continue to work with the DfE Neurodivergence Task and Finish Group and DWP Academic Panel on Neurodivergence on the final report to be completed by summer 2025, and to align our work so recommendations are integrated across systems. Chairs of both these groups have seen and support this report.

This report, including its recommendations, was co-developed by the ADHD Taskforce supported by additional groups of experts by experience, experts in evidence and clinicians. Not every statement in the report will be fully endorsed by all but the report represents a consensus

Taskforce members: Anita Thapar (Chair), Char Bailey (lived experience expert), Jawad Choudhury (lived experience expert, youth member), Lucy Clement (GP, lived experience expert), Tamsin Crook (parent, lived experience expert), Keith Fraser (Chair of Youth Justice Board), Karen Guldberg (Chair of DfE Neurodivergence Task and Finish Group), Dan Harris (employment, lived experience expert), Adrian James (Medical Director NHS England – Mental Health and Neurodiversity), Rachel D'Souza (Children's Commissioner for England), Louise Ansari (CE of Healthwatch), Thea Stein (CE of Nuffield Trust).

References

1. Asherson P (2024). ADHD across the lifespan. Medicine 52(8): 512–517.
2. Young S, Moss D, Sedgwick O, Fridman M, Hodgkins P (2015). A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations. Psychol Med 45(2): 247–258. doi: 10.1017/S0033291714000762
3. Riglin L, Todd A, Blakey R, et al (2023). Young-adult social outcomes of attention-deficit/hyperactivity disorder. J Clin Psychiatry 84(2): 22m14379. doi: 10.4088/JCP.22m14379
4. Helgesson M, Björkenstam E, Rahman S, et al (2023). Labour market marginalisation in young adults diagnosed with attention-deficit hyperactivity disorder (ADHD): A population-based longitudinal cohort study in Sweden. Psychol Med 53(4): 1224–1232. doi: 10.1017/S0033291721002701
5. Thapar A, Cooper M (2016). Attention deficit hyperactivity disorder. Lancet 387(10024): 1240–1250.
6. Daley D, Jacobsen RH, Lange AM, Sørensen A, Walldorf J (2019). The economic burden of adult attention deficit hyperactivity disorder: A sibling comparison cost analysis. Eur Psychiatry 61: 41–48. doi: 10.1016/j.eurpsy.2019.06.011
7. Mathews F, Ford TJ, White S, Ukoumunne OC, Newlove-Delgado T (2024). Children and young people's reported contact with professional services for mental health concerns: a secondary data analysis. Eur Child Adolesc Psychiatry 33(8): 2647–2655. doi: 10.1007/s00787-023-02328-z
8. Raman SR, Man KKC, Bahmanyar S, et al (2018). Trends in attention-deficit hyperactivity disorder medication use: a retrospective observational study using population-based databases. Lancet Psychiatry 5(10): 824–835. doi: 10/1016/S2215-0366(18)30293-1
9. French B, Davies J, Williams C, Kirby A (2025). UK ADHD treatment rates – a regional variation model.
10. Thapar A, Cooper M, Rutter M (2017). Neurodevelopmental disorders. Lancet Psychiatry 4(4): 339–346.
11. Polanczyk GV, Salum GA, Sugaya LS, Caye A, Rohde LA (2015). Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. J Child Psychol Psychiatry Allied Discip 56(3): 345–365. doi: 10.1111/jcpp.12381
12. Ayano G, Tsegay L, Gizachew Y, Necho M, Yohannes K, Abrah A, et al (2023). Prevalence of attention deficit hyperactivity disorder in adults: Umbrella review of evidence generated across the globe. Psychiatry Res 328: 115449. doi: 10.1016/j.psychres.2023.115449
13. NICE (2019). Attention deficit hyperactivity disorder: diagnosis and management. NICE

guideline NG87 (accessed 24 Nov 2021)

