Developing ADHD Services for Children, Young People and Adults in Northern Ireland

Needs Assessment Report

November 2025

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Contents

1. Introduction and Background

Purpose of the Needs Assessment Review

This Needs Assessment Review was commissioned by the Department of Health (DoH) in Northern Ireland to develop proposals for a commissioned Attention Deficit Hyperactivity Disorder (ADHD) Service across Trusts, encompassing both children and adult services and ensuring regional consistency in the context of future plans for a Regional Mental Health Service.

The review identifies:

- the strategic context for the provision of ADHD services, including links to existing strategies and guidance and the position in other jurisdictions;
- the current level of ADHD provision in HSC Trusts, including current referral, assessment, and treatment pathways, identifying the challenges and barriers to the provision of services for ADHD;
- an assessment of the levels of demand and unmet need for ADHD assessment, diagnosis, and treatment; and
- recommendations for the development of effective services and support, consistent with National Institute for Health and Care Excellence [NICE] Guidelines [NG87] www.nice.org.uk/guidance/ng87.

What is Attention Deficit Hyperactivity Disorder (ADHD)?

Attention Deficit Hyperactivity Disorder (ADHD) is a common neurodevelopmental condition with clinical characteristics that include persistent hyperactivity, inattention and impulsivity resulting in significant psychosocial and other impairments (Katzman et al 2017).

Lovett & Harrison 2021 report that ADHD is a diagnosis recognised by both the World Health Organization [ICD-11] (See Appendix 1) and the American Psychiatric Association [DSM-5] (See Appendix 2).

In DSM-5, neurodevelopmental disorders are defined as a group of conditions with onset in the developmental period, inducing deficits, which result in impairments of functioning. Neurodevelopmental disorders comprise intellectual disability (ID); Communication Disorders; Autism Spectrum Disorder (ASD); Attention-Deficit/Hyperactivity Disorder (ADHD); Neurodevelopmental Motor Disorders, including Tic Disorders; and Specific Learning Disorders. The classification of neurodevelopmental disorders in ICD-11 does not vary to any significant degree from that in DSM-5 (Morris-Rosendahl & Marc-Antoine Crocq 2020).

The validity of neurodevelopmental disorders as a construct is supported by the high rates of comorbidity between various disorders within this diagnostic grouping. For example, various studies have demonstrated that 22% to 83% of children with ASD have symptoms that satisfy the DSM-IV criteria for ADHD, and vice versa, with 30% to 65% of children with ADHD presenting with clinically significant symptoms of ASD (Sokolova et al 2017).

Song et al (2021) suggest that, while ADHD was historically first diagnosed and treated during childhood, recent studies recognise that the core symptoms may persist into adulthood, although Lovett and Harrison (2021) propose that the persistence of symptoms into adulthood should not be assumed.

Prevalence Rates

Song et al (2021) conducted research using a meta-analysis approach and found the prevalence of persistent adult ADHD (with a childhood onset) and symptomatic adult ADHD (regardless of a childhood onset) both decreased with advancing age. They established that the prevalence of persistent adult ADHD was 2.58% and that of symptomatic adult ADHD was 6.76%, translating to 139.84 million and 366.33 million affected adults in 2020 globally.

Similarly, in their systemic review and meta-analysis, Salari et al (2023) found that the prevalence of ADHD in children aged 3 to 12 years was 7.6% with a 5.6% rate of prevalence in teenagers aged 12 to 18 years. According to the findings of this study, the prevalence of ADHD in children aged 3 to 12 years is higher than in adolescents aged 12 to 18 years.

Ayano et al (2020) also found the prevalence of DSM-IV-like ADHD was highest in children (11.7%) followed by adolescents (9.7%) and lowest in adults (6.4%). This decrease in prevalence with age supports the hypothesis that ADHD symptoms decrease with brain maturation.

In a UK context, Hire et al (2018) found that approximately 3.4% of children aged 5-15 were diagnosed with ADHD, while the National Institute for Health and Care Excellence [NICE] (2025) estimate that the prevalence of ADHD in adults in the UK is between 3% and 4%, with a male to female ratio of 3:1.

Comorbidities

ADHD in adults is often accompanied by other psychiatric conditions, such as major depressive disorder, anxiety disorder, and alcohol abuse. Indeed, Ginsberg 2014 suggests that adults with ADHD are more likely to present to a psychiatric clinic for treatment of their comorbid disorders than for ADHD, and their ADHD symptoms are often mistaken for those of their comorbidities, although this supposition predates the

significant increase in demand for an ADHD assessment witnessed over recent years.

Conversely, Sibley et al. (2018) reported that very often, late onset ADHD symptoms were due to other conditions such as substance abuse, mental health issues, or other comorbid conditions. Consequently, Lovett & Harrison (2021) argue that clinicians should ensure that other conditions with symptoms that mimic ADHD are evaluated formally prior to making an ADHD diagnosis.

Indeed, in an epidemiological investigation of the prevalence of adult ADHD in outpatients in Ireland, Adamis et al (2023) found that approximately 15% of working-age adults attending general adult Community Mental Health Teams (CMHTs) may have ADHD that is currently undiagnosed.

Psychiatrically, one of the most challenging areas of clinical overlap is between Borderline Personality Disorder (BPD) and ADHD. Misdiagnosis of personality disorder can occur when ADHD is unrecognised or untreated; equally, a subgroup of patients present with genuine comorbidity, in whom effective ADHD treatment should enhance the impact of psychological interventions for personality disorder. Weiner et al (2019) note that ADHD and BPD are both common in adults and highly comorbid. Their symptomatic overlap, including impulsivity, emotional dysregulation, and interpersonal difficulties, often complicates diagnosis. Weiner et al. (2019) further argue that ADHD and BPD should no longer be viewed as exclusively neurodevelopmental or psychological in origin. This has important clinical implications, suggesting that preventive approaches should target both shared trait vulnerabilities and environmental risk factors in childhood to improve outcomes for those at risk.

In a systemic review of evidence connecting adult ADHD with somatic conditions, Intanes et al (2018) identified a consistent association with an increased risk of obesity, sleep disorders, migraine, celiac disease and asthma with less robust evidence found for a number of different disorders such as enuresis, irritable bowel syndrome, restless legs, epilepsy, chronic fatigue syndrome, fibromyalgic syndrome, systemic lupus erythematosus and atopic dermatitis. These are important to consider when assessing and treating either adult ADHD or the somatic diseases.

The presence of a known co-occurring somatic condition has important implications for ADHD treatment. For example, stimulant therapy may be contraindicated or need careful monitoring in the presence of cardiac disease, hypertension, glaucoma, or liver failure (Kooij & Kooij 2012). However, stimulant therapy may have positive effects on the treatment of obesity, sleep disorders, chronic fatigue syndrome, and restless legs. These are important to consider when assessing and treating either adult ADHD or the somatic diseases (Intanes et al 2018).

There is a high prevalence of ADHD in prison populations compared to the general population (Carlander 2024). In their meta-analysis, Young et al (2015) estimated that the prevalence of ADHD among incarcerated populations is significantly higher when compared to the general population, with a fivefold increase in young detainees (30.1 %) and a tenfold increase in adults (26.2 %). Dagistan et al (2022) found that the combination of hyperactivity and impulsivity increases the likelihood of violent crimes with inattention more often associated with economic or negligence-related offenses.

2. Strategic Context

Strategic Drivers

In Health and Wellbeing 2026: Delivering Together, the Government outlined a commitment to tackle the issues faced by the Health and Social Care system, based on leadership and a desire to move beyond short-term approaches and crisis management.

The ambitions set out in Health and Wellbeing 2026: Delivering Together include the development of Health and Social Care Services in which:

- people are supported to keep well in the first place with the information, education, and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- services are efficient and sustainable for the future.

(Department of Health 2016)

These aims will underpin the development of services for people with ADHD and must be addressed if services are to meet the future needs of people living with ADHD, their carers and family.

In accordance with Health and Wellbeing 2026: Delivering Together, ADHD services must be person-centred and focussed on early intervention, supporting independence and wellbeing. This will enable the delivery of a model underpinned by a more holistic approach to health and social care, creating the circumstances for people to stay healthy, well, safe and independent.

An Early Intervention and Prevention Action Plan was developed from 2022–2025 and work is underway to develop a refreshed plan for 2026–2029.

Despite a growing demand for ADHD Services and the endorsement of NICE Guidelines (NG87) during 2018-19, up until now there has been no existing policy position on the provision of ADHD services in Northern Ireland and there are no existing ADHD specific service commissioning arrangements.

In the absence of commissioned services, many people have sought ADHD services through the private sector, but such is the demand for assessment, diagnosis, and treatment, waiting times to access an assessment with clinicians working in a private capacity have also increased considerably.

It has been reported that people who have received an ADHD diagnosis from a private provider are often unable to access prescribed medications through their GP under shared care guidelines with the result that they either go untreated or pay substantial monthly sums for the medication.

The Mental Health Strategy 2021-2031 (Department of Health 2021) sets out the strategic direction for mental health services over a 10 year period, and while reference to ADHD within the strategy is somewhat limited, it commits to continued development of an understanding of specialisms within general mental health services, including services for those with ADHD. Action 23 acknowledges that some individuals will always need specialist help and support, often in the long term. All practicable help and support will be provided to people in need, keeping in line with the vision of person-centred care and a “no wrong door” approach (DoH, 2021)

It must also be recognised that, since publication of the Mental Health Strategy in June 2021, demand for ADHD services, in particular for adults, has increased considerably.

Despite the absence of regional direction, ADHD service provision has grown across Trusts, largely in response to population demand and the development of expertise within Health and Social Care Teams. The DoH understands there are gaps between what can be provided by Trusts and the prevalence of ADHD, leading to extensive waiting times for assessment, treatment, and support. Consequently, the DoH recognises that it is essential to undertake a needs assessment to inform potential commissioning arrangements associated with ADHD services across Trusts, in order to ensure that any future service reflects current and future demand for ADHD diagnosis and support and meets the requirements of NICE guidelines for ADHD services.

It is recognised that a decision to commission ADHD services will necessarily be founded upon an assessment of the level of demand for services and prevailing financial pressures, within the context of an array of Ministerial priorities, not least those set out in the Mental Health Strategy.

Furthermore, in July 2025, the DoH in Northern Ireland published a Health and Social Care Reset Plan to address financial pressures and stabilise the health system. The plan’s key goals are to deliver a more neighbourhood-centered model of care, improve efficiency to save £300 million in 2025/26, and implement a systems management approach to reduce the £600 million budget deficit. The plan also includes specific measures to cut costs and improve the delivery of services.

In October 2025, the DoH also published a review of the deliverability of the Mental Health Strategy - NI Mental Health Strategy: A Review of the Deliverability of the Strategy’s Actions 2026-2029.

This review highlights that at the end of 2024/25, only £12.3 million has been allocated to fourteen actions within the Strategy, representing just 16% of the funding (£1.2bn) deemed necessary for its implementation over that period.

The review proposed that the focus for 2026/27 should be on the Mental Health Workforce and the Regional Mental Health Crisis Service, with both seen as crucial enablers for broader system improvement.

Strengthening the mental health workforce will include a particular emphasis on unlocking the significant yet underutilised potential within the Community and Voluntary (C&V) sector. A focus on developing regionally consistent, person-centred crisis services will help to ensure that individuals in crisis receive appropriate support in the right place, at the right time.

The review also outlines four medium-priority Mental Health Strategy actions proposed for phased implementation in 2027/28 and 2028/29, relating to mental health and older people, Digital Mental Health, Child and Adolescent Mental Health, and supporting individuals with severe and enduring mental ill health.

Regional Standardisation

Action 31 within the Mental Health Strategy calls for the creation of a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

In From Silos to Systems, the report of the project for a Regional Mental Health Service for Northern Ireland (DoH 2022), the three core attributes of a high quality, Regional Mental Health Service are described as:

- A regionally consistent service in terms of models, service delivery, and service structures;
- The establishment of care networks, building capacity and ensuring regionally agreed evidence-based approaches with appropriate agreed care pathways; and
- Locally based service delivery working across primary and secondary mental health care with the full integration of the community and voluntary sector.

Consequently, the development of ADHD Services must reflect these attributes.

The Regional Group on Specialist Medicines has recommended that medicines suitable for shared care arrangements be designated to an advisory list, the Amber List. The Group has further recommended that prescribing responsibility may be transferred to primary care when agreed shared care arrangements have been

established. Such shared care arrangements will make recommendations on the respective clinical responsibilities of both parties.

Recommendation 1

A regionally agreed standardised approach to referral, triage and assessment pathways, developed and maintained through established ADHD Children and Adult clinical networks, is recommended.

Developments in the UK and Ireland

During the mid-1990s, only a handful of specialist adult ADHD services existed in the UK, often composed of small, resource-limited teams (Smith et al 2024).

While there is a consensus among authors that the Covid-19 pandemic exacerbated the issue of waiting times, advances in recognition (Davidovitch et al 2017) and the development of effective medical treatments (Childress et al 2019) are contributing to a consistent increase in clinical demand for ADHD Services across the UK (Renoux et al 2016).

Scotland

In 2021, Scotland identified the need to enhance experiences and outcomes for autistic adults, adults with ADHD, and those with co-occurring neurodevelopmental conditions throughout the diagnosis process and beyond.

The Scottish Government Covid-19 Mental Health Recovery and Renewal Fund provided funding to support focused local work aimed at developing a Stepped-Care neurodevelopmental pathway.

The pathway encompasses local partnerships across four tiers, involving third sector and community teams, employers and employment support providers, further and higher education, new Primary Mental Health Teams (PMHTs) and Community Mental Health Teams (CMHTs) (Rutherford et al 2023).

Wales

In 2022, Julie Morgan MS, Deputy Minister for Social Services announced that, in addition to more than £11.5m already invested to improve autism services, the Welsh Government would be making an additional £12m available to support a new national improvement programme for neurodevelopmental conditions through to 2025.

The purpose of the programme is to support the development of timely and consistent all-age neurodevelopmental services, including additional advice and support services for parents and carers.

To help understand where action should be targeted, the Welsh Government commissioned an independent demand and capacity review. The review highlighted where existing reforms have worked well, where there are gaps, and where urgent attention is needed (Holtom & Lloyd-Jones 2022). In doing so, the reform confirmed a critical disparity between the increasing demand and limited capacity across Welsh neurodevelopmental services, advocating for urgent workforce expansion, better support for people throughout the diagnostic process and the development of an integrated and flexible needs-led service.

In February 2025, Mental Health and Wellbeing Minister, Sarah Murphy, announced an additional £13.7 million investment to improve neurodivergence services and reduce waiting times for autism and ADHD assessments across Wales.

The Neurodivergence Improvement Programme in Wales has delivered substantial improvements, including:

- extended workforce training across health, social care, education, and specialisms
- piloted innovative needs-led profiling tools
- enhanced data collection and reporting systems
- established stronger collaborative relationships between organisations
- piloted new integrated service delivery models
- held an all-Wales accelerated design event

England

In March 2024, NHS England announced it was setting up a taskforce to undertake a review of ADHD services amid concerns about a rise in diagnoses. The Taskforce brought together expertise from across a range of sectors and was tasked with considering how services and support across health, education, justice and the whole of society needed to be transformed to ensure people with ADHD are able to access timely, appropriate, effective and high-quality support beyond health alone. The group was tasked with making recommendations on a whole system approach to managing ADHD.

In April 2025, NHS England's Taskforce published their interim report highlighting that ADHD is not the remit of health alone, suggesting that policies, budgets, spending, service plans and the collection of routine data require the attention of departments and agencies across all levels from government to locality.

In the interim report, the Taskforce recommends that support for ADHD and neurodivergence should begin early, should be needs-led, not rely on, or require, clinician provided diagnosis and begin in preschool or school and also suggesting that an entirely specialist, single diagnosis model is not sustainable or evidence informed. Indeed, the interim report goes further, proposing that NICE should reconsider its stance and interpretation that ADHD always requires a highly specialised, secondary care workforce for diagnosis, treatment initiation, follow-up and other types of support. The Taskforce suggests that NICE 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.

The Taskforce's final report makes a series of recommendations to transform ADHD services across England, many of which require cross-government collaboration.

It calls for ADHD to be recognised and treated as a common condition, supported by new diagnosis models to help reduce waiting lists and that professionals across healthcare including GPs should receive more training on recognising symptoms and having an appropriate role in treatment.

The report also highlights the need for stronger collaboration between government departments across health, education, employment, and criminal justice to ensure more joined-up support.

Ireland

In the Republic of Ireland, there is increased recognition of ADHD reported in general practice clinics and community mental health teams (CMHTs) (Adamis et al 2016; Gavin & McNicholas 2018). Assessment and treatment for children and adolescents with ADHD are offered through Child and Adolescent Mental Health Services (CAMHS). ADHD is one of the most frequently diagnosed conditions within CAMHS, particularly in the 5 to 9-year-old age group (Health Service Executive 2020). Similarly, individuals with comorbid ADHD and intellectual disabilities have access to Mental Health Intellectual Disability Services, which provide comprehensive care for ADHD.

The National Clinical Programme (NCP) for Adults with ADHD recommends developing adult ADHD clinics aligned with the National Model of Care to offer assessment and multi-modal treatment. Based on prevalence evidence and existing mental healthcare policies and structures, the NCP suggests establishing one ADHD clinic team for every 250,000 - 400,000 working-age adults. With the current population, this implies the need for 11 such teams, along with an extra team to collaborate with Forensic Psychiatry Teams serving Dublin prisons (Health Service Executive 2021). Three pilot services were set up in 2022 and are now operational.