14. Young S, Asherson P, Lloyd T, Absoud M, Arif M, Colley WA, et al (2021). Failure of healthcare provision for attention-deficit/hyperactivity disorder in the United Kingdom: a consensus statement. Front Psychiatry 12: 649399. doi: 10.3389/fpsyt.2021.649399
15. French B, Nalbant G, Wright H, et al (2024). The impacts associated with having ADHD: an umbrella review. Front Psychiatry 15: 1343314. doi: 10.3389/fpsyt.2024.1343314
16. Dalsgaard S, Ostergaard SD, Leckman JF, Mortensen PB, Pedersen MG (2015). Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: A nationwide cohort study. Lancet 385(9983): 2190–2196. doi: 10.1016/S0140-6736(14)61684-6
17. Li L, Zhu N, Zhang L, Kuj-Halkola R, D'Onofrio BM, Brikell I, et al (2024). ADHD pharmacotherapy and mortality in individuals with ADHD. JAMA 331(10): 850–860. doi: 10.1001/jama.2024.0851
18. Lichtenstein P, Halldner L, Zetterqvist J, et al (2012). Medication for attention deficit–hyperactivity disorder and criminality. N Engl J Med 367(21): 2006–2014. doi: 10.1056/NEJMoa1203241
19. Sonuga-Barke E, Thapar A (2021). The neurodiversity concept: is it helpful for clinicians and scientists? Lancet Psychiatry 8(7): 559–561.
20. Agnew-Blais JC, Polanczyk GV, Danese A, Wertz J, Moffitt TE, Arseneault L (2018). Young adult mental health and functional outcomes among individuals with remitted, persistent and late-onset ADHD. Br J Psychiatry 213: 526–534. doi: 10.1192/bjp.2018.97
21. Martin J, Langley K, Cooper M, Rouquette OY, John A, et al (2024). Sex differences in attention-deficit hyperactivity disorder diagnosis and clinical care: a national study of population healthcare records in Wales. J Child Psychol Psychiatry Allied Discip 65(12): 1648–1658. doi: 10.1111/jcpp.13987
22. Shakeshaft A, Blakey R, Kwong ASF, Riglin L, Davey Smith G, Stergiakouli E, et al (2023). Mental-health before and during the COVID-19 pandemic in adults with neurodevelopmental disorders. J Psychiatr Res 159: 230–239. doi: 10.1016/j.jpsychires.2023.01.029
23. Raw JAL, Waite P, Pearcey S, Shum A, Patalay P, Creswell C (2021). Examining changes in parent-reported child and adolescent mental health throughout the UK’s first COVID-19 national lockdown. J Child Psychol Psychiatry Allied Discip 62(12): 1391–1401. doi: 10.1111/jcpp.13490
24. Sibley MH, Mitchell JT, Becker SP (2016). Method of adult diagnosis influences estimated persistence of childhood ADHD: a systematic review of longitudinal studies. Lancet Psychiatry 3(12): 1157–1165. doi: 10.1016/S2215-0366(16)30190-0
25. Department of Health and Social Care (2024). Independent investigation of the NHS in England.

27 Bellato A, Hall CL, Groom MJ, Simonoff E, Thapar A, Hollis C, et al (2024). Practitioner review: clinical utility of the QbTest for the assessment and diagnosis of attention-deficit/hyperactivity disorder – a systematic review and meta-analysis. J Child Psychol Psychiatry Allied Discip 65(6): 845–861. doi: 10.1111/jcpp.13901

Annex 1: Healthwatch England Report

ADHD Taskforce priorities: a deliberative public engagement

https://nds.healthwatch.co.uk/reports-library/adhd-task-force-priorities-deliberative-public-engagement

Annex 2: Evidence summary

Introduction

The evidence group was set up as a small core group of academics to support the taskforce with a review of the evidence base. Additional members have joined to assist with this work.

The evidence group was set a series of questions in December 2024 to inform the interim report. This paper shares a summary of the published, peer-reviewed evidence; the group also share their assessment of each paper based on (1) quality of evidence and (2) relevance to the UK context (both rated as high, medium or low).

Summary of evidence

1. What is the prevalence of ADHD and is it increasing?

In an English population sample of 2 to 19 year olds the ADHD prevalence was 3% (MHCYP Survey Forbes et al 2018, low, high); there is no evidence that the prevalence has increased since 1999 (Sadler et al 2018, low high).

Meta-analysis of global studies suggest an ADHD prevalence in children of around 3–5% (Polanczyk et al 2015, high, low). Geographical location does not influence prevalence significantly so these estimates can reasonably be applied to a UK population (Polanczyk et al 2014, high, moderate; Cortese et al 2023, moderate, low). There is no evidence of an increase in the number of children in the population meeting criteria for ADHD diagnosis over time.

For adults, meta-analyses suggest a global population prevalence for ADHD of 2–3% (Chaulagain et al 2023, high, medium; Ayano 2024, high, medium; Simon et al 2009, high, medium), which could be reasonably applied to a UK population.

2. What is the current level of access to clinical support and is there over or under-diagnosis of ADHD in England/UK?

Contact with services: In 2017, approximately one-quarter of those aged 5 to10 years and one-third of those aged 11 to 16 years who met criteria for ADHD in the population reported contact with a mental health specialist in the previous year. We do not know if their ADHD was recognised (Mathews 2024, medium, high).

There is a lack of comparable data from national studies of adults.

While English health service records have shown increased recognition of ADHD in both children and adults from 2000 to 2018, the administrative prevalence is reported as 2.55% in boys and 0.67% in girls. In adults it was 0.74% in men and 0.20% in women. As the actual population prevalence in children is 5% and in adults is 2–3%, under-recognition of ADHD remains a problem in England (McKechnie et al 2023).

Medication rates: English health service records also show that prescription rates of medications to treat ADHD have risen from 2000 to 2018 (McKechnie et al 2023, medium, high). However, only 0.2% of the 7,655,931 individuals received ADHD medication prescriptions.

Furthermore, the latest data from prescribing studies show that only 25% of children and 15% of adults with ADHD received pharmacological treatment, with regional rates across the UK varying up to 12-fold (French et al 2025c, medium, high). The evidence from randomised controlled trials is that 70–90% will benefit from drug treatment so we are under-prescribing ADHD medication in England.

Data suggest that support for GPs to prescribe ADHD medication is patchy (Gudka et al 2024, medium, high; Price et al 2024, medium, high). Evidence suggests that only 1 in 6 children transitioning to adult life successfully accessed adult services, although this might be improving with time (Jung et al in revision, medium, high).

Waiting times: There are no national reports on waiting times for adults. In a national survey of commissioners, primary care clinicians and people with lived experience, 40% reported waiting times of 2 years or more (BBC 2024; Price et al 2024, medium, high). Waiting lists are reported to have increased to 10–15 years in some areas of the UK (Communicaton and Engagement 2021, low, high; Children's Commissioners for England 2024, low, high).

3. What are the costs of not treating ADHD?

Using Danish patient registry data, a cost difference between adults with ADHD and their same-sex siblings was approximately £17,000 more per adult with ADHD per year. The UK cost estimate was **£17 billion** at a prevalence of 2.5%. This suggests there are extensive costs in adulthood of not identifying and treating ADHD in childhood (Daley et al 2019).

In a Danish dataset, access to care for children with ADHD appears to reduce costs for both education and crime (French 2025a, high, high).

No published papers on the contemporary costs of untreated ADHD in the UK exist yet, but an evaluation of the costs of undiagnosed ADHD will report by June 2025 (French et al 2025b, high, medium).

4. How cost-effective are treatments for ADHD?

Pharmacological and non-pharmacological treatments have consistently been shown to be more cost-effective than no treatment in the UK (Dijk et al 2021, high, medium).

Meta-analytic evidence from randomised controlled trials shows that stimulants for ADHD in children and young people have one of the highest effect sizes for efficacy, not only in psychiatry but across medications used in general medicine, at least in the short term (Leucht et al 2012, high, high; Cortese et al 2018, high, high). Effect sizes are generally lower in trials of stimulants in adults than those in children but still indicate a significant effect in terms of decreasing the severity of ADHD.

While it is challenging to assess effects in the longer-term via standard randomised trials, discontinuation trials show persistence of effects in the longer-term (summarised in Cortese et al 2020). Quasi-experimental designs of treatment using ADHD medication suggest that pharmacological treatment of ADHD is associated with lower risk of long-term unemployment in adults (Li et al 2022) and may be protective for future criminality (Lichtenstein et al 2012), substance misuse (Quinn et al 2017) and depression (Chang et al 2016). Quasi-experimental designs of treatment using ADHD medication suggest that pharmacological treatment of ADHD is associated with lower risk of long-term unemployment in adults (Li et al 2022), decreased risk of car accidents and injuries (Chang et al 2019) and may be protective for future criminality (Lichtenstein et al 2012), substance misuse (Quinn et al 2017) and depression (Chang et al 2016).