Each adult ADHD clinic is proposed to be led by a consultant psychiatrist and comprise a multidisciplinary team including a senior psychologist, senior occupational therapist, clinical nurse specialist, and administrator. These public clinics would serve adults over 18 years old and accept referrals from general adult and child CMHTs, with team premises provided by the local mental health service.

The national model of care for adult ADHD provides a clinical pathway including the referral procedure. The first step is for a general practitioner to refer a patient to their local general adult CMHT to be assessed for comorbid mental illness and screened for adult ADHD. Where clinical findings suggest a potential diagnosis of adult ADHD, the general adult CMHT refers the patient to the ADHD adult clinic for further assessment and management (Raaj et al 2024) The advantage of this cohort of patients being assessed at the secondary care level (CMHT) is that it ensures any significant mental health problems are identified and treated before the patient is referred to a tertiary-level adult ADHD clinic.

Models of Care and Service Provision

Male et al (2020) advocate for a diagnostic pathway facilitating the assessment of ADHD, autism and related neurodevelopmental conditions under a single umbrella. This approach incorporates a multi-disciplinary team, comprising paediatricians, psychiatrists, psychologists, therapists providing unified screening and diagnostic processes for neurodevelopmental concerns in children.

Male et al (2020) contend that because Autism and ADHD frequently co-exist, potentially share genetic links (Ghirardi et al 2018) and often present similarly, assessments should be undertaken through a single pathway, arguing that such an approach improves efficiency, reduces costs and enhances patient and family experiences, not least through shorter waiting times.

This approach has been adopted within Scotland through the introduction of Pathfinder Adult Neurodevelopmental Pathways (Rutherford et al 2023), which involves the development of local pilot sites offering adult neurodevelopmental pathways encompassing ADHD, autism, and related conditions. The Commissioner for Children in Wales (2023) has also advocated for a needs-led rather than diagnosis-led services for neurodivergent children.

These initiatives reflect a growing international drive for integrated neurodevelopmental care pathways, providing holistic assessment and support (Fulceri et al 2023).

Asherson et al (2022) propose integrating adult ADHD care within primary care, encouraging GP-led identification and routine monitoring, with specialist support and based on appropriate training and supervision for GPs and support staff. They argue that improving access to treatment and support for individuals with ADHD within

primary care is likely to have benefits for treatment efficacy across other physical and mental health conditions, in addition to common mental health complaints, which are typically managed within primary care. They contend that this has the potential to reduce overall volumes of work and lead to better utilisation of GP time and resources.

Asherson et al (2022) advocate for a stepped care model through which the annual treatment review for straightforward cases within primary care would allow secondary care services to focus their limited resources more on new patients and those with more complex clinical presentations.

Bullock & Ford (2022) describe a nurse-led clinic for children where specialist nurses conduct ADHD assessments, interventions and monitoring, in line with NICE guidelines. Three nurse prescribers were recruited into the service, who took on the role of ADHD pathway leads. Monthly ADHD multidisciplinary team meetings ensured a comprehensive and timely assessment process for each patient, based on their presentation and concerns. The MDT included:

- Nursing leads (independent prescribers);
- Psychologists;
- Play specialists;
- Parenting specialists;
- Healthcare support workers;
- Psychiatrists.

The nurse leads are independent prescribers and manage treatment through direct prescribing or review and monitoring of Shared Care Arrangements, in collaboration with Primary Care. The model empowers nursing staff to deliver psychoeducation, symptom tracking, and care coordination, reducing the reliance on psychiatrists and freeing up senior clinician capacity.

Lee et al (2020) describe the successful implementation of a pharmacist-psychiatrist collaborative practice agreement in an adult ADHD clinic at an academic medical centre in San Diego, California. Adult patients undergo a comprehensive assessment overseen by a Neuropsychologist, including a full neuropsychological evaluation, a detailed childhood and adult history and assessment of ADHD symptoms (using rating scales) as well as potential cognitive, mood, anxiety, and other comorbid psychiatric and developmental disorders. Patients diagnosed with ADHD who wish to receive medication were introduced to the pharmacist-psychiatrist collaborative practice model and were given an initial prescription with instructions for follow up with the pharmacist.

During follow-up visits, the pharmacist evaluated the patient’s response to medication therapy, symptom improvement, side effects, and adherence before

reviewing the patient together with the psychiatrist to agree on the best treatment strategy and plan.

Recommendation 2

As ADHD frequently co-exists with autism spectrum disorder, other neurodevelopmental disorders and mental health problems, and in keeping with developments across the UK, assessment and treatment provision should be considered a component of an integrated and needs-led neurodevelopmental Service. This recommendation is consistent with the Emotional Health & Wellbeing Framework, which was recently subject to public consultation.

(a) The development of an integrated and needs-led neurodevelopmental Service is likely to be more readily achievable across Children's Services than it is in adults, where a phased approach to developing integration will be necessary. However, stronger links between services for Adults with ADHD and/or ASD should be established as soon as possible, recognising that there are also capacity challenges within ASD Services that must be addressed.

Recommendation 3

The development of a stepped-care approach is recommended, delivering holistic treatment, care and support, tailored to an individual's level of need and appropriately resourced across primary and secondary health care. This could be achieved by providing ring-fenced funding for ADHD. GP practices should be incentivised to contribute to the delivery of ADHD care and treatment.

There should be investment in training to enable GPs and the Primary Care workforce to undertake post-diagnostic support and NICE recommended physical health monitoring with a smooth pathway for the patient back to the Secondary Care Service, when the need arises.

GPs with a special interest, together with other practitioners in primary care roles (e.g. pharmacists for prescribing, mental health trained nurse practitioners) should be provided with the opportunity to train in specialist aspects of ADHD care such as assessment, treatment and prescribing with referral to secondary or specialist services for more complex cases.

This could be achieved by providing ring-fenced funding for ADHD to support locally commissioned services or through the new neighbourhood plan.

Recommendation 4

Specialist training in ADHD for practitioners in Primary and Secondary Care Services should be identified and delivered on an ongoing basis.

3. Literature Review

Aetiology and Epidemiology

While ADHD was first described by Alexander Crichton in 1798, scientists and clinicians have struggled to understand its causes (Price and Raffelsbauer 2012), although Faraone et al (2021) suggest numerous genetic and environmental risk factors accumulate in various combinations to cause ADHD, with these risk factors leading to subtle changes in multiple brain networks and in the cognitive, motivational, and emotional processes they control.

In a small number of cases, ADHD-like symptoms may be caused by a single genetic abnormality (Faraone and Larsson, 2018), extreme deprivation early in life (Kennedy et al 2016), or early traumatic brain injury (Stojanovski et al 2019). However, in most cases, many genetic and environmental risk factors accumulate to cause the disorder (Faraone et al 2015) with the environmental risks for ADHD impacting very early in life, during the foetal or early postnatal period. While these findings assist in understanding the causes of the disorder, they are not helpful in diagnosing ADHD (Faraone et al 2021).

Faraone et al (2021) also point out that people diagnosed with ADHD have an increased risk of failure at school and exhibiting antisocial behaviour. They also have an elevated risk for experiencing mental health problems, somatic disorders, drug and alcohol abuse, accidental injuries, and premature death, including attempted and completed suicide.

In a meta-analysis of 19 studies, Willcutt (2012) found that 5.9% of young people meet the diagnostic criteria for ADHD with Polanczyk et al, (2007) suggesting that 1.5% of children meet the criteria for the more severe form, known as hyperkinetic syndrome. In their meta-analysis incorporating six studies with over 5300 participants, Simon et al (2009) estimated the prevalence of ADHD in adulthood to be 2.5%. Similarly, in a meta-analysis involving 20 studies across 13 countries, Fayyad et al (2017) estimated that 2.8% of adults meet the criteria for ADHD, which is consistent with meta-analysis undertaken by Faraone et al (2006) involving 21 studies, which suggests that approximately one in six youths with ADHD will meet full diagnostic criteria for ADHD at age 25.

Furthermore, in a meta-analysis involving over 32,000 older adults, a prevalence of 2.2% based on ADHD rating scales was found, however, this dropped to 1.5 % in people at least fifty years old and in two further meta-analyses, performed by the same research team, prevalence rates of only 0.2 % and 0.02 % were reported among persons at least fifty years old (Dobrosavljevic et al 2020).

ADHD occurs throughout the developed and developing world and is more common in males compared with females (Faraone et al 2021). In a meta-analysis of parent ratings of symptoms in 29 studies and teacher ratings in 24 studies, Willcutt (2012) found a roughly two-to-one male to female ratio. Although, in a recent study using national healthcare records, to investigate sex differences in diagnosis and clinical care in young people with ADHD living in Wales, Martin et al (2024) found that of the 16,458 individuals diagnosed with ADHD, only 20.3% were females, with a male-to-female ratio of 3.9:1, concluding that females with ADHD are experiencing later recognition and treatment, partly because of diagnostic overshadowing from other mental health conditions, such as anxiety and depression, or initial misdiagnosis.

The American Psychiatric Association (2013) describe the clinical presentation of ADHD as primarily inattentive, predominantly hyperactive-impulsive, or combined, depending on the nature of their symptoms. In a study conducted by Willcutt et al (2012), it is proposed that inattention is more strongly associated with academic impairment, low self-esteem, negative occupational outcomes, and lower overall adaptive functioning, while hyperactive-impulsive symptoms are associated with peer rejection, aggression, risky driving behaviours, and accidental injuries.

Impact on Other Aspects of Life

ADHD is a disorder associated with serious distress and/or impairments in living. Although, as documented below, many severe adverse outcomes have been associated with ADHD, the typical patient does not experience all, or even most, of these problems. Many patients live enjoyable and productive lives, especially if they receive treatment.

In a meta-analysis conducted by Lee et al (2016), comprising seven studies involving over 5000 young people, their parents reported significant impairments in the quality of life experienced by youths with ADHD when compared to typically developing peers. In particular, their emotional, social and school functioning were considerably impaired. Using measures such as rejection and likability, popularity, and friendships Ros and Graziano (2018) found that children with ADHD had moderate-to-significant impairments in socialising with peers, together with moderate impairments in social skills, including sharing, cooperating, turn-taking, reciprocity. The children with ADHD also had difficulties with social-information processing, such as recognising social cues, identifying problems, generating solutions, and avoiding biases.

In addition, in a meta-analysis of 17 studies, the parents of children with ADHD reported a moderate deficit in their quality of life relative to other parents (Dey et al 2019).

Recognition, Referral, Assessment and Treatment

NICE guidelines provide a comprehensive approach to recognising, diagnosing and managing ADHD in children, young people and adults based around multidisciplinary specialist ADHD teams with expertise in the diagnosis and management of ADHD (NICE 2018).

In terms of recognition, NICE (2018) highlight the need for awareness of groups of people who may have increased prevalence of ADHD compared with the general population, including:

- people born preterm
- looked after children and young people
- children and young people diagnosed with oppositional defiant disorder or conduct disorder
- children and young people with mood disorders (for example, anxiety and depression)
- people with a close family member diagnosed with ADHD
- people with epilepsy
- people with other neurodevelopmental disorders (for example, autism spectrum disorder, tic disorders, learning disability [intellectual disability] and specific learning difficulties)
- adults with a mental health condition
- people with a history of substance misuse
- people known to the Youth Justice System or Adult Criminal Justice System
- people with acquired brain injury.

NICE (2018) also advise of the need to be aware that ADHD is thought to be under recognised in girls and women and that they:

- are less likely to be referred for assessment for ADHD
- may be more likely to have undiagnosed ADHD
- may be more likely to receive an incorrect diagnosis of another mental health or neurodevelopmental condition.

As ADHD is a spectrum disorder and ADHD traits are ubiquitous, the Royal College of Psychiatrists in Scotland (2023) recommend that a threshold is set for referral to specialist services with the need for evidence of a specific cluster of symptoms present in two or more settings and evidence of these symptoms interfering with or reducing the quality of an individual's functioning prior to the initiation of a referral.

When a child or young person presents in primary care with behavioural and/or attention problems suggestive of ADHD, primary care practitioners should determine the severity of the problems, how these affect the child or young person and the parents or carers, and the extent to which they pervade different domains and settings. If such problems are having an adverse impact on their development or family life, the primary care should consider the following, prior to referral to secondary or specialist care:

- a period of watchful waiting of up to 10 weeks, with signposting to relevant support (including e.g. digital resources) during this period, where appropriate
- offering parents or carers a referral to a group-based ADHD-focused support (NICE 2018)

Referral from the community to secondary care may involve health, education and social care professionals (NICE 2018).

A diagnosis of ADHD should only be made on the basis of:

- a full clinical and psychosocial assessment of the person, which includes discussion about behaviour and symptoms in different domains and settings;
- a full developmental and psychiatric history; and
- observer reports and assessment of the person's mental state. (NICE 2018)

NICE (2018) also state that rating scales such as the Conner's rating scales and the Strengths and Difficulties Questionnaire are valuable adjuncts with observations (for example, at school) providing useful information, particularly when there is doubt about symptoms.

The Royal College of Psychiatrists in Scotland (2023) advises that a good quality assessment takes time, is preferably multidisciplinary and involves information gathered from a variety of sources, such as third parties, school records and previous health assessments. Longitudinal assessment is also recommended. While Asherson et al (2022) suggest that the diagnostic assessment requires at a minimum a focused assessment at interview of ADHD symptoms and impairments, an informant account from childhood where possible, an account of the course and impact of ADHD symptoms from childhood, and an assessment of common comorbidities.

Bullock and Ford (2022) recommend the deployment of the diagnostic screening tool, the Qb test, which provides objective information to aid ADHD assessment; it uses age- and gender-normative data to assess the three core symptoms,

hyperactivity, impulsivity and inattentiveness. They suggest the Qb test is an essential part of the ADHD pathway with the results used together with other ADHD assessment tools to aid clinical judgement.

NICE (2018) state that for a diagnosis of ADHD, symptoms of hyperactivity, impulsivity and/or inattention should:

- meet the diagnostic criteria in DSM-5 or ICD-11 (hyperkinetic disorder; but exclusion based on a pervasive developmental disorder or an uncertain time of onset is not recommended) and
- cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings and
- be pervasive, occurring in 2 or more important settings including social, familial, educational and/or occupational settings. As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people, there should also be an assessment of their parents' or carers' mental health.

Clinicians need to be aware of gender differences in presentations. Biederman et al (2002) point out that girls with ADHD were more likely than boys to have the predominantly inattentive type of ADHD and are less likely to exhibit problems in school or in their spare time. Consequently, the apparent absence of overt symptoms and less externalised behaviours can impair the recognition of ADHD in girls.

As there exists a considerable overlap between the symptoms of ADHD and other major psychiatric disorders, in particular, bipolar disorder, BPD or emotionally unstable personality disorder and anxiety disorders (Kessler et al 2006), the Royal College of Psychiatrists in Scotland (2023) suggest that the clinical assessment for ADHD should take into account the presence of medical and psychiatric conditions which can simulate ADHD or the presence of comorbid disorders.

NICE (2018) recommend that following a diagnosis of ADHD, support should include a structured discussion about the potential impact of ADHD upon their life. Where appropriate, this should involve their families or carers. This structured discussion should inform the development of a shared treatment plan and include:

- identifying the positive impacts of receiving a diagnosis, such as:
- improving their understanding of symptoms
- identifying and building on individual strengths
- improving access to services
- the negative impacts of receiving a diagnosis, such as stigma and

labelling
- a greater tendency for impulsive behaviour
- the importance of environmental modifications to reduce the impact of ADHD symptoms
- education issues (for example, reasonable adjustments at school and college)
- employment issues (for example, impact on career choices and rights to reasonable adjustments in the workplace)
- social relationship issues
- the challenges of managing ADHD when a person has coexisting neurodevelopmental or mental health conditions
- the increased risk of substance misuse and self-medication
- the possible effect on driving

Pliszka (2007) proposes that all mental health assessments should include a screen for ADHD by specifically asking questions around the major symptom domains of ADHD (inattention, impulsivity, and hyperactivity) and establishing if such symptoms cause impairment.

Recommendation 5

Due to a dramatic increase in demand for ADHD Services in recent years, referral criteria should be agreed by Primary and Secondary Care professionals.

Advice and Support Following Diagnosis

NICE (2018) also recommends that people diagnosed with ADHD (and their families or carers, as appropriate) should be informed about sources of information, including local and national support groups and voluntary organisations, websites and supports for education and employment. In addition, people who have been assessed but whose symptoms and impairment fall short of a diagnosis of ADHD, may benefit from similar information.

The NICE (2018) guidelines also advocate for specific support for families and carers, where appropriate involving schools, colleges and universities and when an individual with ADHD has a comorbid condition, involve other relevant healthcare professionals

Medication is recommended when ADHD symptoms are still causing significant impairment in at least one domain of everyday life despite environmental modifications (NICE, 2018).

NICE (2018) recommends that all medications should only be initiated by a healthcare professional with training and expertise in diagnosing and managing ADHD and only following a full baseline assessment that includes:

- Confirmation that they continue to meet the criteria for ADHD
- A review of their mental health and social circumstances
- A review of their physical health

A referral for a cardiology opinion may be needed, if indicated.