Evidence from the emulated target trial approach also shows that stimulants, like some other medications in general medicine, decrease the risk of mortality (Li et al 2024, high, high).

Only one cost-effective analysis of a parent training intervention for pre-school children with ADHD has been conducted in the UK (Sonuga-Barke 2018, high, high). This found individual intervention (New Forest Parenting Programme) to be very slightly more cost-effective than group intervention.

We have been unable to find any cost-effectiveness studies of psychological treatments in adults.

5. What evidence-based strategies could we use for clearing waiting lists?

Interim support: Mental health difficulties may deteriorate while people are on waiting lists (Punton et al 2022, medium, medium); offering interim support while waiting can enhance clinical outcomes (Valentine 2024, medium, high).

Parenting support: Unguided app-based parenting support could be one low-cost solution. A cost effectiveness evaluation of the STEPS (Structured E-Parenting Support) app will report shortly (Kostyrka-Allchorne et al 2022, medium, high).

Supporting teachers: Enhancing teachers' understanding of ADHD and supporting them to better manage ADHD in the classroom could also reduce ADHD symptom expression and key impairments while waiting (Corkum et al 2019; medium, low).

Primary care: An increased workforce capable of supporting and making ADHD diagnoses (e.g. recognising 'ADHD specialists' in primary care and education who can conduct assessments) could be transformative. With enhanced training and support (French et al 2020, medium, high), ADHD could be diagnosed and managed at primary care level, with the more complex cases being passed up to other services for additional assessment and intervention.

Screening wait lists: Early clinical screening using validated tools (different to profiling) may be helpful to ensure that patients are on the correct assessment pathway, are safe to wait or could be redirected to another assessment waiting list at the earliest time point (Adamou et al 2022, medium, high; Loh 2022, medium, medium).

Increasing the speed of the diagnostic process: The QbTest can increase the speed of ADHD diagnostic decision making in children and young people by over 40% with no loss of diagnostic accuracy (Hollis et al 2018, high, high; see below).

6. What types of digital technology could help improve outcomes or efficiency?

For clinicians: technology can improve system efficiency by:

- collecting ongoing information from service users or streamlining administrative tasks (Bond et al 2023, low, low)
- offering more efficient and objective measurement of outcomes, treatment response and adverse events (Denyer 2022, medium, high).
- speeding up assessment. Assessment and diagnosis of ADHD is a complex process taking around 2.5 hours of clinic time to reach a diagnosis (Hollis et al 2018, high, high). The QbTest can enhance clinician confidence, reduce the number of appointments needed to make a diagnosis and rule out ADHD at an earlier point in the assessment process (Hollis et al 2018, high, high). QbTest is NOT a freestanding diagnostic test – it is intended to be used to aid clinical diagnosis and management of ADHD and is NICE recommended to help diagnose ADHD in people aged 6 to 17 years (NICE 2024, high, high, Bellato et al 2023; high, high)

For those with ADHD:

- the uptake and adherence to digital health interventions (DHIs) tends is much higher with human support than with unsupported/self-help apps (Garrido et al 2019, high, medium).
- people with ADHD state a preference for DHI as an adjunct to usual care (Gudka et al 2024, medium, high), which could provide targeted health care transition information, self-management support and psychoeducational materials
- DHIs could be ‘prescribed’ by GPs or practitioners funded under the Additional Roles Reimbursement Scheme (ARRS) without additional training (e.g. social prescribers specialist nurses to support long-term condition management of ADHD). DHIs could also offer early intervention support for those awaiting assessment or with sub-threshold symptoms (Ford et al 2023, medium, high), thus helping patients to manage their condition while waiting for specialist care
- another potential early intervention approach for children with ‘probable’ ADHD waiting for assessment is online parent training (STEPS-App) for initial management of ADHD. This app is currently under evaluation in the OPTIMA randomised clinical trial (Kostyrka-Allchorne et al 2022, medium, high) – see earlier

- other interventions that could be digitalised include psychoeducation apps and therapeutic interventions. However, these solutions must be evidence based and cost-effective. Currently, the evidence-base for therapeutic DHIs for people with ADHD is limited (Hollis et al 2017, high, high)

7. How should we set standards for ADHD assessment?

Recommendations for setting minimal acceptable standards for ADHD assessment are supported by empirical evidence and clinical consensus and should be used for all providers (Chaulagain et al 2023, high, medium; Faraone et al 2021, high, medium; the ADHD Assessment Quality Assurance Standard for Children and Teenagers (CAAQAS), Young et al 2024, low, high; the Adult ADHD Assessment Quality Assurance Standard (AQAS), Adamou et al 2024, low, high).