In a systematic review and network meta-analysis study conducted by Cortese et al (2018), which was aimed at estimating the comparative efficacy and tolerability of oral medications for ADHD in children, adolescents, and adults, stimulants were found to be highly effective in reducing the symptoms of ADHD. Taking into account both efficacy and safety, the medications with the best benefit-to-risk ratios were methylphenidate for children and adolescents, and amphetamines for adults.

For children aged 5 years and over, methylphenidate is recommended by NICE (2018) as the first line pharmacological treatment and then sets out guidance on switching medications where insufficient benefit has been observed.

NICE (2018) advocates offering lisdexamfetamine or methylphenidate as first-line pharmacological treatment for adults with ADHD before again outlining alternative medications where insufficient benefit has been derived.

In children under 5 years, the first line treatment recommended by NICE (2018) is ADHD-focused group parent-training. Medication for ADHD should not be prescribed for any child under 5 years without a second specialist opinion from an ADHD service with expertise in managing ADHD in young children.

During titration, NICE (2018) recommends recording ADHD symptoms, impairment and adverse effects at baseline and at each dose change on standard scales, completed by parents and teachers, and progress reviewed regularly (for example, by weekly telephone contact) with a specialist. Following titration and dose stabilisation, NICE (2018) recommends that prescribing and monitoring of ADHD medications should be carried out under a Shared Care Protocol with Primary Care. Regular monitoring of medication effectiveness, side effects, growth (for children), and physical health is required

Non-Pharmacological Treatments

Evidence supporting the benefits of non-pharmacological therapies is variable, however, NICE (2018) recommends the provision of information about ADHD with additional support to the parents and carers of all children aged 5 years and over and young people with ADHD. The support, which may be group based, should include:

- education and information on the causes and impact of ADHD
- advice on parenting strategies
- with consent, liaison with school, college or university
- both parents and carers, if feasible.

Faraone et al (2021) report that behavioural treatments for ADHD are diverse and have a different content and focus depending on the age of the patient, suggesting that for pre-school and primary school children, parents are trained to improve their methods of discipline and interaction with their children, while for adolescents and adults, therapy helps patients improve their organisational skills.

In a systematic review and meta-analysis, Rimestad et al (2019) found that parent training is partially supported as an efficacious intervention for pre-school children.

NICE (2018) also advises consideration of cognitive behavioural therapy (CBT) for young people and adults with ADHD who have benefitted from medication but whose symptoms continue to cause a significant impairment in at least one domain.

In a systemic review for the Cochrane Library, Lopez et al (2018) report that CBT may improve the core symptoms of ADHD, reducing inattention, hyperactivity and impulsivity, finding that when combined with pharmacotherapy, there was evidence of an improvement in a person's overall level of functioning in life and a reduction in depression and anxiety when compared to that seen with pharmacotherapy alone. None of the included studies reported severe adverse events.

Knouse et al (2017) conducted a meta-analysis of CBT for adults with ADHD, finding moderate improvements in self-reported ADHD symptoms and related impairment. However, in another meta-analysis conducted by Young et al (2020) incorporating four studies involving adults with ADHD, the use of CBT resulted in moderate improvements compared with waiting list controls, while in three of the studies, CBT led to only small to moderate improvements compared with active controls.

Nasri et al (2020) conducted a relatively small study aimed at evaluating the feasibility and preliminary effects of a new group treatment manual for adults with ADHD in which 18 adults participated in a 14-week therapy programme, involving a combination of cognitive and dialectical behaviour therapy (DBT). The primary

outcome of this study was that ADHD symptoms significantly decreased, remaining stable for 6 months with measures of depression, perceived stress, and anxiety also significantly reduced.

In a research report investigating the use of digital interventions available to help manage and/or diagnose ADHD in adults in the UK (excluding Scotland), Bosnic et al (2024) recommend the use of apps featuring therapeutic model adaptation, psychoeducation, social support, and various trackers and alerts to help both the people on waiting lists for assessment and those who have been diagnosed to improve their capacity for ADHD self-management.

The Royal College of Psychiatrists (2023) suggest that many adults with ADHD may benefit from the practical and emotional support offered by multidisciplinary mental health teams, particularly highlighting the benefits of occupational therapists (OTs) in helping patients to structure their time, improve their organisational skills and assist with access to further education and/or employment.

Children and Young People Transitioning to Adult Services

While the transition period through which a young person transitions to Adult Services may depend on individual factors, NICE (2018) guidelines advocate for the reassessment of a young person with ADHD who has been receiving treatment and care from CAMHS or paediatric services at school-leaving age, to establish the need for referral and continued treatment into adulthood.

Lovett & Harrison (2021) point out that persistence of ADHD symptoms into adulthood should not be assumed, highlighting that, while studies differ in the rate of persistence found, there is agreement that many children with ADHD are no longer clinically symptomatic as adults.

If treatment is necessary, arrangements should be made for a smooth transition to adult services with details of the anticipated treatment and services that the young person will require. Furthermore, following transition to adult services, adult service professionals should carry out a comprehensive assessment of the person with ADHD that includes personal, educational, occupational and social functioning, and assessment of any coexisting conditions, especially drug misuse, personality disorders, emotional problems and learning difficulties (NICE 2018).

Recommendation 6

A standardised pathway, based on best practice, should be developed to promote the smooth transition of young people to Adult Services, ensuring that a comprehensive reassessment of the young person is undertaken to evaluate the need for ongoing treatment and care to determine if referral to

Adult Services is required. The Transition Pathway should be regionally agreed by Children and Adult Services Clinical Networks.

ADHD in Prisons and Forensic Services

Overall, the links between ADHD and criminality are complex, although ADHD has also been shown to be associated with criminality and antisocial behaviour and consequently, there is a high prevalence of ADHD in prison populations compared to the general population (Carlander et al 2024).

Specifically, Mohr-Jensen and Steinhausen (2016) reported that individuals with childhood ADHD had a two to three times increased risk of being arrested, convicted, or incarcerated in adulthood with thefts, assaults and possession of weapons or drugs among the most frequently committed crimes.

While estimates vary, research indicates an increased prevalence of ADHD among the prison population, reported as 25.5% (Young et al 2015) to 26% (Baggio et al 2018), which is significantly greater than the 2–3% often reported for the general adult population (Fayyad et al 2017; Simon et al 2009). Fazel and Favril (2024) contend that previous meta-analyses may have overestimated the prevalence of ADHD in prisoners by including data from selected samples, arguing that a prevalence of 8.3% or 1 in 12 prisoners is the best approximation. However, Bagio and Efthamoui (2024) defended their meta-analysis suggesting that, due to their use of too restrictive exclusion criteria and suboptimal analysis, the ADHD prevalence provided by Fazel and Favril (2024) was an underestimation, concluding that the pooled prevalence estimated through their reanalysis was 22.2%.

In their meta-analysis comprising 21 studies and over 19,500 prison inmates, Young et al (2015) found no variance in the prevalence of ADHD observed between males and females or adolescents and adults.

In prison, ADHD often goes unidentified, yet with an earlier onset of offending, higher rates of recidivism and a more severe level of aggression, the management of inmates with ADHD is more difficult and costly (Young and Thome 2011).

Young et al (2018) argue that, given the evidence that treatment improves symptoms and outcomes, the accurate identification and comprehensive treatment of people in prison with ADHD is necessary, with effective intervention expected to positively impact on the offender and society, leading to increased productivity, a reduced burden on resources, and critically reduced rates of re-offending. Although, in a later study conducted by Carlander et al (2024), the researchers pointed to the limited empirical evidence to support the efficacy of pharmacological ADHD treatment on criminal recidivism in inmates diagnosed with ADHD. However, Carlander et al (2024) also acknowledged that the evidence suggests that these treatments can

reduce ADHD symptoms and enhance rehabilitation outcomes, which may in turn, lower the rate of reoffending.

Although there is insufficient evidence from randomised-control trials associated with the treatment of the prison population with ADHD, Young et al (2018) further contend that the provision of appropriate pharmacological and non-pharmacological interventions within prison is a process reliant on prison staff and inmate self-awareness of ADHD symptoms and treatments, the availability of trained mental health clinicians, and the administration of specifically targeted multimodal treatments.

Specific screening programmes for individuals with ADHD and their comorbidities can help identify at-risk individuals early and reduce their involvement with the judicial system (Modesti et al 2025). They further contend that providing early interventions, including psychological, educational, and family support in childhood and adolescence represents a crucial opportunity to prevent the development of antisocial trajectories.

Reporting on the expert consensus arising from a meeting hosted by The United Kingdom ADHD Partnership (UKAP; www.UKADHD.com), Young et al 2018 outlined the following recommendations:

Identification and Assessment

1.	Prison staff training to develop awareness of ADHD symptoms and co-morbid conditions (including how these may differ by age and gender), treatments, expected outcomes and the potential impact of prison regime on the offender with ADHD (e.g. greater risk of suicide, impact of segregation). This should include recognition that many offenders mental health issues are secondary to ADHD.
2.	For youths, adoption of a suitable primary screen (e.g. CHAT) and a clinical diagnostic interview (e.g. ACE). If a rating scale is given (e.g. SNAP-IV, CBRS) this should be sensitive to both inattention and hyperactivity/impulsivity symptoms.
3.	For adults, adoption of a suitable primary screen (e.g. B-BAARS) and a clinical diagnostic interview (e.g. ACE+, CAADID, DIVA-2). If a rating scale is given (e.g. BAARS) this should be sensitive to both inattention and hyperactivity/impulsivity symptoms.

Interventions and Treatment

4.	All treatments should include psychoeducation about ADHD, including symptoms, co-morbidity, pharmacological and non-pharmacological treatments, side-effects of treatment and expected outcomes.

5.	Adoption of appropriate pharmacological and non-pharmacological Treatments.
6.	Adoption of appropriate educational and occupational programmes designed to increase engagement.
7.	Educational and occupational programmes should be prioritised that advance vocational, creative, technical, and/or athletic skills.

Care Management and Multiagency Liaison

8.	There should be close liaison between education and mental health services within the criminal justice system.
9.	A care plan coordinator should be assigned to the offender while in prison.
10.	A comprehensive care plan should be established, including a medication management plan, for the offender while in prison.
11.	The care plan should also plan to prepare the offender with ADHD for release from prison (e.g. effecting a seamless transition to ensure continuity of care and uninterrupted treatment with ADHD medication; arranging appropriate links with supportive services and agencies).
12.	A critical time intervention approach should be established for a designated person to support the offender through the release process, support implementation of the care plan and ensure engagement in healthcare.

ADHD - Suicide and Self-Harm

Several recent studies and reviews have documented a strong association between ADHD and suicidal spectrum behaviours (Impey & Heun 2012; Balazs & Kereszteny 2017; Giupponi 2018; Septier et al 2019; Garas & Balazs 2020). One of the theories underpinning this association is the concept of impulsivity, which is recognised as a core symptom of ADHD (American Psychiatric Association 2013) and a factor known to correlate with suicidal behaviour (Brezo et al 2006).

A further theory behind the possible association between ADHD and suicide is that two-thirds of ADHD cases have at least one comorbid psychiatric diagnosis (Biederman et al 1991).

In a cohort study conducted in Denmark, Fitzgerald et al 2019 reported a fourfold higher rate of suicide attempts and deaths in patients with ADHD with the risk increasing to over tenfold for people with ADHD and a comorbid psychiatric diagnosis. In their meta-analysis Septier et al 2019 found that people with ADHD attempted suicide at twice the rate of typically developing people, had over three times the rate of suicidal ideation and over six times the rate of completed suicide.

In their Taiwanese study involving over 20,000 adolescents and young adults with ADHD and over 61,000 age- and sex-matched non-ADHD individuals, Huang et al 2018 found that those with ADHD were almost four times more likely to attempt suicide, and over six times as likely to repeat suicide attempts.

In their systemic review of suicide Balazs & Kereszteny 2017 highlighted that, based on studies over the previous four years, more than half of the adolescent patients with ADHD had suicidal thoughts and for adults, one third of ADHD patients had suicidal ideation. Based on these results, Balazs & Kereszteny 2017 recommended the introduction of routine screening questions on suicidal thoughts in both adult and children ADHD clinics.

Balazs & Kereszteny 2017 found that ADHD is related to high suicidality in both girls and boys, across the age spectrum, highlighting that the early recognition and treatment of ADHD, either as a comorbid condition or as a main diagnosis, can play an important role in the secondary prevention of suicide.

Furthermore, Chen et al 2014 found that the results of their study pointed to a potential protective effect of ADHD drug treatment on suicidal behaviour, particularly for stimulant drugs. In addition, Huang et al 2018 methylphenidate or atomoxetine treatment did not increase the risk of suicide attempts or repeated suicide attempts but Long-term methylphenidate treatment was associated with a lower risk for repeated suicide attempts among men.

4. Themes arising from Engagement with People with Lived Experience of ADHD

Engagement with people who have lived experience, often referred to as 'Experts by Experience' is fundamental to planning for the development of ADHD services. Consequently, the views of several people, including adults with an ADHD diagnosis and a number of parents of children diagnosed with ADHD, were sought to inform the outputs and recommendations articulated in this report.

Four adults with lived experience were each interviewed online individually and a collective discussion was conducted with three parents of children with ADHD. There was considerable overlap and commonality in the experiences described by the four people with lived experience. Indeed, they all reported having been diagnosed with ADHD in adulthood, having resorted to seeking an assessment through the Private Sector. In all four cases, this involved committing considerable time and energy into conducting their own research into finding an explanation for their experiences and then identifying where they could find help.

In three out of four cases, the individuals had sought referral through Health & Social Care Services and were on waiting lists, however, in one case the waiting list was stood down and the two others came to realise that it would be several years before they would be seen, if ever at all. This was a source of considerable frustration with one participant commenting that they were *'on a waiting list for a service that didn't really exist'* and highlighting the need for people to be aware of this at the point of referral.

All four participants were misdiagnosed at some point with their symptoms being attributed to either depression, anxiety or a combination of both. They all recognised that they have experienced significant mental health problems that have not been limited to anxiety and depression, including:

- Emotional dysregulation
- Low self-esteem and low self-worth (two participants discussed having experienced Imposter Syndrome)
- Rejection Sensitivity Dysphoria (RSD)
- Suicidal ideation
- Drug and alcohol misuse

One individual talked about having made a significant attempt on his life that necessitated admission to hospital and subsequent, albeit temporary, detention to a Mental Health Inpatient Unit under the Mental Health (Northern Ireland) Order 1986. Another participant discussed how she planned to end her life by overdose, explaining *'I just wanted to die because I could not manage'.*

The people with lived experience described having a constant sense that something was wrong when they were growing up and they all reported having difficult and traumatic childhoods, contributing to their comorbid mental health problems both during their formative years and in adulthood.

During childhood, they often faced criticism for their behaviours and/or inattentiveness. One participant reported on how he had been referred to in school as *'intelligent but a messer'*, while another described how she had been told that she was not smart enough to undertake the transfer test. These and similar experiences had a devastating impact on the confidence and self-esteem of individuals with all four participants reporting that they had experienced Rejection Sensitivity Dysphoria (RSD). RSD is characterised by short-lived but intense emotional pain triggered by a distinct event of real or perceived rejection, criticism, or teasing.

Two participants described challenging experiences at University, with one unable to complete her degree and another becoming completely overwhelmed when required to complete her dissertation, so much so that she barely left her home for two years. A participant reflected on how access to treatment for ADHD has transformed his life to the point where he has been able to undertake a PhD stating, *'I totally recognise what I'm worth now'*.

A feeling of not fitting in was a common thread and all of the participants described difficulties in maintaining relationships with family relations frequently strained. Notably, these participants reported that since their diagnosis and beginning treatment, they are now enjoying much improved relationships with their loved ones.

Alcohol and drug misuse was also described by two individuals and in both cases, substance misuse is no longer a problem since receiving their ADHD diagnosis.

Participants also talked about difficulties with maintaining employment and moving from job to job was an experience shared by individuals. One participant, in particular, reflected on the degree to which impulsivity had impacted on her life in a significant way, such as resigning from jobs and other rash life changing decisions.

As well as comorbid mental health difficulties, all of the individuals have experienced multiple co-existing physical and/or neurodevelopmental problems, including autism, dyslexia, fibromyalgia, Ehlers-Danlos Syndrome, Postural Orthostatic Tachycardia Syndrome and difficulties managing weight. The link between these problems and ADHD is recognised in the literature. One participant reports that she believes that had she been diagnosed and treated for ADHD earlier, she would not have experienced the stress and anxiety that is often recognised as a trigger for her co-morbid health problems.

In addition, female participants reported considerable additional difficulties with experiencing Pre-menstrual Dysphoric Disorder and during Perimenopause, highlighting a worsening impact on ADHD symptoms for women, including increased problems with focus, memory, emotional regulation and sleep.

Female participants also talked about how ADHD in girls has been historically under-recognised and consequently, under-diagnosed. A number of reasons are cited in the literature to help explain why ADHD may be underdiagnosed in girls, including mental health problems overshadowing symptoms of ADHD, a relatively higher threshold for an ADHD diagnosis for females compared to males and the fact that ADHD in females may be more likely to present as the inattentive rather than the hyperactive-impulsive or combined subtype. It is also proposed that females may be better able to employ masking and/or compensating strategies for coping with ADHD symptoms.