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References

Adamou M, Jones SL, Marks L, Lowe D (2022). Efficacy of continuous performance testing in adult ADHD in a clinical sample using QbTest+. J Atten Disord 26(11): 1483–1491. doi: 10.1177/10870547221079798

Adamou M, Arif M, Asherson P, Cubbin S, Leaver L, Sedgwick-Müller J, et al (2024). The adult ADHD assessment quality assurance standard. Front Psychiatry 15: 1380410. doi: 10.3389/fpsyt.2024.1380410

Ayano G, Tsegay L, Gizachew Y, Necho M, Yohannes K, Demelash S, Alati R (2024). Prevalence of ADHD in adults: an umbrella review of international studies. Eur Psychiatry 67(S1): S343–S343. doi: 10.1016/j.psychres.2023.

BBC News (2024, April 3). NHS cannot meet autism or ADHD demand, report says.

Bellato A, Hall CL, Groom MJ, Simonoff E, Thapar A, Hollis C, Cortese S (2024). Practitioner review: clinical utility of the QbTest for the assessment and diagnosis of attention-deficit/hyperactivity disorder – a systematic review and meta-analysis. J Child Psychol Psychiatry 65(6): 845–861. doi: 10.1111/jcpp.13901

Bond RR, Mulvenna MD, Potts C, O'Neill S, Ennis E, Torous J (2023). Digital transformation of mental health services. NPJ Mental Health Res 2(1): 1–9.

Chang Z, D'Onofrio BM, Quinn PD, Lichtenstein P, Larsson H (2016). Medication for attention-deficit/hyperactivity disorder and risk for depression: a nationwide longitudinal cohort study. Biol Psychiatry 80(12): 916–922. doi: 10.1016/j.biopsych.2016.02.018

Chang Z, Ghirardi L, Quinn PD, Asherson P, D'Onofrio BM, Larsson H (2019). Risks and benefits of attention-deficit/hyperactivity disorder medication on behavioral and neuropsychiatric outcomes: a qualitative review of pharmacoepidemiology studies using linked prescription databases. Biol Psychiatry 86(5): 335–343. doi: 10.1016/j.biopsych.2019.04.009

Chaulagain A, Lyhmann I, Halmøy A, Widding-Havneraas T, Nyttingnes O, Bjelland I, Mykletun A (2023). A systematic meta-review of systematic reviews on attention deficit hyperactivity disorder. Eur Psychiatry 66(1), e90. doi: 10.1192/j.eurpsy.2023.2451

Children’s Commissioner for England (2024). Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions | Children's Commissioner for England

Communication and Engagement (2021). Pandemic triggers rise in ADHD referrals. Monash Health.

Corkum P, Elik N, Blotnicky-Gallant PAC, McGonnell M, McGrath P (2019). Web-based intervention for teachers of elementary students with ADHD: randomized controlled trial. J Atten Disord 23(3): 257–269. doi: 10.1177/1087054715603198

Cortese S, Song M, Farhat LC, Yon DK, Lee SW, Kim MS, et al (2023). Incidence, prevalence, and global burden of ADHD from 1990 to 2019 across 204 countries: data, with critical re-analysis, from the Global Burden of Disease study. Mol Psychiatry 28(11): 4823–4830. doi: 10.1038/s41380-023-02228-3

Cortese S (2020). Pharmacologic treatment of attention deficit-hyperactivity disorder. N Engl J Med 383(11): 1050–1056

Cortese S, Adamo N, Del Giovane C, Mohr-Jensen C, Hayes AJ, Carucci S, et al (2018). Comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults: a systematic review and network meta-analysis. Lancet Psychiatry 5(9): 727–738. doi: 10.1016/S2215-0366(18)30269-4

Daley D, Jacobsen RH, Lange AM, Sørensen A, Walldorf J (2019). The economic burden of adult attention deficit hyperactivity disorder: A sibling comparison cost analysis. Eur Psychiatry 61: 41–48. doi: 10.1016/j.eurpsy.2019.06.011