Inevitably, all of the participants had attended their Emergency Department and/or their GP at some point to seek help and a lack of awareness of ADHD amongst health and social care professionals was a common experience.

Following their diagnosis, all four participants were commenced on medication with one person having to discontinue due to experiencing side-effects. However, that individual discussed how confirmation of the diagnosis helped to explain their experiences and changed their perspective on what they had previously been regarded as *'personality flaws'*.

They also talked about improvements in their quality of life, including improved relationships, more considered and better decision making, less risk taking, reduced fatigue, better weight control and improved focus. These improvements have had a significant positive impact in their work environments, educational experiences and family life.

The parents of children and young people with ADHD reported better experiences in accessing services for an assessment, albeit waiting times were protracted in two out of three cases, with one child waiting three years for their assessment, while the parents of another child sought an assessment through the Private Sector and paying for medication for a period of time, prior to gaining access to an assessment and diagnosis through the local Trust.

The parents described a wide range of problems experienced by their children before their diagnosis and commencement of treatment, although one parent explained that, through their choice, their child had not yet started medication, however, they were at the point of contemplating reaching out to the service because of their son's ongoing symptoms.

The range of difficulties described by parents included risky behaviours, such as running into the road, highly emotional states, increased impulsivity, aggression, difficulties forming friendships, playing truant, poor academic performance, strained relationships with siblings and oppositional behaviour.

While two of the parents talked about the benefits of the medication prescribed for their children, they all discussed the immense value gained from non-pharmacological approaches, including parental psychoeducation and training, counselling for children provided within the Voluntary Sector, 1:1 support within the school environment, support through transitions in the young person's life, for example, beginning university.

The parents discussed the need to develop holistic services providing early intervention with the capacity to dramatically reduce waiting times for assessment. As a result of their personal experiences, they were all strong advocates for strengthening Voluntary Sector provision and they recognise the importance of a cross-departmental approach involving the criminal justice system, the Department for Communities and Department of Education. In particular, they highlighted the importance of improved training for teachers.

Recommendation 7

ADHD training should be available to all practitioners across the Health & Social Services system and in particular, targeted at those who regularly assess patients' needs (e.g. staff working in Emergency Departments) and those practitioners providing care for populations of people in which ADHD may be prevalent (e.g. people with mental health problems and looked after children).

Recommendation 8

Children, young people and adults with ADHD benefit from early intervention, therefore pre-assessment support (including parent/family support) should be available. This should largely be delivered through additional investment in the Community and Voluntary Sector.

5. Existing Trust Services for People with ADHD

Children Services

Northern Health & Social Care Trust

There are four pathways to assessment and diagnosis for children and young people in the Northern Trust, including referral to the Paediatric ADHD Assessment Service through which the majority of referrals flow. This is a nurse-led service comprising Band 7 Specialist Nurses and Band 5 Nurses. The service is also supported by administrative staff.

When a child reaches the top of the waiting list they are offered a full ADHD assessment, which incorporates four pieces of information to be completed:

- Parent to complete a questionnaire capturing the child's health development, social and family history
- Parent to complete online ADHD rating scale
- School to complete a detailed report
- School to complete online ADHD rating scale

The ADHD Nurse Specialist will analyse the returned information and if appropriate, will offer a Quantitative Behavioural (Qb) test, which will be conducted by the Band 5 Nurse. Following this, the child's parent/guardian will have a comprehensive neurodevelopmental telephone assessment with an ADHD Nurse Specialist before a recommendation is made as to whether the assessment meets the criteria for onward referral to an Acute Paediatric Consultant who will determine final diagnosis and subsequent clinical management.

However, if a child has other presenting conditions and they are in receipt of services for those problems, their ADHD assessment will be completed as part of that journey, including assessment and follow-up care through the:

- Step 3 CAMHS
- Children's Learning Disability Therapeutic Service
- Community Paediatric Medical Services

South Eastern Health and Social Care Trust

In South Eastern Trust, Child Health Services provide a dedicated Children's ADHD Service.

The Multidisciplinary Team consists of Consultant Paediatricians, Consultant Psychiatrists, Speciality Doctors, Non-medical Prescribing (NMP) Nurses, and Nurses undertaking NMP training, Child Health Assistants and Administrative staff. Multidisciplinary working is strengthened though reflective practice sessions, which take place every two months, providing an opportunity to discuss and learn from cases selected by team members. There is a strong clinical interface between CAMHS and ADHD for one sector within the Trust, discussion and co-working of children and young people occurs.

Referrals are channelled through a single point of entry to the Community Children's Health Service (this includes Child health referrals and some CAMHS referrals, either pre-or post CAMHS daily gateway) where, using the clinical information available, they are triaged by the multidisciplinary team at twice weekly meetings to determine the most appropriate clinical pathway.

Thereafter, home and school questionnaires, together with an ADHD rating scale are sought. As there is a three year waiting time, this information is also requested when the patient is appointed for assessment. A Qb test may also be used, particularly in cases where there is some variance in the information collated and if they are attending the Nurse-led diagnostic service for assessment. The Nurse-led diagnostic service is suitable for a sub-set of children and young people who come through the neurodevelopmental pathway.

The Qb test is undertaken with band 3 Child Health Assistants, with the ordering clinician responsible for test results and follow up action. The Child Health Assistants signpost parents to supports and resources on –line or within the community.

The neurodevelopmental pathway is for Children and Young People (CYP) who are presenting with traits of autism but there is also evidence of complexity, e.g. trauma, and /or presenting with possible ADHD traits. These CYP are captured on the ASD waiting list, rather than the ADHD waiting list.

In addition, the Children's Disability Team will contribute to the assessment process for those children with severe intellectual disability who are attending a special school.

One consultant will continue to provide care for young people over the age of 18, following stabilising of treatment, whilst the young people await access to the adult service.

The team report that the availability of this range of information helps to streamline the assessment process, thereby facilitating a diagnosis at the initial assessment. The team would be keen to obtain developmental history for all children and young

people, similar to autism service, to allow parents to discuss issues away from their child and reduce the possibility of children and young people needing to move pathways at a late stage in their journey.

Southern Health and Social Care Trust

GPs will refer to the Emotional Health and Well Being (EHWB) Single Point of Entry (SPOE) with a query of ADHD. This referral, dependent on the child's age, will be signposted to Community paediatrics (under 12yrs) or to CAMHS (over 12yrs). They will complete a holistic assessment of the child and will refer to the Trust ADHD service. This service is a multidisciplinary service with 0.2 WTE doctor (CAMHS) and two 0.8 WTE band 6 practitioners.

GPs are asked to provide some screening information. Some integrated ASD and ADHD clinics are provided to facilitate a single wait and assessment experience for children who present with what appears to be an ASD/ADHD comorbidity.

Both services are integrated and are clinically led by the CAMHS Consultant Psychiatrist.

Prior to all assessment appointments, the SNAP-IV is completed by parents and teachers and Qb testing is undertaken with the Band 6 nurses, although due to resource limitations, this can be a source of delay. Waiting times for the Community Paediatric Service are over 12 months, while the CAMHS assessment can be provided in nine weeks.

The wait for the Trust ADHD service is currently 19 months.

Every child has access to pre-assessment support and Early Intervention Workshops are delivered to parents. In addition, an online parent information session is provided, and parents must link into this as it is integral to the assessment process.

If a diagnosis is confirmed and the child or young person requires medication, this is completed by community paediatrics (under 12) or by CAMHS (over 12). Once the assessment is complete there is no wait for these services.

Belfast Health and Social Care Trust

The Community Paediatrics Team provide a Children's ADHD Service in the Belfast Trust.

This service provides diagnostic assessments for children from the age of 6 years to the end of their primary 7 year. Post-primary diagnostic assessments and assessments for children with severe learning difficulty/disability are not provided.

Monitoring reviews are conducted for all children who have been prescribed ADHD medications until they are 18 years old.

The Multidisciplinary Team consists of Consultant Paediatricians, Speciality Doctors, two Non-medical Prescribing (NMP) Nurses (who have recently completed training), Health Care Assistants and Administrative staff.
Multidisciplinary working is strengthened through peer review and reflective practice sessions, which occur once per month. This provides an opportunity to discuss and learn from cases selected by team members. At this team meeting, there is an opportunity to discuss cases with a psychology consultant colleague with a special interest in Trauma.

Referrals are accepted from GPs, health care professionals and educational psychologists. Referral forms have recently been updated to request information from the health care professional and by the child's teacher/SENCO. These referrals are channelled through a partial booking office in community paediatrics. They are triaged weekly by consultant paediatricians and/or NMP nurses on the Encompass system.

The ADHD assessment pathway has been subject to service development over the past 12 months. This took place in response to long waiting times and a desire for quality improvement. Changes to the assessment pathway followed with a pilot project involving the ADHD assessments undertaken with P7 pupils.

When a child nears the top of the waiting list; parents will be contacted to seek permission to send standardised Conner's rating scales to the parent and school.

Following receipt of the completed Conner's questionnaires; an appointment is booked for a QB test. The QB test is carried out by health care assistants or NMP nurses. When the QB test is completed, the child's case will be listed for a multi-disciplinary screening meeting. These occur once per week with consultant paediatricians and NMP Nurses. The Conner's and QB results are reviewed in line with NICE Guidance. The relevant medical history is reviewed, where available on the electronic records systems (e.g. ECR, Paris and Encompass).

If the Conner's questionnaires do not meet diagnostic criteria in line with NICE Guidance, and the QB test is not suggestive or supportive of a diagnosis of ADHD; the child is discharged from the assessment at this point. A report of the investigations and multi-disciplinary discussions are sent to parents/guardians and GP. The letter also contains details on sources of support for the family e family support hubs.

If Conner's questionnaires and/or QB are suggestive of difficulties, which are in keeping with ADHD, further assessment is warranted and the child's

neurodevelopmental history is completed with their parent/guardian. At this point, further information may be collected, for example social communication questionnaires or further evidence from school.

The child and their parent/carer will then be offered a face to face appointment where they will have a clinical examination and receive feedback on their assessment.

If a young person receives a diagnosis of ADHD, medication will be discussed alongside sign posting to sources of support for the family.

If the child is established on medication, they will remain under review in the community paediatric ADHD clinic, in line with the shared cared agreement. They will attend regularly for height, weight and blood pressure monitoring.

If the young person remains on medication at 17 years old, a QB test on and off medication will be conducted in preparation for transition to adult services. In Belfast Trust, the referral of a young person to adult services takes place within 9 weeks of their 18th birthday and only if they remain on medication. If a young person with ADHD is not on medication at the point of exit from our service, they are discharged to their GP with advice regarding onward referral to adult services, should they request this in the future.

The Belfast CAMHS Team undertake ADHD assessments with children and young people attending their service with a co-existing mental health problem, including children from the South Eastern Trust area. The Connors rating scale is used with schools and families prior to the assessment.

The Consultant Nurse and Non-medical Prescribing Nurses may conduct the diagnostic assessment but the decision to confirm an ADHD diagnosis will be discussed by the Multidisciplinary Team and confirmed by a Consultant Psychiatrist, who is also responsible for initiating medication prescribing. The Non-Medical Prescribing Nurses will undertake patient reviews at the ADHD Clinic, which at this point, is only available in Belfast but it is hoped that the service will be extended to include the provision of a clinic in the South Eastern Trust in the near future.

The Consultant Psychiatrist will review those patients with drug and alcohol misuse problems who are prescribed medication for ADHD.

Due to the limited capacity in Adult Services, transitioning young people is very challenging with significant numbers of patients remaining with the CAMHS Team for years beyond their 18th birthday, which in turn, impacts on the overall capacity of CAMHS.

Western Health and Social Care Trust

Currently three referral pathways exist within the Western Trust's ADHD Services.

Pathway 1: Community Paediatric ADHD Assessment Service

This pathway operates for primary school age children in the Fermanagh locality sector area only. (Primary school age children assessed/diagnosed by the Community Paediatrician with medication as part of their treatment plan are subsequently transitioned to CAMHS at secondary school age for ongoing medication monitoring/management).

Pathway 2: CAMHS Multi-disciplinary Specialist ADHD team

This pathway operates for all other locality sectors in the Trust area plus primary school age children deemed more complex with comorbid presentations in the Fermanagh locality sector area and in addition secondary school age young people requiring ADHD assessment in Fermanagh area.

Pathway 3: Children with Disability ADHD Service

This pathway operates with respect to children with an intellectual disability that require ADHD assessment. The assessment is completed by the community nursing learning disability team ADHD Nurse Specialist which is supported by the Consultant Psychiatrist for Learning Disability.

Configuration:

CAMHS has a specialist ADHD multi-disciplinary team comprising of Consultant Child Psychiatrists who provide sessional input, a 1.0 WTE Specialist ADHD Nurse Practitioner, 1.0 WTE Social work ADHD clinician and sessional input provided from a Clinical Psychologist, sessional input from a Community Paediatrician (northern sector of Trust) with sessional input also provided from an assistant psychologist and a non-medical prescriber (medication monitoring clinics).

All Community Paediatric ADHD assessments and subsequent diagnosis is completed by Paediatric medical staff

Referrals:

CAMHS referrals, which are triaged through a single point of entry, are accepted from GPs, School Nurses, Educational Psychologists and Multidisciplinary (Mental Health) practitioners in Primary Care. WTCAMHS applies threshold criteria at the point of referral, which has helped to ensure improved rates of appropriate referrals.

In recognition of the delays in conducting assessments, support is available for children on the waiting list.

Assessment:

There is some variance in the assessment pathways when comparing Community Paediatrics with CAMHS, although both teams use the Connors rating scales and Qb testing, Paediatricians request a written report from the child's school or Educational Psychologist. CAMHS also request school reports /information but may in addition carry out school observations (complex presentations) and have a well-established CAMHS/ Educational Psychology Service interface meeting to discuss referrals/comorbid or more complex cases.

Diagnosis:

Responsibility for the diagnostic assessment is confined to medical staff (Consultant Paediatrician and Speciality Doctors) through the Community Paediatric pathway.

Whilst a Specialist ADHD Nurse may lead the diagnostic assessment in CAMHS in the northern sector of the Trust a weekly multi – disciplinary meeting is convened to reflect on individual cases and discuss diagnosis with the CAMHS Consultant Psychiatrist, particularly around complex cases. The Consultant Child Psychiatrist is part of the ADHD diagnostic decision within the southern sector of the Trust through weekly multi-disciplinary ADHD team meeting.

Post Diagnosis treatment/intervention:

The ADHD service offered by CAMHS is not confined to pharmacological treatment and monitoring with young people able to access social skills training and anxiety management. There are also groups available to support children with issues such as sleep and confidence. In addition, young people with more complex needs may be offered Cognitive Behaviour Therapy.

CAMHS currently provide and support an email service for families and children post diagnosis. This service provides resources and details of events/courses on a weekly basis. The CAMHS ADHD service is currently developing an email service for families on the waiting list that will provide learning in relation to ADHD, sleep and brain development, the Service would hope to incrementally build on this which is due to commence by September 2025.

Adult Services

Northern Health and Social Care Trust

A limited resource, comprising 0.4 WTE Consultant Psychiatrist and 0.4 WTE Advanced Nurse Practitioner is available in the Northern Trust to provide a dedicated ADHD Service. The service was created out of existing resource to pilot clinical pathways as a basis for a potential commissioned service.

Referrals are accepted from GPs who are required to evidence that the patient meets the criteria for the service. Thereafter, the referrals are triaged to identify any comorbidity or clinical risk, which if present, may indicate the need for a more urgent mental health assessment. Also, self-administering screening documents are issued to the patient for completion.

The information sought includes a comprehensive developmental history from a family member and the patient is asked to provide relevant background history, which may include their employment history, school reports or appraisals. A Diagnostic Interview for ADHD in Adults (DIVA) may be included before arriving at a diagnosis. The Advanced Nurse Practitioner may diagnose but this will be confirmed by the Consultant Psychiatrist.

Prior to treatment initiation, a physical health check is conducted, including identification of any history of cardiac difficulties, a cardiovascular examination and an ECG.

Some Adult Services that have sought to develop specialist/dedicated ADHD Services are less able to support the timely transition from Children Services.

There are no non-pharmacological interventions available through the Trust but patients will be signposted to sources of information, as well as the Voluntary sector. Patients with an existing ADHD diagnosis who are transitioning from Children's Services will be directly allocated to appropriate Community Mental Health Team for ongoing monitoring.

South Eastern Health and Social Care Trust

New referrals are accepted at South Eastern Trust, however, given the inadequate resource available, which encompasses only 0.8 WTE Consultant Psychiatry, new assessments are limited to patients transitioning from Children's Services and because of the growing number of young people requiring transfer to Adult Services, long delays have emerged with the result that Paediatric Services may remain involved in monitoring ADHD patients into their twenties.

New patients receive a comprehensive review with the Consultant Psychiatrist and a physical health check is conducted. No non-pharmacological treatments are available but people will be signposted to the Community and Voluntary Sector.

New referrals are triaged and any patients who appears to be experiencing mental health problems will be directed through the Trust's Mental Health Assessment Centre.

Healthcare in Prisons

South Eastern Health and Social Care Trust is responsible for the delivery of healthcare in prisons across Northern Ireland. While clinicians within the Healthcare in Prisons Service estimate significant ADHD prevalence rates among inmates, which is in keeping with estimates in the literature, the Trust is not commissioned to provide ADHD Services and therefore, the resources required to conduct the range of assessments required to inform a diagnosis are not available.