Denyer H, Ramos-Quiroga JA, Folarin A, et al (2022). ADHD remote technology study of cardiometabolic risk factors and medication adherence (ART-CARMA): a multi-centre prospective cohort study protocol. BMC Psychiatry 22(1): 813. doi: 10.1186/s12888-022-04429-6

Dijk HH, Wessels LM, Constanti M, Van Den Hoofdakker BJ, Hoekstra PJ, Groenman AP (2021). Cost-effectiveness and cost utility of treatment of attention-deficit/hyperactivity disorder: a systematic review. J Child Adolesc Psychopharmacol 31(9): 578–596. doi: 10.1089/cap.2021.0068

Faraone SV, Banaschewski T, Coghill D, Zheng Y, Biederman J, Bellgrove MA, et al (2021). The World Federation of ADHD International Consensus Statement: 208 evidence-based conclusions about the disorder. Neurosci Biobehav Rev 128: 789–818. doi: 10.1016/j.neubiorev.2021.01.022

Forbes N, Pearce N, Vizard T, Sadler K, Ford T, Goodman A, et al (2018). The mental health of children and young people in England 2017: Hyperactivity disorders. London: Health and Social Care Information Centre.

Ford T, Mathews F, Newlove-Delgado T (2023). Mental health related service contacts in children with ‘sub-threshold/sub-clinical’ psychopathology in the Mental Health of Children and Young People in England national survey. Eur Psychiatry 66: S466–S466.

French B, Hall C, Perez Vallejos E, Sayal K, Daley D (2020). Assessing the efficacy of online ADHD awareness training in primary care: Pilot randomised control trial evaluation with nested qualitative interviews. JMIR Medical Education 6(2). doi: 10.2196/19871

French B, Smith L, Daley D (2025a). Danish cohort data on the cost-benefits of an ADHD diagnosis (in preparation).

French B, Daley D, Angell K, Cassidy S, Knapp M (2025b). The economic cost of untreated ADHD/autism (in preparation).

French B, Kirby A, Davies J, Williams C (2025c). UK ADHD treatment rates – a regional variation model. doi: 10.21203/rs.3.rs-5956482/v1

Garrido S, Millington C, Cheers D, Boydell K, Schubert E, Meade T, Nguyen QV (2019). What works and what doesn't? A systematic review of digital mental health interventions for depression and anxiety in young people. Front Psychiatry 10: 759.

Gudka R, Becker K, Ward J, Smith JR, Mughal F, Melendez-Torres GJ, et al (2024). Primary care provision for young people with ADHD: A multi-perspective qualitative study. Br J Gen Pract 74(743): e408–e416. doi: 10.3399/BJGP.2023.0626

Hollis C, Falconer CJ, Martin JL, Whittington C, Stockton S, Glazebrook C, Davies EB (2017). Annual research review: digital health interventions for children and young people with mental health problems – a systematic and meta-review. J Child Psychol Psychiatry 58(4): 474–503. doi: 10.1111/jcpp.12663

Hollis C, Hall CL, Guo B, James M, Boadu J, Groom MJ, et al (2018). The impact of a computerised test of attention and activity (QbTest) on diagnostic decision-making in children and young people with suspected attention deficit hyperactivity disorder: single-blind randomised controlled trial. J Child Psychol Psychiatry 59(12): 1298–1308. doi: 10.1111/jcpp.12921

Jung RS, Saunders C, White SR, Lewis, Cardinal RN, Ford TJ (in revision). Transition of care in young people with attention-deficit/hyperactivity disorder from child to adult services. J Mental Health.

Kostyrka-Allchorne K, Ballard C, Byford S, Cortese S, Daley D, Downs J, et al (2022). Online Parent Training for The Initial Management of ADHD referrals (OPTIMA): the protocol for a randomised controlled trial of a digital parenting intervention implemented to support parents and children on a treatment waitlist. Trials 23(1): 1003. doi: 10.1186/s13063-022006952-z.