Consequently, the role of the Healthcare in Prisons Service is largely limited to continuing the treatment prescribed for patients who enter the prison system with an existing or historical diagnosis of ADHD.

In an extremely small number of cases, where an individual is exhibiting overt symptoms and behaviours consistent with ADHD, an assessment may be initiated, however, a number of factors need to be considered, including the duration of the patient's sentence, the likelihood of follow-up by a Community Mental Health Service and the willingness of GPs to enter into a Shared Care arrangement. If a patient has a short prison sentence, it is unlikely that an assessment will be offered given the probability that follow-up in the community will not be available.

Southern Health and Social Care Trust

Adult Mental Health Services in the Southern Trust do not provide a dedicated ADHD Service but will accept responsibility for young people transitioning from the Trust's CAMHS Team and also on occasions, referrals from GPs for an adult who had a confirmed diagnosis of ADHD but who has had a break in treatment.

Patients are allocated to a Consultant Psychiatrist, who will conduct an assessment to establish the individual's holistic needs and manage their ongoing treatment in a shared care arrangement with the GP.

Belfast Health and Social Care Trust

There is no dedicated ADHD Team within Adult Services at Belfast Trust. However, a small resource has been identified in an attempt to meet the needs of patients transitioning from the CAMHS or Paediatric Teams, as well as a small number of

referrals from Mental Health Teams where a practitioner has identified ADHD as a potential component of the patient's presentation. This consists of 0.5 WTE Consultant Psychiatrist and 0.2 WTE Advanced Nurse Practitioner (ANP), who undertake the review of patients prescribed ADHD medications, aiming to see patients according to their individual needs or at least annually when patients have reached a level of stability but it is extremely challenging to achieve that standard. There is insufficient capacity to provide non-pharmacological interventions.

Other patients with ADHD who have a comorbid mental illness may be receiving treatment and care through the Community Mental Health Service, in which case their reviews will be carried out by a General Adult Psychiatrist.

The service continues to accept referrals from Primary Care but the waiting time is several years. In order to identify some level of priority, the service introduced a brief triage questionnaire to assist GPs in determining the appropriateness of referrals. Currently, there are over 4,000 people waiting on an assessment.

Western Health and Social Care Trust

New patients are not accepted into Western Trust. ADHD services current pathway accepts referrals from CAMHS and the Paediatric service with a confirmed diagnosis and concordance with medication. As ADHD services are not commissioned within the Western Trust, no dedicated resource is assigned to same. Monitoring of medication exists out of current medical resources.

Medication is monitored as per guidelines and physical health standards. A physical health monitoring team (L'Derry area) is due to commence as a test of change within existing resources. Outcomes will be tracked regarding same.

ADHD services are currently delivered to 349 patients within the WHSCT as per the pathway outlined.

Themes Emerging from Engagement with Trusts

Up to this point, ADHD Services have not been specifically commissioned and, in general, Trusts have developed pathways for people with ADHD without any additional funding. In the absence of investment, services have adapted and reconfigured existing resources in an attempt to meet the needs of this population of patients.

Partly as a consequence of the lack of commissioning, considerable variability has evolved between and even within Trusts in the arrangements supporting the provision of ADHD assessment, care and treatment to children, young people and adults.

The skill mix of multidisciplinary teams varies, with different approaches adopted to referral processes and assessment pathways. Some Trusts apply referral criteria, while others accept all referrals for triage and a range of assessment instruments are used across the region.

When examining the reasons for variance within Trusts' Children's Services, the mode of provision is somewhat dependent on the needs of the child or young person. For example, children and young people with moderate to severe mental health problems are more likely to receive care and treatment for ADHD that is provided by the Trust's CAMHS Service.

The clearest common thread across all Trusts is that demand for ADHD assessment and monitoring far outstrips the capacity that has been created. As a consequence, most Trusts require referrers to provide supplementary evidence before an assessment will be offered.

While the development of Children Services' ADHD Services is more evident compared to Adult Services, a considerable gap exists between the number of referrals received by Trusts and the number of assessment appointments available. The result is significant numbers of children waiting over a long waiting time that can often be measured in years rather than weeks. Notably, Trusts report obvious deterioration in patients' presentation at the point of assessment compared to the point of referral. This often manifests in intensifying problems with the patient's functioning, emotional wellbeing and presenting risks.

Furthermore, services are frequently unable to carry out reviews within the timeframes outlined within clinical guidelines.

Some Children's Services in Trusts report significant delays in transitioning young people to Adult Services at a particularly important point in their lives, with the result that significant numbers of young adults remain the responsibility of Children's Services long after their 18th birthday.

Healthcare in Prison staff also report challenges in transitioning patients to Adult Services upon their release as a major barrier to the commencement of treatment in prisons.

All Trusts' Children and Adult Services report that they are largely limited to a focus on assessment, diagnosis, and prescription and monitoring of pharmacological treatment. There is limited capacity to provide non-pharmacological interventions with a significant reliance upon signposting to the voluntary sector.

A particular challenge is achieving a balance between new patient assessment capacity and review capacity. For example, an attempt to address waiting times

through an increase in the provision of new assessments will inevitably add to the requirement for review appointments, impacting on the service's ability to review patients in keeping with best practice standards.

Access to specialist training is also variable with staff reporting that while there is a strong emphasis on multidisciplinary supervision, learning and support, opportunities to undertake formal education programmes in ADHD have largely not existed. There was clear support from medical staff contributing to the engagement for the development of specialist nursing roles, including non-medical prescribing and Advanced Nurse Practitioner.

In addition, some Trusts report challenges with retaining staff who have been supported to undertake additional training, such as the Non-medical prescribing programme.

There is widespread support for the expansion of multidisciplinary team (MDT) roles (e.g. Advanced Nurse Practitioners, Non-medical prescribing Pharmacists) to include carrying out diagnostic assessments, predicated on the individual having accessed appropriate training with appropriate governance and supervision/support arrangements in place.

There is significant support from within Children Services across Trusts for an integrated neurodevelopmental service through which, for example, children and young people may have both an ASD and ADHD assessment.

Recommendation 9

Establish a Regional Network to support continuous learning and promote best practice

(a) **Separate networks for ADHD practitioners working in Children and Adults Services offer a pragmatic approach to establishing forums but a level of collective working would create an environment through which shared learning can take place and shared processes, such as managing transitions, can be enhanced.**

6. The Multidisciplinary Team

An ADHD diagnosis may be made by medical or non-medical professionals who are appropriately qualified with training and expertise, providing appropriate training, supervision and governance structures are in place, which ensure that all of the necessary information is gathered.

The NHS Education for Scotland Training Framework structure provides guidance on matching skills and knowledge to practice, regardless of professional background. Within this framework, four levels provide a guide to the readiness to contribute to or lead ADHD diagnostic assessments and professional learning needs (See Appendix 3).

All clinicians and practitioners should ensure that assessments are compliant with protocols and clinical guidelines, to identify those who require medical or psychiatric assessment, to explore underlying medical explanations, trauma or co-occurring conditions.

Therefore, knowledge and skills in relation to good quality assessment and co-occurring neurodevelopmental and mental health conditions are important in differential diagnosis.

Diagnosis should not be made solely on the basis of rating scales or observational data. However, it acknowledged that rating scales are valuable clinical tools.

Neurodevelopmental assessment is often best carried out within multidisciplinary teams to enable robust person-centred clinical assessment and decision making. If exploring co-morbidity, more formal assessment from a range of professionals may be required (e.g. neuropsychological, occupational, sensory or communication assessments).

Where medical evaluation is required (such as when prescribing is being considered) a clinician with competencies in medical evaluation will be required (paediatricians, psychiatrists or neurologists, Advanced Nurse Practitioners, GPs).

The multidisciplinary team might involve a range of professions, including:

- Paediatricians
- Psychiatrists
- Occupational Therapists
- Nurse/ Advanced Nurse Practitioners
- Non-medical prescriber (e.g. Pharmacists, Allied Health Professional or Nurses)
- Clinical Psychologists

- Speech and Language Therapists
- Specialist GPs

(The above has been adapted from Scotland's National Autism Implementation Team's (2023) Discussion Topics: Who can diagnose ADHD in adults?)

Currently ADHD Services are delivered by multidisciplinary teams consisting of consultant paediatricians, consultant adult and child and adolescent psychiatrists, specialty doctors, non-medical prescribing (NMP) nurses, child health assistants and administrative staff. Going forward these teams would be enhanced by the addition of specialist allied health professionals, particularly speech and language therapists and occupational therapists as currently present in other neurodevelopmental clinical settings, such as autism services.

ADHD service provision to children and young people extends across Paediatric Services and CAMHS in different configurations and targeting different populations according to age bands.

Recommendation 10
Not every service will look the same and a flexible approach to team composition is required. Children, young people and adults with ADHD require holistic and integrated care to address a wide range of personal, social, educational and occupational needs and therefore, the membership of multidisciplinary teams needs to reflect the requirement to meet these needs.

Recommendation 11

The Children's Services Clinical Network should determine a standardised approach to the configuration of Paediatric and CAMHS Services to best meet the needs of children and young people.

Recommendation 12

There is an urgent need to build capacity through workforce planning, professional development and multidisciplinary mentorship, as a basis for the development of ADHD Services providing timely access to assessment, diagnosis and support. Secondary Care Services should work towards providing this as part of a neurodevelopmental pathway.

7. Demand and Capacity Modelling

The most significant challenge in conducting a Needs Assessment to estimate the level of demand for ADHD Services and subsequently, the capacity to meet that level of demand, has been the absence of consistent, valid and reliable data. Consequently, the following demand and capacity modelling exercise has been conducted to inform the first phase of funding required by ADHD Services. Subsequent funding decisions must be based on data that is reliable and comparable and the collation of such information should commence as soon as possible.

Recommendation 13

Given the absence of valid, reliable and comparable information, a phased approach to investment in ADHD service development is recommended, recognising the need to strengthen data collection and analysis to provide an evidential basis for future decisions on the additional funding required for future phases of investment.

The absence of meaningful and comparable data has also resulted in adopting a mixed methodologies approach to estimating levels of demand and capacity requirements.

Demand and Capacity Model for Children's ADHD Services

South Eastern Health and Social Care Trust (SEHSCT) and the Northern Health and Social Care Trust (NHSCT) appear to be the services for children and young people that are best developed and cohesive, compared to the other Trusts. Consequently, SEHSCT accepted referral information has been used to estimate referrals in each of the other Trusts. This has then been compared to NHSCT reported data to support the estimation.

In SEHSCT the referral rate is not captured but a reliable proxy figure utilised is 'accepted for ADHD assessment' = 656 for 2024/25; 592 for 2025/26 extrapolated estimate. In addition, referrals on the neurodevelopmental pathway in SEHSCT will include children and young people awaiting an ADHD assessment, as well as those awaiting Autism assessment. The number of referrals accepted for the neurodevelopmental pathway are 404 for 2024/25; 426 for 2025/26 extrapolated estimate. Approximately 30% on this pathway will be awaiting an ADHD assessment.

The higher level in each of those years have been used to allow for the fact that an unknown number of SEHSCT patients will be served by the Belfast Trust's CAMHS Service and potentially a proportion of these patients will be diagnosed with ADHD by Belfast Trust.

Adding the number of 'accepted for ADHD assessment' (656) to the additional 30% from the neurodevelopmental pathway (128) gives an estimated 784 referrals in SEHSCT.
Therefore, 784 accepted referrals has been adopted as the baseline and information from the 2021 Census has been used to determine relative population sizes, thereby estimating the number of accepted referrals in each of the other Trusts, assuming that similar referral rates and acceptance rates apply.

Trust	Population aged 0-17*	Proportion of regional <18y population	Estimated accepted referrals
SEHSCT	81, 944	18.8%	784
NHSCT	107, 482	24.7%	1029
BHSCT	75, 762	17.4%	725
SHSCT	98, 314	22.6%	942
WHSCT	71, 569	16.4%	692

* Based on 2021 Census Data

The NHSCT do not measure an 'accepted for ADHD assessment' rate but report an average annual referral rate of 1202. If it is assumed that a modest number of referrals are triaged out (i.e. 10-15%), their 'accepted for ADHD assessment' would be 1082 (if 10% screened out) to 1022 (if 15% screened out).

The demand (i.e. estimated number of accepted referrals in the table above) provides a basis on which to determine the level of staffing capacity required.

Based on an anticipated level of complexity across the patient population, it is proposed that each team will require 1.0WTE Consultant Psychiatrist and 1.0WTE Speciality Doctor to bring direct clinical expertise to the assessment and treatment of more complex presentations, while also providing clinical leadership and supervision to a team of practitioners with the requisite assessment, prescribing and psychosocial skills and competencies. It is anticipated that the medical team will assess a minimum of five new patients each week (5x40wks = 200 annually) with the remaining referrals requiring to have assessments carried out by other practitioners.

It is acknowledged that the allocation of medical staff does not reflect population size in each Trust and therefore, it could potentially be adjusted to reflect Trust population, with the necessary adjustments being made to the other professionals in the team to ensure adequate capacity to assess new referrals. It is also recognised that, where there are difficulties recruiting medical staff, consideration may be given to, for example, recruiting a Consultant Nurse or Consultant Pharmacist as an alternative to a Speciality Doctor.

Trust	Estimated accepted referrals	No. to be seen by medical team	No. to be seen by practitioners
SEHSCT	784	200	584
NHSCT	1029	200	829
BHSCT	725	200	525
SHSCT	942	200	742
WHSCT	692	200	492

I. Practitioner Capacity

A standard job plan for an ADHD Practitioner (e.g. Non-medical prescribing nurse) could not be found but an example of a job plan has been adapted from guidance provided by NHS England (2019) for Allied Health Professionals (AHPs) and this has been used to determine how many of ADHD practitioners are needed to conduct the required number of new assessments each year.

A job plan is a prospective, professional agreement describing each employee's duties, responsibilities, accountabilities and objectives. It describes how an employee's working time will be used according to the specific categories of direct clinical care (DCC), specified supporting professional activities (SPA).

DCC includes all clinical and clinically related activity, including activities such as multidisciplinary team meetings and patient-related clinical administrative tasks (e.g. record keeping).

SPA includes, but is not limited to, activities such as appraisal, teaching, training, research, audit, clinical management and Continuous Professional development (CPD) activities.

A 70:30 ratio of DCC:SPA is commonly accepted and therefore, has been adopted for the ADHD Practitioner.

	Monday	Tuesday	Wednesday	Thursday	Friday
a.m.	MDT Meetings, Consultation Triage (DCC)	Supervision, Training, CPD (SPA)	1 X New Patient Assessment Clinic (DCC)	3 X Treatment Initiation/ & Medication Titration Clinic (DCC)	7 X Review Patient Clinic (DCC)
p.m.	1 X New Patient Assessment Clinic (DCC)	3 X Review Patient Clinic, Carer Contacts, Telephone Calls etc. (DCC)	Administration, Clinical & Social Care Governance (SPA)	1 X New Patient Assessment Clinic (DCC)	Audit, Research & QI (SPA)

Each week the practitioner will provide:

3 new patient assessments (may include transitions)
3 Treatment Initiation and/or Medication Titration contacts
10 Review Contacts

Based on a 40 week year, each practitioner will provide:

120 new patient assessments (may include transitions) per year
120 Treatment Initiation and/or Medication Titration contacts per year
400 Review Contacts per year

Therefore, to estimate the number of practitioners required to undertake new assessments, the following calculation has been completed:

$$\frac{\text{No of cases to be seen by Practitioners}}{120} = \text{Estimated No. of Practitioners Required}$$

This yields the following skill mix required for new assessments only:

Trust	Consultant / Specialty Doctor WTE	Practitioner WTE *	Total WTE
SEHSCT	2.0	5.5	7.5
NHSCT	2.0	7.0	9.0
BHSCT	2.0	4.5	6.5
SHSCT	2.0	6.5	8.5
WHSCT	2.0	4.5	6.5

* Rounded up to the nearest 0.5WTE

II. Skill Mix required within the Team

While the above has focused on estimating the number of clinicians and practitioners required to conduct assessments, a range of staff will be required within teams to provide assessment, treatment initiation appointments, medication and physical health monitoring reviews, psychosocial support, business support and management and leadership.
Therefore, it is proposed that the skill mix of the team will include:

- 1.0WTE Consultant Paediatrician or CAMHS Consultant Psychiatrist
- 1.0WTE Specialty Doctor
- 1.0WTE Band 8A Service Lead & Practitioner
- Variable WTE practitioners (to reflect expected demand as outlined above; could be from range of professional backgrounds)
- 1.0-1.5WTE Band 3 Health Care Assistant (for physical health monitoring)
- 1.0WTE Band 3 Administrator (may vary according to the number of reviews)

In estimating the skill mix required to deliver a holistic and person-centred service to people, some assumptions have been made, which include:

- Medical staff job plans will include clinics to review patients who have been assessed by practitioners but who require a level of reassessment by a clinician to determine how their needs are best addressed
- Medical staff will also support practitioners where there are challenges in achieving the optimum response to prescribed medications
- The Consultant will provide a minimum of two treatment Initiation and/or medication titration contacts per week (1.0WTE X 2 contacts X 40 weeks = 80 per year)
- The Speciality Doctor will conduct three treatment Initiation and/or medication titration reviews per week)
- Each Doctor will provide a minimum of 10 patient reviews per week, (2.0WTE X 10 reviews X 40 weeks = 800 per year)

Consequently each Trust's capacity to carry out new assessments, treatment initiation or medication titration contacts and review appointments each year is as follows:

Trust	Total WTE *	New Assessments	Treatment Initiation	No. of Monitoring Reviews
SEHSCT	7.5	860	860	3, 000
NHSCT	9.0	1, 040	1, 040	3, 600
BHSCT	6.5	740	740	2, 600
SHSCT	8.5	980	980	3, 400
WHSCT	6.5	740	740	2, 600

* Excluding Service Lead, HCA and Admin

In recognition of the particular and unique circumstances in the Belfast Trust area, where currently, there is no existing ADHD Service for post-primary children, an additional Consultant and practitioner post at Band 7 has been added to meet the significant additional demand that will arise when services are developed.