Leucht S, Hierl S, Kissling W, Dold M, Davis JM (2012). Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. Br J Psychiatry 200(2): 97–106. doi: 10.1192/bjp.bp.111.096594

Li L, Chang Z, Sun J, et al (2022). Association between pharmacological treatment of attention-deficit/hyperactivity disorder and long-term unemployment among working-age individuals in Sweden. JAMA Netw Open 5(4):e226815. doi: 10.1001/jamanetworkopen.2022.6815

Li L, Zhu N, Zhang L, Kuja-Halkola R, D'Onofrio BM, Brikell I, et al (2024). ADHD pharmacotherapy and mortality in individuals with ADHD. JAMA 331(10): 850–860. doi: 10.1001/jama.2024.0851

Lichtenstein P, Halldner L, Zetterqvist J, Sjölander A, Serlachius E, Fazel S, et al (2012). Medication for attention deficit-hyperactivity disorder and criminality. N Engl J Med 367(21): 2006–2014.DOI: 10.1056/NEJMoa1203241

Loh HW, Ooi CP, Barua PD, Palmer EE, Molinari, Rajendra Acharya FU (2022). Automated detection of ADHD: Current trends and future perspective. Computers Biol Med 146: 105525. doi: 10.1016/j.compbiomed.2022.105525

Mathews F, Ford TJ, White S, Ukoumunne OC, Newlove-Delgado T (2024). Children and young people's reported contact with professional services for mental health concerns: a secondary data analysis. Eur Child Adolesc Psychiatry 33(8): 2647–2655. doi: 10.1007/s00787-023-02328-z

McKechnie DGJ, O'Nions E, Dunsmuir S, Petersen I (2023). Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: population-based cohort study. BJPsych Open 9(4):121. doi: 10.1192/bjo.2023.512

National Institute for Health and Care Excellence (NICE) (2024). Digital technologies for assessing attention deficit hyperactivity disorder (ADHD). Diagnostics guidance DG60.

Polanczyk GV, Willcutt EG, Salum GA, Kieling C, Rohde LA (2014). ADHD prevalence estimates across three decades: an updated systematic review and meta-regression analysis. Int J Epidemiol 43(2): 434–442. doi: 10.1093/ije/dyt261

Polanczyk GV, Salum GA, Sugaya LS, Caye A, Rohde LA (2015). Annual research review: a meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. J Child Psychol Psychiatry 56(3): 345–365. doi: 10.1111/jcpp.12381

Price A, Becker K, Ward JH, Ukoumunne OC, Gudka R, Salimi A, et al (2024). Support for primary care prescribing for adult ADHD in England: national survey. Br J Gen Pract 74(748): e777–e783. doi: 10.3399/BJGP.2023.0595

Punton G, Dodd AL, McNeill A (2022). 'You're on the waiting list': an interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. PLOS ONE 17(3): e0265542. doi: 10.1371/journal.pone.0265542

Quinn PD, Chang Z, Hur K, Gibbons RD, Lahey BB, Rickert ME, D'Onofrio BM (2017). ADHD medication and substance-related problems. Am J Psychiatry 174(9): 877–885. doi: 10.1176/appi.ajp.2017.16060686

Sadler K, Vizard T, Ford T, Goodman A, Goodman R, McManus S (2018). The mental health of children and young people in England 2017: Trends and characteristics. London: Health and Social Care Information Centre.

Simon V, Czobor P, Balint S, Meszaros A, Bitter I (2009). Prevalence and correlates of adult attention-deficit hyperactivity disorder: meta-analysis. Br J Psychiatry 194(3): 204–211. doi: 10.1192/bjp.bp.107.048827

Sonuga-Barke EJ, Barton J, Daley D, Hutchings J, Maishman T, Raftery J, Thompson MJ (2018). A comparison of the clinical effectiveness and cost of specialised individually delivered parent training for preschool attention-deficit/hyperactivity disorder and a generic, group-based programme: a multi-centre, randomised controlled trial of the New Forest Parenting Programme versus Incredible Years. Eur Child Adolesc Psychiatry 27: 797–809. doi: 10.1007/s00787-017-1054-3

Valentine AZ, Hall SS, Sayal K, Hall CL (2024). Waiting-list interventions for children and young people using child and adolescent mental health services: a systematic review. BMJ Mental Health 27(1): e300844.

Young S, Absoud M, Al-Attar Z, Ani C, Colley W, Cortese S, Crame J, Gudjonsson G, Hill P, Hollingdale J, Mukherjee RAS, Ozer S, Partridge G, Smith J, Woodhouse EL, Lewis A. The ADHD Assessment Quality Assurance Standard for Children and Teenagers (CAAQAS). *Neuropsychiatr Dis Treat*. 2024;20:2603-2628 https://doi.org/10.2147/NDT.S472923