Note: The Band 8A Service Lead & Practitioner has not had any clinical activity allocated against the post to ensure that effective management, co-ordination and leadership is available to the team but will be able to contribute to and support the provision of assessments and reviews, adding capacity to the service.

The level of Health Care Assistant (HCA) resource, required to carry out physical health monitoring has been based on an estimated 50-60 contacts per week. Consequently, WHSCT will need 1.0WTE, NHSCT, SEHSCT and SHSCT will require an additional 0.5WTE (1.5WTE in total). BHSCT have also been allocated an additional 0.5WTE HCA, given the expected increase in demand discussed above.

III. The Total Staffing Complement for each Trust

Trust	Consultant	Sp. Doctor	Service Lead	Practitioner Band 8A	Practitioner Band 7	HCA Band 3	Admin. Band 3	Total WTE *
SEHSCT	1.0	1.0	1.0	3.5	2.0	1.5	1.0	11.0
NHSCT	1.0	1.0	1.0	4.5	2.5	1.5	1.0	12.5
BHSCT	2.0	1.0	1.0	3.0	2.5	1.5	1.0	12.0
SHSCT	1.0	1.0	1.0	4.0	2.5	1.5	1.0	12.0
WHSCT	1.0	1.0	1.0	3.0	1.5	1.0	1.0	9.5
TOTAL	6.0	5.0	5.0	18.0	10.0	6.5	5.0	57.0

Total staffing costs for Children's Services are set out in Appendix 4.

Demand and Capacity Model for Adult ADHD Services

In order to estimate the number of new referrals and young people transitioning to Adult Services each year, a number of assumptions are required:

- Prevalence range: 2.5% (persistent adult ADHD) and 3.4% (cross-national adult ADHD).
- NICE benchmarking suggests that 25 individuals per 100,000 population will transition into adult services every year (Royal College of Psychiatrists 2023).
- New referral rates are unknown and may vary and so, based on clinical experience and advice, a range has been estimated at ~0.1% of adults annually (Scenario A) and ~0.3% of adults annually (Scenario B).
- Accepted referrals: It will be assumed that of the total number of new referrals received by Trust each year, 70% will be accepted, with 30% failing to meet the criteria necessary to offer an assessment.

Trust	Adults 18+*	Prevalence 2.5%	Prevalence 3.4%	Transitions per Year	Referrals A	Accepted A	Referrals B	Accepted B
SEHSCT	285, 984	7, 150	9, 723	92	378	265	950	665
NHSCT	371, 785	9, 295	12, 641	120	492	344	1, 235	865
BHSCT	287, 628	7, 191	9,779	91	379	265	954	668
SHSCT	292, 660	7, 317	9, 950	98	391	274	976	683
WHSCT	230, 047	5, 751	7, 822	75	305	214	765	536
Total	1,468,104	3, 703	49, 916	476	1, 945	1, 362	4, 880	3, 417

* Based on 2021 Census Data

The higher estimate of new referrals (~0.3%), together with the estimated number of young people transitioning from Children Services to Adult Services (Column Referrals B), has been adopted to determine the estimated number of practitioners required to deliver the service.

The higher estimate of new referrals is deemed appropriate, given the significant numbers of people currently waiting for an assessment.

Based on an anticipated level of complexity across the patient population, it is proposed that each team will require 1.0WTE Consultant Psychiatrist and 1.0WTE Speciality Doctor to bring direct clinical expertise to the assessment and treatment of more complex presentations, while also providing clinical leadership and supervision to a team of practitioners with the requisite assessment, prescribing and psychosocial skills and competencies. It is anticipated that the medical team will assess a minimum of five new patients each week (5x40wks = 200 annually) with the remaining referrals requiring to have assessments carried out by other practitioners.

It is acknowledged that the allocation of medical staff does not vary according to each Trust's population size and therefore, it could potentially be adjusted to reflect Trust population, with the necessary adjustments being made to the other professionals in the team to ensure adequate capacity to assess new referrals. It is also recognised that where there are difficulties recruiting medical staff, consideration may be given to, for example, recruiting a Consultant Nurse or Consultant Pharmacist as an alternative to a Speciality Doctor.

It is also recognised that currently, there is an existing workforce pressure with insufficient numbers of Consultant Psychiatrists available to recruit to vacant posts across the region. However, this paper is based on the ideal skill mix to deliver a holistic and person-centred service to people with ADHD. Nevertheless, it is accepted that the skill mix may need to vary according to the various workforce challenges and pressures that exist in any given area, at any given time.

Trust	Estimated accepted referrals*	No. to be seen by medical team	No. to be seen by practitioners
SEHSCT	665	200	465
NHSCT	865	200	665
BHSCT	668	200	468
SHSCT	683	200	483
WHSCT	536	200	336

*Includes young people transitioning to from Children Services

I. Practitioner Capacity

In accordance with the methodology applied to estimate the number of practitioners required to conduct assessments in Children Services, a standard job plan has been adopted for the ADHD Practitioner, which outlines a 70:30 ratio of direct clinical care (DCC) to specified supporting professional activities (SPA).

	Monday	Tuesday	Wednesday	Thursday	Friday
a.m.	MDT Meetings, Consultation Triage (DCC)	Supervision, Training, CPD (SPA)	1 X New Patient Assessment Clinic (DCC)	3 X Treatment Initiation/ & Medication Titration Clinic (DCC)	7 X Review Patient Clinic (DCC)
p.m.	1 X New Patient Assessment Clinic (DCC)	3 X Review Patient Clinic, Carer Contacts, Telephone Calls etc. (DCC)	Administration, Clinical & Social Care Governance (SPA)	1 X New Patient Assessment Clinic (DCC)	Audit, Research & QI (SPA)

Each week the practitioner will provide:

3 new patient assessments (may include transitions)

3 Treatment Initiation and/or Medication Titration contacts

10 Review Contacts

Based on a 40 week year, each practitioner will provide:

120 new patient assessments (may include transitions) per year

120 Treatment Initiation and/or Medication Titration contacts per year

400 Review Contacts per year

Therefore, to estimate the number of practitioners required to undertake new assessments, the following calculation has been completed:

No of Cases to be seen by Practitioners = Estimated No. of Practitioners Required

120

This yields the following skill mix required to conduct new and transition assessments:

Trust	Consultant / Specialty Doctor WTE	Practitioner WTE *	Total WTE *
SEHSCT	2.0	4.0	6.0
NHSCT	2.0	6.0	8.0
BHSCT	2.0	4.0	6.0
SHSCT	2.0	4.5	6.5
WHSCT	2.0	3.0	5.0

* Rounded up to the nearest 0.5WTE

II. Skill Mix required within the Team

While the above has focused on estimating the number of clinicians and practitioners required to conduct assessments, a range of staff will be required within teams to provide assessment, treatment initiation appointments, medication and physical health monitoring reviews, psychosocial support, business support and management and leadership.

Therefore, it is proposed that the skill mix of the team will include:

- 1.0WTE Consultant Psychiatrist
- 1.0WTE Specialty Doctor
- 1.0WTE Band 8A Service Lead & Practitioner
- Variable WTE practitioners (to reflect expected demand as outlined above; could be from range of professional backgrounds)
- 1.0WTE Band 3 Health Care Assistant (for physical health monitoring)
- 1.0WTE Band 3 Administrator (may vary according to the number of reviews)

In estimating the skill mix required to deliver a holistic and person-centred service to people, some assumptions have been made, which include:

- Medical staff job plans will include clinics to review patients who have been assessed by practitioners but who require a level of reassessment by a clinician to determine how their needs are best addressed
- Medical staff will also support practitioners where there are challenges in achieving the optimum response to prescribed medications
- The Consultant will provide a minimum of two treatment Initiation and/or medication titration contacts per week (1.0WTE X 2 contacts X 40 weeks = 80 per year)
- The Speciality Doctor will conduct three treatment Initiation and/or medication titration reviews per week)
- Each Doctor will provide a minimum of 10 patient reviews per week, (2.0WTE X 10 reviews X 40 weeks = 800 per year)

Consequently each Trust's capacity to carry out new or transition assessments, treatment initiation or medication titration contacts and review appointments each year is as follows:

Trust	Total WTE *	New or Transition Assessments	Treatment Initiation	No. of Monitoring Reviews
SEHSCT	6.0	680	680	2, 400
NHSCT	8.0	920	920	3, 200
BHSCT	6.0	680	680	2, 400
SHSCT	6.5	740	740	2, 600
WHSCT	5.0	560	560	2, 000

* Excluding Service Lead, HCA and Admin

Note: The Band 8A Service Lead & Practitioner has not had any clinical activity allocated against the post to ensure that effective management, co-ordination and leadership is available to the team but they will be able to contribute to and support the provision of assessments and reviews, adding capacity to the service.

The level of Health Care Assistant (HCA) resource, required to carry out physical health monitoring has been based on an estimated 50-60 contacts per week. Consequently, the NHSCT will require an additional 0.5WTE (1.5WTE in total).

III. The Total Staffing Complement by Trust

Trust	Consultant	Sp. Doctor	Service Lead	Practitioner Band 8A/7	HCA	Admin.	Total WTE *
SEHSCT	1.0	1.0	1.0	4.0	1.0	1.0	9.0
NHSCT	1.0	1.0	1.0	6.0	1.5	1.0	11.5
BHSCT	1.0	1.0	1.0	4.0	1.0	1.0	9.0
SHSCT	1.0	1.0	1.0	4.5	1.0	1.0	9.5
WHSCT	1.0	1.0	1.0	3.0	1.0	1.0	8.0
TOTAL	5.0	5.0	5.0	21.5	5.5	5.0	47.0

Total staffing costs for Adult Services are set out in Appendix 5.

Demand and Capacity Model for Healthcare in Prisons ADHD Services

Data relating to the Northern Ireland Prison Population 2024/25 was published in October 2025, reporting that the overall average daily prison population increased by 1.8% from the previous year to 1,911 with 4,228 total receptions into prison, which were accounted for by 3,152 prisoners.

In February 2021 a snap-shot analysis, carried out during the committal triage process by nursing staff, found that 3% of new committals had an existing diagnosis of ADHD and a further 1% had a diagnosis of Autistic Spectrum Disorder. However, it is known that, due to the absence of services offering assessment and diagnosis of neurodevelopmental disorders, those figures will not represent the population of people in prison with either ADHD or ASD.

There is considerable variation across the research on the estimated prevalence of ADHD among prison populations. For example, Fazel and Favril (2024) argue that a prevalence of 8.3% or 1 in 12 prisoners is the best approximation, while other estimates are much higher at 22.2% (Bagio and Efthamoui 2024), 25.5% (Young et al 2015) to 26% (Baggio et al 2018). Despite this variance, it is widely accepted that prevalence in prisons is higher than in the general population. In addition, as the evidence suggests treatment can reduce ADHD symptoms and enhance rehabilitation outcomes, which may assist in lowering the rate of reoffending (Carlander et al 2024), dedicated investment in Healthcare in Prison Services is required to support improved access to assessment, diagnosis and treatment.

However, Tully (2022) argues that such uncertainty about the scale of the problem in prisons warrants a cautious approach to avoid the disproportionate allocation of resources at the expense of treating other common conditions found within prison populations, such as depression, personality disorder and substance abuse. Consequently, potential demand for ADHD assessment has been calculated by applying a prevalence rate across a range of between 10% and 30% of prisoners as a basis for understanding the level of need and the staffing complement required to meet that need.

I. Estimated ADHD Prevalence in the Prison Population

Measure	Population	10%	15%	20%	25%	30%
Average daily prison population	1,911	191	287	382	478	573
Annual new receptions into prison	3,152	315	473	630	788	946

In determining the initial resource required to meet the level of need in prisons, taking into account Tully's (2022) advice for caution, a phased approach to investment is recommended. Hence, a moderate estimated prevalence of 10% has been applied, which means that on any given day, 191 people in prisons will have ADHD while up to 315 people received into prison each year may require assessment across the three prisons in Northern Ireland.

One of the challenges in delivering healthcare interventions within the prison environment is gaining access to patients, which is usually limited to 9:30-12noon and 2-4pm. Cells are locked outside of these hours, significantly impacting on practitioners' ability to undertake clinical work. In particular, new assessments, which may take 3-4 hours to complete, can only be conducted during the morning. While treatment initiation, medication triage, psychosocial education and medication monitoring consultations are limited to afternoons.

A standard job plan for an ADHD Practitioner could not be found but an example of a job plan has been adapted from guidance provided by NHS England (2019) for AHPs and this has been used to determine how many of these practitioners are needed within Healthcare in Prisons to conduct the required number of new assessments each year.

II. ADHD Band 7 HiP Practitioner Job Plan

	Monday	Tuesday	Wednesday	Thursday	Friday
a.m.	MDT Meetings, Consultation Triage (DCC)	1 X New Patient Assessment Clinic (DCC)	1 X New Patient Assessment Clinic (DCC)	Audit, Research & QI (SPA)	1 X New Patient Assessment Clinic (DCC)
p.m.	4 X Review Patient Clinic (DCC) Admin (SPA)	Clinical & Social Care Governance (SPA)	2 X Treatment Initiation/ & Medication Titration Clinic (DCC) Admin (SPA)	4 X Review Patient Clinic (DCC) Admin (SPA)	2 X Treatment Initiation/ & Medication Titration Clinic (DCC) Admin (SPA)

Therefore, applying a straightforward assumption that each practitioner will be limited to three new assessments per week, working over a 40 week year, 3.0WTE would be required to assess 315 patients.

However, based on an anticipated level of complexity across this patient population, it is recommended that the team comprises 0.5WTE Consultant Psychiatry bringing direct clinical expertise to the assessment and treatment of more complex presentations, while also providing leadership and supervision to a team of practitioners with the requisite assessment, prescribing and psychosocial skills and competencies.

1.0WTE Service Lead is required to provide day to day management and leadership.

Assuming the Consultant Psychiatrist and Service Lead undertake two new assessments per week and Band 7 Practitioners complete three new assessments

per week, with an Occupational Therapist providing psychosocial and occupational interventions, the team will include the following:

Role	WTE
Consultant Psychiatrist	0.5
ADHD Service Lead/Practitioner Band 8A	1.0
ADHD Practitioner Band 7	2.0
Occupational Therapist Band 7	1.0
Administration	0.5
Total	**5.0**

Total staffing costs for Adult Services are set out in Appendix 6. However, because of the way in which Healthcare in Prison is funded, a modest additional investment to support additional pharmacy provision and medications dispensing.

8. Digital Technologies and Data

As highlighted in the Mental Health Strategy 2021-2031 (DoH 2021), advances in digital technologies to support the traditional delivery of services has become commonplace. In particular, since the outbreak of the COVID-19 pandemic, people requiring mental health services have been accessing support in innovative ways using digital technology. Digital technologies are not replacements or proxy versions of traditional therapeutic modalities, but they do provide an alternative source of support.

One area that is being explored is the better utilisation of mobile and web applications. Since May 2020, HSC representatives have been working with the Organisation for the Review of Care and Health Apps (ORCHA) to evaluate apps available to people with health and social care needs. This has culminated in the creation of an HSC Apps Library, which is a public resource providing access to safe and independently assessed apps that are available to both children and adults. The apps are reviewed and scored to ensure they are based on:

- professional/clinical input/evidence;
- the data provided by users is secure, their privacy respected and they offer an appropriate level of cyber security; and
- they are accessible and have involved users in their development.

Only apps that meet the threshold of 65% appear on the library.

Other apps addressing a range of mental health problems, including anxiety, depression, self-harm and suicide are also available through the HSC Apps Library, allowing clinicians and practitioners to signpost patients to this important source of additional support. Furthermore, individuals may be signposted to apps in advance of their engagement with the ADHD Service, affording people on waiting lists an accessible level of support.

Currently, only one app within the library is dedicated to ADHD (*Inflow – Manage your ADHD*), which is available for both children and adults. However, other apps identified may be submitted to ORCHA for review, providing the developer is keen to go through the process, although some may already have NHS Digital accreditation.

Digital technologies for assessing ADHD

NICE (2024) recommend the use of the QbTest as an option to help diagnose attention deficit hyperactivity disorder (ADHD) in people aged 6 to 17 years, highlighting that it should only be used with standard clinical assessment by a healthcare professional. NICE (2024) also report the clinical trial evidence suggests

that information from QbTest helps to reduce the time it takes for people children and young people to get a diagnostic decision.

NICE (2024) report that, for people under 18, there is limited evidence for the use of other technologies other than QbTest. For adults, there is limited evidence for any of the technologies, and the evidence from people under 18 is not generalisable to adults. So, more research is needed in this group.

NICE (2024) also suggest that following an ADHD diagnosis, technologies could also be used to help evaluate response to treatment, which may aid decisions about continuing or changing treatment. This could help make sure people are having the best possible medication and dosage to manage symptoms and reduce side effects and reduce overprescribing. However, little evidence exists on whether any technologies are clinically or cost effective for evaluating response to treatment and so more research is needed to help assess this.

Recommendation 14

In accordance with Action 30 within the Mental Health Strategy 2021-2031 (DoH 2021), it is recommended that digitalised approaches to aid pre-assessment education and support, assessment, enhance the accessibility of support and augment therapy processes are embraced as integral components of the ADHD Service, at all steps of care. Consideration could be given to promoting existing approved Apps immediately while other elements of the pathway are developed.

Data

While data collection in relation to ADHD is extremely limited, information derived from an analysis of Primary Care records provides some interesting insights with 26,914 people having a code on their record referring to ADHD, with the ratio of male to females is 2.6:1, which is consistent with NICE (2025) Attention deficit hyperactivity disorder: How common is it?

- 69% (n= 18,676) have ever received ADHD medication, dispensed from a community pharmacy

- 40% (n=10,661) have received ADHD medication dispensed from a community pharmacy since June 2015, with the remaining 60% with a diagnosis having not received medications from a community pharmacy since June 15 either indicating either:

- they choose not to start ADHD medication or
- they have stopped taking the medication or
- they may be obtaining the medication from non-community pharmacy sources.
- they have not yet been prescribed the medication. This may include those on waiting lists following private diagnoses and are waiting to be reviewed in the HSC

There is little difference in the gender balance (70% males, 68% females) of those people with a diagnosis who have ever had ADHD medication prescribed for them.

However, when taking into account those who have obtained medication since June 2015, there is a gender difference with 38% of males and 45% of females with a diagnosis of ADHD having obtained medication from community pharmacies since June 2015. This may suggest that, for reasons unknown, males are more likely than females to discontinue the ADHD medication.

As the table below, illustrates, there is variation across Trust areas in terms of the proportion of people with an ADHD diagnosis on their records who have received medications from community pharmacies since June 2015. The Northern and Southern areas are lowest at 28 and 29%.

Trust	Total WTE *
SEHSCT	52%
NHSCT	29%
BHSCT	42%
SHSCT	28%
WHSCT	39%

Young people with an ADHD diagnosis are more likely than adults to have received medication since June 2015.

74% of people aged under 18 years old with a diagnosis of ADHD have ever received medication while 57% of children and young people with a diagnosis have received ADHD medication from a community pharmacist since June 2015. The remaining 43% did not receive medications over the same period of time. It is not known to what extent this transpired because medication was not deemed necessary or a decision was made not to take ADHD medication prescribed. No data is available on whether children have received medications from other sources.

30% of adults with a diagnosis have received ADHD medication from a community pharmacy since June 2015, with the remaining 70% not having received

medications. Again, no data is available to help understand whether medications were received from other sources. 67% of adults with a diagnosis have ever received ADHD medication, perhaps suggesting a large number have discontinued the medication. It is not known to what extent this arose because the medication was discontinued as they no longer needed it or because having become an adult, they were no longer able to obtain a prescription from Adult Services, or they decided themselves to stop taking the medication.

A regional snapshot audit of neurodevelopmental need was conducted within mainstream acute mental health settings, the aim of which was to gather prevalence data on the number of individuals with suspected or diagnosed autism and/or ADHD who are coming into contact with Adult Mental Health Crisis and Inpatient Services across HSC Trusts.

A data collection template was shared with HSC Trusts, who were asked to log all relevant cases they encountered over two specified days. In each instance, they were asked to detail suspected or diagnosed neurodevelopmental need, length of time in service and complexity of need to inform an understanding of the level of need amongst existing mental health patient populations. The results were as follows:

- **Day one:** ADHD prevalence estimates ranging from:
  - 1.3% to 4.7% in adult mental health inpatient settings (PICU)
  - 0% to 16.7% in adult psychiatric intensive care inpatient settings.
  - 6.7% to 20% in crisis and home treatment settings.

- **Day two: ADHD prevalence estimates ranging from:**
  - 3.8% to 8.1% in adult mental health inpatient settings
  - 0% to 11.1% in adult psychiatric inpatient settings.
  - 0% to 10% in crisis and home treatment settings.

While it is estimated that 3-4% of adults in UK have ADHD (NICE, 2018), these audit results suggest that ADHD needs are generally over-represented within acute mental health settings, in particular in some PICU and crisis teams, emphasising the need for staff training. In addition, clinicians who were involved in the audit indicated that, of those patients with probable neurodevelopmental needs, a confirmed diagnosis would have been helpful in determining treatment pathways.

While information of this type provides interesting insights, as highlighted previously, a significant challenge associated with conducting this Needs Assessment exercise has been the absence of consistent, valid and reliable data to inform service planning.

There are a number of reasons why this situation has arisen, including;

- The absence of national standards and guidance
- The evolving nature of service development
- Levels of demand on services reducing the capacity of staff to strengthen data collection

This problem is not confined to Northern Ireland. In a study of six ADHD Services conducted by Fenny and Blythe (2025) in England, which aimed to find out what data is available, collected and used to plan and manage adult NHS ADHD assessment services, triage and referral processes varied across areas, and so did the data that flowed from them.

Fenny and Blythe (2025) recommended that data on ADHD should be improved so that it can support a wider programme of improvement in services and in access to them. Accurate, consistent and sufficiently comprehensive data will be fundamental to understanding the challenges that need to be addressed, adapting to variation and changes within them, and monitoring progress.

High-quality data is crucial to inform planning and service improvement and its collection needs to be mandated for all providers (NHS England 2025).

Recommendation 15

Funding is needed to support the development of a comprehensive and standardised regional data set, which must involve engagement with providers and clinical staff to determine the data needed to inform future investment and to drive improvement plans.

This will involve the continuous monitoring and analysis of information that will include triage, assessment, diagnosis and treatment, and waiting list data, along with an ongoing evaluation of the implementation of the stepped care model, including assessing the roles of Primary Care and the Voluntary Sector.

9. Delivering Non-Pharmacological Interventions

Support for people should be needs-led and not rely on, or need to wait for, a diagnosis by a clinician, thereby preventing further harm and facilitating early intervention. First-line non-pharmacological support for ADHD, as recommended by NICE, does not always necessitate an immediate, accurate, specialist diagnosis or always have to be delivered by the NHS (NHS England 2025).

As the priority is to urgently facilitate the assessment and diagnosis of individuals with ADHD, it is recommended that non-pharmacological interventions to support people are provided through existing pathways, such as SureStart Projects, which are designed to enhance children's learning skills, health and wellbeing, and social and emotional development and the Condition Management Programme (CMP), which aims to improve self-efficacy in relation to participants' skills and abilities in managing their health condition(s) to support the participant to remain in, return to or progress towards work.

Recommendation 16

It is recommended that, where appropriate, people are signposted to existing services dedicated to meeting their specific needs.

In addition, HSC Trusts may wish to consider the reconfiguration of staff resource currently delivering care and treatment to people with ADHD to align them more closely with the core ADHD Services recommended in this paper.

Non-pharmacological interventions will include:

- Psychoeducation tailored to meet the needs of children, young people and adults
- Psychoeducation for the parents and families
- Dedicated Parenting Programmes
- Intervention and Support Programmes for children, young people and adults
- Maintenance and Support Groups for parents and individuals
- A Helpline available 7 days per week

Recommendation 17

It is recommended that consideration is given to recruiting People with Lived Experience to support delivery of non-pharmacological interventions.

These non-pharmacological interventions must be available region-wide and include in-person and online therapy options.

It is difficult to predict the level of demand for non-pharmacological support, not just because of the absence of valid and reliable data to determine the level of need, but also, not everyone with ADHD will require additional support. However, it is known that currently, existing C&V providers are overstretched with significant numbers of people waiting to access support.

Consequently, it is recognised that significant additional investment is required in the C&V Sector to deliver non-pharmacological interventions, the costs of which are set out in Appendix 7. However, an ongoing robust evaluation of need is required to accurately identify the total funding needed to ensure that the needs of people are addressed.

Recommendation 18

In keeping with the Mental Health Strategy 2021-2031 and the Health and Social Care Reset Plan, which aims to deliver a more neighbourhood-centred model, it is recommended that investment should, at least initially, be directed towards the Community and Voluntary (C&V) Sector to provide non-pharmacological interventions to people who need pre-diagnostic and/or post-diagnostic support.

10. Waiting List Strategy

Significant numbers of children, young people and adults are waiting for an ADHD assessment.

HSC Trusts have reported that almost 7,000 children and young people are on their ADHD waiting lists and the three HSC Trusts aiming to provide new patient assessments report that over 9,500 adults are awaiting a new assessment, with one Trust reporting they are also experiencing substantial delays in transitioning young people from Children's Services to Adult Services.

The result is that the wait for an ADHD assessment is measured in years and in the case of adults, the wait is several years, while the numbers of children and young people waiting continues to grow with some young people reaching adulthood before receiving the offer of an assessment.

It is not acceptable that people are waiting to access ADHD Services for such long periods of time. Indeed, the aim should be to deliver equity with the introduction of similar waiting time standards for ADHD as for other health conditions.

Long waiting times also increases risk for people with ADHD. These risks include a deterioration in mental health, increased risk of suicide, entry into the criminal justice system, substance misuse and enormous costs. Also, uncomplicated ADHD is easier to support and treat than once ADHD adverse impacts have emerged (NHS England 2025).

There is also a need to support people on ADHD waiting lists, informed by emerging evidence, and to determine an optimum way to triage and prioritise referrals to ensure that assessment is offered to those most in need, highlighting the need for referral/triage criteria (see recommendations 1 & 6). In addition, a strategy is required to address existing waiting list numbers in an effective and ethically acceptable manner.

Consequently, a list of 10 actions to address waiting list numbers was developed) and shared with the Needs Assessment Oversight Group. Feedback from this exercise resulted in a reduction in the number of options deemed appropriate to 6 actions, as set out below and in Appendix 8.

It is acknowledged that, given the numbers involved, implementation of some of the options outlined will necessitate considerable non-recurrent investment.

Recommendation 19

It is recommended that a group is established to carry out an option appraisal and further develop the strategy needed to reduce and eventually, to bring waiting times down to a standard commensurate with other health conditions. It is essential that membership of this group involves People with Lived Experience and Carers, as well as clinicians, practitioners, commissioners and policy leads.

Waiting List Strategy Shortlisted Options

Option	Action	Advantages	Disadvantages
1.	Conduct a cleansing exercise by calling all individuals on the waiting list to determine if they wish to be offered an assessment	• Honours the initial decision to aim to provide an assessment	• Potentially time consuming exercise that may not rule out many people
2.	Apply one-off set of criteria **to introduce a level of priority** to referrals e.g. people with a history of self-harm, people known to the CJS/YJ	• Potentially identifies higher risk referrals • May reduce burden on other areas of the HSC system	• Potential delays to assessing people who had sought help at an earlier point • Potentially time consuming exercise
3.	Provide a screening assessment to determine the appropriateness of offering a full assessment	• Would free up senior clinical capacity	• Validity of self-administered questionnaires unclear
4..	Place a freeze on new referrals (excluding transitions) until the waiting list is cleared	• Reduces the admin burden (inc. triage etc) associated with processing new referrals • Allows newly developed services to 'bed-in'	• Disadvantages people in need • May lead to an avalanche of referrals at a future point
5.	Adopt regional approach to clearing waiting lists	• Services with additional capacity can carry out extra assessments • Reduces geographical variation • Facilitates services in developing from a similar starting point	• Patients may be less willing to travel across Trust boundaries
6.	Non-recurrent investment (i.e. waiting list initiative funding)	• Continuity of service provision and patient experience • Providing the service closer to the patient's home	• Costly option • Staff burn-out

11. Funding Requirements

Staffing and Goods and Services Costs

Service	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Children's	57.0	£4,448,249.00	£323,787.00	£22,000.00	£4,794,036.00
Adults	47.0	£3,694,203.00	£268,879.00	£20,000.00	£3,983,082.00
Healthcare in Prisons	5.00	£384,955.00	£28,025.00	£1,000.00	£413,980.32
Total	109.0	£8,527,407.00	£620,691.00	£43,000.00	£9,191,098.00

Additional Costs

Voluntary Sector organisation costs have been calculated according to the estimated costs of specific programmes (See Appendix 7).

The estimated costs of increased medication prescriptions has been based on information on the 2023-24 costs when the total expenditure on ADHD medications was £4,688,244 for 10,618 distinct patients.

Therefore, the average cost per patient each year was identified as £442 and an assumption was made that approximately 70% of new patient 'accepted referrals' would require the prescription of medication.

Consequently, assuming that 70% of the 4172 children accepted for assessment require medications, the total cost is £1,290,640. Similarly, assuming 70% of the 3417 adults accepted for assessment need medications, the total cost is £1,057,264 and the total additional Cost is £2,347,904.

Training Costs are based on information provided by a training organisation, which includes training in Assessment, Diagnosis and Pharmacological Treatment for £660 for both and £295 for Psychosocial Support. Therefore, an initial cost of £85, 000 has been estimated, enabling all clinicians and practitioners to access this training, although it is expected that funding requirement should reduce substantially on a recurrent basis.

The cost of service evaluation and research is based on the creation of a Band 8B post to lead commissioning, which will include the development and oversight of a comprehensive and standardised regional data set, designed to underpin and inform service planning and future investment requirements. In addition, investment in

research, aimed at enhancing the effectiveness and efficiency of assessment pathways, including the development of new technologies, will be required and an estimated £100,000 has been identified to support this crucial work.

Summary of Additional Costs

Service	Total Costs
Voluntary Sector Provision	£834,100
Increased Medication Prescriptions	£2,347,904
Training	£85, 000
Service Evaluation and Research	£197,758
Total	£3,464,762

Total Funding Requirements

Together with staff costs, the total cost of Phase 1 ADHD Service provision is estimated to be **£12,655,860.**

The above estimate excludes additional pharmacy, medications dispensing costs and cleaning costs, although funding requirements for these activities are expected to be modest.

In addition, non-recurrent service start-up costs, such as IT are not included.

12. Recommendations

Recommendation 1

A regionally agreed standardised approach to referral, triage and assessment pathways, developed and maintained through established ADHD Children and Adult clinical networks, is recommended.

Recommendation 2

As ADHD frequently co-exists with autism spectrum disorder, other neurodevelopmental disorders and mental health problems, and in keeping with developments across the UK, assessment and treatment provision should be considered a component of an integrated and needs-led neurodevelopmental Service. This recommendation is consistent with the Emotional Health & Wellbeing Framework, which was recently subject to public consultation.

(b) The development of an integrated and needs-led neurodevelopmental Service is likely to be more readily achievable across Children's Services than it is in adults, where a phased approach to developing integration will be necessary. However, stronger links between services for Adults with ADHD and/or ASD should be established as soon as possible, recognising that there are also capacity challenges within ASD Services that must be addressed.

Recommendation 3

The development of a stepped-care approach is recommended, delivering holistic treatment, care and support, tailored to an individual's level of need and appropriately resourced across primary and secondary health care. This could be achieved by providing ring-fenced funding for ADHD. GP practices should be incentivised to contribute to the delivery of ADHD care and treatment.

There should be investment in training to enable GPs and the Primary Care workforce to undertake post-diagnostic support and NICE recommended physical health monitoring with a smooth pathway for the patient back to the Secondary Care Service, when the need arises.

GPs with a special interest, together with other practitioners in primary care roles (e.g. pharmacists for prescribing, mental health trained nurse practitioners) should be provided with the opportunity to train in specialist aspects of ADHD care such as assessment, treatment and prescribing with referral to secondary or specialist services for more complex cases.

This could be achieved by providing ring-fenced funding for ADHD to support locally commissioned services or through the new neighbourhood plan.

Recommendation 4

Specialist training in ADHD for practitioners in Primary and Secondary Care Services should be identified and delivered on an ongoing basis.

Recommendation 5

Due to a dramatic increase in demand for ADHD Services in recent years, referral criteria should be agreed by Primary and Secondary Care professionals.

Recommendation 6

A standardised pathway, based on best practice, should be developed to promote the smooth transition of young people to Adult Services, ensuring that a comprehensive reassessment of the young person is undertaken to evaluate the need for ongoing treatment and care to determine if referral to Adult Services is required. The Transition Pathway should be regionally agreed by Children and Adult Services Clinical Networks.

Recommendation 7

ADHD training should be available to all practitioners across the Health & Social Services system and in particular, targeted at those who regularly assess patients' needs (e.g. staff working in Emergency Departments) and those practitioners providing care for populations of people in which ADHD may be prevalent (e.g. people with mental health problems and looked after children).

Recommendation 8

Children, young people and adults with ADHD benefit from early intervention, therefore pre-assessment support (including parent/family support) should be available. This should largely be delivered through additional investment in the Community and Voluntary Sector.

Recommendation 9

Establish a Regional Network to support continuous learning and promote best practice

(b) Separate networks for ADHD practitioners working in Children and Adults Services offer a pragmatic approach to establishing forums but a level of collective working would create an environment through which shared learning can take place and shared processes, such as managing transitions, can be enhanced.

Recommendation 10

Not every service will look the same and a flexible approach to team composition is required. Children, young people and adults with ADHD require holistic and integrated care to address a wide range of personal, social, educational and occupational needs and therefore, the membership of multidisciplinary teams needs to reflect the requirement to meet these needs.

Recommendation 11

The Children's Services Clinical Network should determine a standardised approach to the configuration of Paediatric and CAMHS Services to best meet the needs of children and young people.

Recommendation 12

There is an urgent need to build capacity through workforce planning, professional development and multidisciplinary mentorship, as a basis for the development of ADHD Services providing timely access to assessment, diagnosis and support. Secondary Care Services should work towards providing this as part of a neurodevelopmental pathway.

Recommendation 13

Given the absence of valid, reliable and comparable information, a phased approach to investment in ADHD service development is recommended, recognising the need to strengthen data collection and analysis to provide an evidential basis for future decisions on the additional funding required for future phases of investment.

Recommendation 14

In accordance with Action 30 within the Mental Health Strategy 2021-2031 (DoH 2021), it is recommended that digitalised approaches to aid pre-assessment education and support, assessment, enhance the accessibility of support and

augment therapy processes are embraced as integral components of the ADHD Service, at all steps of care. Consideration could be given to promoting existing approved Apps immediately while other elements of the pathway are developed.

Recommendation 15

Funding is needed to support the development of a comprehensive and standardised regional data set, which must involve engagement with providers and clinical staff to determine the data needed to inform future investment and to drive improvement plans.

This will involve the continuous monitoring and analysis of information that will include triage, assessment, diagnosis and treatment, and waiting list data, along with an ongoing evaluation of the implementation of the stepped care model, including assessing the roles of Primary Care and the Voluntary Sector.

Recommendation 16

It is recommended that, where appropriate, people are signposted to existing services dedicated to meeting their specific needs.

Recommendation 17

It is recommended that consideration is given to recruiting People with Lived Experience to support delivery of non-pharmacological interventions.

These non-pharmacological interventions must be available region-wide and include in-person and online therapy options.

Recommendation 18

In keeping with the Mental Health Strategy 2021-2031 and the Health and Social Care Reset Plan, which aims to deliver a more neighbourhood-centred model, it is recommended that investment should, at least initially, be directed towards the Community and Voluntary (C&V) Sector to provide non-pharmacological interventions to people who need pre-diagnostic and/or post-diagnostic support.

Recommendation 19

It is recommended that a group is established to carry out an option appraisal and further develop the strategy needed to reduce and eventually, to bring waiting times down to a standard commensurate with other health conditions.

It is essential that membership of this group involves People with Lived Experience and Carers, as well as clinicians, practitioners, commissioners and policy leads.

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Appendix 1 - ICD-11

The ICD-11 (International Classification of Diseases, 11th Revision) includes ADHD under the category of Neurodevelopmental disorders. ADHD in ICD-11 is coded as 6A05 and is referred to as “Attention deficit hyperactivity disorder”.
ICD-11 Definition of ADHD (6A05):

ADHD is characterized by a persistent pattern of inattention and/or hyperactivity-impulsivity that:

- Begins during the developmental period, typically early to mid-childhood.
- Is inconsistent with the developmental level of the individual.
- Negatively impacts academic, occupational, or social functioning.

Core Symptoms According to ICD-11:

1. Inattention - may include symptoms like:

- Frequently losing focus or being easily distracted.
- Difficulty sustaining attention in tasks or play.
- Frequently making careless mistakes.
- Avoiding or being reluctant to engage in tasks that require sustained mental effort.
- Often losing items necessary for tasks (e.g., toys, books, tools).
- Forgetfulness in daily activities.
- Difficulty organizing tasks and activities.

2. Hyperactivity - may include:

- Fidgeting or squirming in seat.
- Leaving seat in situations were staying seated is expected.
- Running or climbing in inappropriate situations.
- Inability to play or engage in leisure activities quietly.
- Being “on the go” or acting as if “driven by a motor.”

3. Impulsivity - may include:

- Blurting out answers before questions are completed.
- Difficulty waiting one’s turn.
- Interrupting or intruding on others (e.g., conversations, games).

ICD-11 ADHD Subtypes:

ICD-11 includes specifiers based on the predominant symptom presentation:

- 6A05.0: ADHD, predominantly inattentive presentation
- 6A05.1: ADHD, predominantly hyperactive-impulsive presentation
- 6A05.2: ADHD, combined presentation
- 6A05.3: Other specified presentations
- 6A05.4: Unspecified presentation

Onset and Impact

- Symptoms must begin in childhood (but can be diagnosed later).
- Must cause functional impairment in multiple settings (e.g., home, school, work).

Appendix 2 - DSM-5

DSM-5-TR diagnostic criteria include 9 symptoms and signs of inattention and 9 of hyperactivity and impulsivity. Diagnosis using these criteria requires ≥ 6 symptoms and signs from one or each group (or five for adults and adolescents 17+). Also, the symptoms need to

- Be present often for ≥ 6 months
- Be more pronounced than expected for the child's developmental level
- Occur in at least 2 situations (eg, home and school)
- Be present before age 12 (at least some symptoms)
- Interfere with functioning at home, school, or work

Inattention symptoms:

- Does not pay attention to details or makes careless mistakes in schoolwork or with other activities
- Has difficulty sustaining attention on tasks at school or during play
- Does not seem to listen when spoken to directly
- Does not follow through on instructions or finish tasks
- Has difficulty organizing tasks and activities
- Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort over a long period of time
- Often loses things necessary for school tasks or activities
- Is easily distracted
- Is forgetful in daily activities

Hyperactivity and impulsivity symptoms:

- Often fidgets with hands or feet or squirms
- Often leaves seat in classroom or elsewhere
- Often runs about or climbs excessively where such activity is inappropriate
- Has difficulty playing quietly
- Often on the go, acting as if driven by a motor
- Often talks excessively
- Often blurts out answers before questions are completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others

Diagnosis of the predominantly inattentive type requires ≥ 6 symptoms and signs of inattention. Diagnosis of the hyperactive/impulsive type requires ≥ 6 symptoms and signs of hyperactivity and impulsivity. Diagnosis of the combined type requires ≥ 6 symptoms and signs each of inattention and hyperactivity/impulsivity

Appendix 3 - The NHS Education for Scotland (NES) Training Framework

Professional Learning	
Although there is no specific training framework focussed on ADHD or neurodevelopmental conditions, the NES Training Framework structure provides guidance on matching skills and knowledge to practice, regardless of professional background. Four levels can guide readiness to contribute to or lead ADHD diagnostic assessments and professional learning needs.	
Informed level:	Recognises ADHD signs and symptoms, and has the knowledge and skills to work with people with ADHD in their role, including an understanding of reasonable adjustments in the setting they work in.
Skilled level:	Can discuss and make a referral for assessment of ADHD. Can support individuals to complete screening assessments and can undertake some aspects of ADHD assessment. May have related and transferable knowledge of neurodevelopmental and mental health conditions and may regularly meet individuals with ADHD in their work role.
Enhanced level:	Regularly works with individuals who may have ADHD. May or may not work in a specialist neurodevelopmental service. Competent in carrying out some or all aspects of an ADHD specific assessment, depending on complexity, using a range of clinical tools, and in interpreting findings from the assessment. Able to use a formulation approach to consider assessment findings in relation to co-occurrence or differential diagnoses, including mental health conditions, neurodevelopmental conditions or substance use. Supervision may be sought in particularly complex cases or where differential diagnoses require involvement of a different member of the team.
Specialist/ Expertise level:	Highly specialist skills and knowledge. Staff may work within a team specialising in ADHD or neurodevelopmental conditions and may be involved in leadership or service development roles. Skills include diagnostic assessment of neurodevelopmental conditions and ADHD specific diagnoses, in addition to mental health diagnoses and complex presentations where co-morbidity / co-occurrence is present. Regularly has a role in diagnostic assessment and can offer supervision and training to others developing knowledge and skills. Provides leadership to clinical and strategic planning.

Appendix 4 - Annual Cost of Staffing for Children's Services by Trust

Belfast Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	2.0	£317,224.00	£22,980.00	£4,000.00	£344,204.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,645.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	3.0	£232,656.00	£16,935.00	£0.00	£249,591.00
Practioner B7	2.5	£166,390.00	£12,133.00	£0.00	£178,523.00
HCA	1.5	£52,290.00	£3,851.00	£0.00	£56,141.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	12.0	£993,453.00	£72,275.00	£6,000.00	£1,071,728.00

* Excludes on-call allowances

Northern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,645.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	4.5	£348,984.00	£25,403.00	£0.00	£374,387.00
Practioner B7	2.5	£166,390.00	£12,133.00	£0.00	£178,523.00
HCA	1.5	£52,290.00	£3,851.00	£0.00	£56,141.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	12.5	£951,179.00	£69,253.00	£4,000.00	£1,024,432.00

* Excludes on-call allowances

South Eastern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,645.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	3.5	£271,432.00	£19,758.00	£0.00	£291,190.00
Practioner B7	2.0	£133,112.00	£9,706.00	£0.00	£142,818.00
HCA	1.5	£52,290.00	£3,851.00	£0.00	£56,141.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	11.0	£840,349.00	£61,181.00	£4,000.00	£905,530.00

* Excludes on-call allowances

Southern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,645.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	4.0	£310,208.00	£22,580.00	£0.00	£332,788.00
Practioner B7	2.5	£166,390.00	£12,133.00	£0.00	£178,523.00
HCA	1.5	£52,290.00	£3,851.00	£0.00	£56,141.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	12.0	£912,403.00	£66,430.00	£4,000.00	£982,833.00
* Excludes on-call allowances					

Western Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,645.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	3.0	£232,656.00	£16,935.00	£0.00	£249,591.00
Practioner B7	1.5	£99,834.00	£7,280.00	£0.00	£107,114.00
HCA	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	9.5	£750,865.00	£54,648.00	£4,000.00	£809,513.00
* Excludes on-call allowances					

Appendix 5 - Annual Cost of Staffing for Adult Services by Trust

Belfast Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,644.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	2.5	£193,880.00	£14,113.00	£0.00	£207,993.00
Practioner B7	1.5	£99,834.00	£7,280.00	£0.00	£107,114.00
HCA	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	9.0	£712,089.00	£51,826.00	£4,000.00	£767,914.00

* Excludes on-call allowances

Northern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,644.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	4.0	£310,208.00	£22,580.00	£0.00	£332,788.00
Practioner B7	2.0	£133,112.00	£9,706.00	£0.00	£142,818.00
HCA	1.5	£52,290.00	£3,851.00	£0.00	£56,141.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	11.5	£879,125.00	£64,003.00	£4,000.00	£947,127.00

* Excludes on-call allowances

South Eastern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,644.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	2.5	£193,880.00	£14,113.00	£0.00	£207,993.00
Practioner B7	1.5	£99,834.00	£7,280.00	£0.00	£107,114.00
HCA	1.5	£34,860.00	£2,567.00	£0.00	£37,427.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	9.5	£712,089.00	£51,826.00	£4,000.00	£767,914.00

* Excludes on-call allowances

Southern Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,644.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	3.0	£232,656.00	£16,935.00	£0.00	£249,591.00
Practioner B7	1.5	£99,834.00	£7,280.00	£0.00	£107,114.00
HCA	1.5	£34,860.00	£2,567.00	£0.00	£37,427.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	10.0	£750,865.00	£54,648.00	£4,000.00	£809,512.00
* Excludes on-call allowances					

Western Trust	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	1.0	£158,622.00	£11,490.00	£2,000.00	£172,112.00
Sp. Doctor	1.0	£112,481.00	£8,164.00	£2,000.00	£122,644.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	2.0	£155,104.00	£11,290.00	£0.00	£166,394.00
Practioner B7	1.0	£66,556.00	£4,853.00	£0.00	£71,409.00
HCA	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Admin	1.0	£34,860.00	£2,567.00	£0.00	£37,427.00
Total	8.0	£640,035.00	£46,576.00	£4,000.00	£690,610.00
* Excludes on-call allowances					

Appendix 6 - Annual Cost of Staffing for Healthcare in Prisons by Trust

Healthcare in Prisons	WTE	Total S&W	G&S up to 10% of basic pay	Excess	Total
Consultant*	0.5	£79,311.00	£5,745.00	£1,000.00	£86,056.00
Service Lead	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B8A	1.0	£77,552.00	£5,645.00	£0.00	£83,197.00
Practioner B7	1.0	£66,555.00	£4,853.00	£0.00	£71,408.00
OT B7	1.0	£66,555.00	£4,853.00	£0.00	£71,408.00
Admin	0.5	£17,430.00	£1,284.00	£0.00	£18,714.00
Total	5.0	£384,955.00	£28,025.00	£1,000.00	£413,980.00
* Excludes on-call allowances					

Appendix 7 – Voluntary Sector Funding Requirements

Services Offered & Outcomes	Target	Cost
ADHD Information Sessions Outcomes: To enable parents to increase their knowledge and understanding of ADHD, feel supported and connected with other families, and gain confidence in identifying their child's needs. It also facilitates access to other relevant support, empowering parents to take informed next steps for their child's well-being	12 sessions per year Up to 50 parents per session 600 parents	£16,800
Parenting Programmes Parents are supported to understand ADHD, reduce stress, and strengthen relationships, enabling them to better support their child. Outcomes: To empower parents, improve home environments, and enable children/young people to better manage the features of ADHD. Improved parent–child relationships; reduced hostility and stress; increased confidence; reduced isolation; enhanced emotional well-being.	30 x 10 week Programmes 450 parents	£150,000
Parenting Maintenance Parents will be invited to attend 2x 2-hour maintenance sessions, where they can consolidate and review the skills learnt on the programme and discuss any challenges/progresses they have made.	30 x (2x2Hours) 450 parents	£45,000
Parent or Adult Support Meetings Group meetings will act as forums where participants can learn more about ADHD. Outcomes: To provide ongoing support, peer connection, and emotional resilience through quarterly group meetings.	24 meetings delivered Up to 50 participants per meeting 1200 individuals	£31,200
Young People's Programmes	82 x 6 Week Programmes	£205, 000

Outcomes: To empower young people to understand and manage their ADHD, strengthen resilience, and reach their potential socially, at home, and in school.	492 young people	
Post-Intervention Programmes Variety of Post-Intervention Programmes options and Support Meetings Offering continued long-term support. Outcomes: Enable ongoing involvement, reduce isolation. Enabling people to further augment the overall improvements they have experienced.	80 Sessions up to 10 people 20 people per year up to 10 sessions 1000 people	£35,000
Individual Counselling Outcomes: To improve emotional well-being and coping for people experiencing significant distress related to ADHD.	104 Individuals completing block of 8 sessions	£156,000
Adult Group Intervention Programmes Outcomes: To increase adult understanding of ADHD and provide strategies to manage anxiety, frustration, and daily challenges.	14 x 10 Week Programme 200 adults	£58,100
Sibling Groups Outcomes: Siblings to gain understanding of ADHD, experience reduced stress/conflict, and develop stronger family relationships and coping strategies. To promote a positive and nurturing family atmosphere and promote lower stress levels and better mental health.	10 programmes x 5 weeks Up to 10 young people per programme 100 young people	£25,000
Advice Line	42 Hours of Telephone	£50,000

Outcome: To provide immediate support, guidance, reassurance, and crisis support, and information to families and individuals affected by ADHD. Individuals feel heard, understood, and no longer alone.	advice line each week (e.g. 12 to 6pm Mon-Sun) 1000+ families supported	
Training & Capacity Building	Minimum 40 organisations	Based on 3 Hour Training within community £24,000 Based on 3 Hour Training £38,000
Outcome: To increase workforce and community capacity to support ADHD through informed, inclusive practice. Workforce and community organisations have improved understanding of ADHD, increased confidence in supporting individuals.		
	Total Cost	£834,100

Appendix 8 – Waiting List Options Short List

Option	Action	Advantages	Disadvantages
1.	Conduct a cleansing exercise by calling all individuals on the waiting list to determine if they wish to be offered an assessment	• Honours the initial decision to aim to provide an assessment	• Potentially time consuming exercise that may not rule out many people
2.	Apply one-off set of criteria **to introduce a level of priority** to referrals e.g. people with a history of self-harm, people known to the CJS/YJ	• Potentially identifies higher risk referrals • May reduce burden on other areas of the HSC system	• Potential delays to assessing people who had sought help at an earlier point • Potentially time consuming exercise
3.	Provide a screening assessment to determine the appropriateness of offering a full assessment	• Would free up senior clinical capacity	• Validity of self-administered questionnaires unclear
4.	Place a freeze on new referrals (excluding transitions) until the waiting list is cleared	• Reduces the admin burden (inc. triage etc) associated with processing new referrals • Allows newly developed services to 'bed-in'	• Disadvantages people in need • May lead to an avalanche of referrals at a future point
5.	Adopt regional approach to clearing waiting lists	• Services with additional capacity can carry out extra assessments • Reduces geographical variation • Facilitates services in developing from a similar starting point	• Patients may be less willing to travel across Trust boundaries
6.	Non-recurrent investment (i.e. waiting list initiative funding)	• Continuity of service provision and patient experience • Providing the service closer to the patient's home	• Costly option • Staff burn-out