



Neurodivergence Improvement Programme

Adult ADHD in Wales:

ADHD Roundtable Outcomes



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1. Executive Summary

This report recognises the highly positive engagement and momentum generated by the Adult ADHD Roundtable held on the 3 July 2025, an initiative championed by the Minister for Mental Health and Wellbeing. Bringing together clinicians, academics and policy leaders (**Annex 1** Attendees), the ADHD roundtable event fostered dynamic and open discussions and practical solutions, confirming the value of this collaborative approach. The event has not only highlighted shared challenges but generated some genuine consensus on finding shared solutions. Most importantly, it has shone a light on growing innovation, best practice and a collaborative commitment to improving adult ADHD services across Wales.

While acknowledging ongoing challenges such as regional variation, extended waiting times, and resource pressures, this report focusses on the impressive work already underway: new service models, streamlined assessment processes, digital innovations, workforce training, and integrated care models are flourishing in parts of Wales. The roundtable's constructive spirit has inspired actionable steps and will strengthen partnership working, ensuring that the evolving needs of adults with ADHD will be met through inclusive, person-centered pathways.

The ADHD roundtable discussions focused on three core questions, exploring ideas around effective screening for adult ADHD, use of digital innovations in adult ADHD pathways and the minimum requirements for proportionate adult ADHD assessments.

The discussions yielded several areas for potential development which will need to be explored further to ensure that there is a structured and comprehensive approach to addressing the identified issues and gaps.

In particular, the discussions provided five sets of key dyads (conceptual pairs) which will require careful consideration in formulating solutions:

- Simplex and complex
- Generalist and Specialist
- Diagnosis and Intervention/Support



- medical and social
- Manual and Digital

A Task and Finish Group is recommended as an outcome of the Roundtable, with selected membership to assess and define the potential areas of development and to progress the next steps.

2. Introduction

Adult ADHD services in Wales are under increasing pressure due to rising demand, inconsistent service provision, and limited resources. The Neurodivergence Improvement Programme (NDIP) aims to address these challenges through a whole-system, all-age approach. This report captures the current position, stakeholder insights, and strategic recommendations to support the development of equitable, efficient, and person-centered ADHD services.

3. Background

In response to growing concerns about long waiting times and inadequate support for neurodivergent adults, the Welsh Government launched the NDIP in 2022, with an initial £12 million investment, followed by an additional £13.7 million in 2025. Despite this, adult ADHD services remain underdeveloped compared to autism services, with no dedicated national pathway or consistent standards.

The NDIP established an Adult ADHD Pathway Group to scope current provision and identify improvement opportunities. This group has provided information to shared current pathways and service models across Wales, supported the National Neurodivergence Team to progress resource development, trialed a minimum viable data set, considered the Adult ADHD Quality Assurance Standard (AQAS), a set of NICE compliant guidelines produced by the UK Adult ADHD Network (UKAAN), and shared post diagnostic course resources and outcomes of pilots.

Annex 2 sets out the current understanding of how Health Boards are developing their adult ADHD Pathway and services.

Annex 3 sets out the current estimated demand for ADHD services in Wales. There is currently no reliable way to determine demand for adult ADHD services in Wales. However, estimating service capacity is difficult due to complex referral



processes and inaccessible data. Health Boards have provided only rough estimates based on differing circumstances, staffing, resources, and case complexity, making comparisons or benchmarks impossible.

4. Overview of current services

The work of the NDIP has found that there is significant variation in service models across Health Boards. Some have developed standalone ADHD teams (e.g. Aneurin Bevan University Health Board, Powys Teaching Health Board), while others embed ADHD within Community Mental Health Teams (CMHTs), often leading to capacity issues and inconsistent care.

Waiting times for an assessment range from 16 months to over five years, with referral rates increasing exponentially.

Annex 3 highlights the current waiting time estimates for each Health Board. Challenges faced by the Health Boards include limited prescribing capacity, lack of shared care agreements, and minimal post-diagnostic support.

5. Highlights from the ADHD Roundtable Discussion

The ADHD Roundtable, jointly chaired by Sarah Murphy MS, Minister for Mental Health and Wellbeing and Albert Heaney CBE, Chief Social Care Officer, brought together clinicians, academics, and policy leads to explore solutions. The discussions focused on screening, digital innovation, assessment models, and workforce development.

The agenda for the Adult ADHD Roundtable included three core questions. These were:

Question 1: How can we effectively and efficiently screen for adult ADHD? Are there screening tools which are thorough and reliable enough to reduce overall assessment process, particularly for non-complex cases?

Question 2: How can we make the best use of digital innovations in adult ADHD pathways (e.g. QB test)?



Question 3: What would the minimum requirements be for a more proportionate adult ADHD assessment?

These questions generated constructive debate and a suite of practical recommendations. Key topics and outcomes from the meeting included:

Screening and Assessment

- Broad consensus emerged that most individuals on ADHD waiting lists likely meet diagnostic criteria, making extensive pre-screening inefficient.
- Participants advocated for a tiered approach: streamlined assessments for non-complex cases and specialist input for complex presentations.
- Tools like ASRS and DIVA were endorsed by the participants, but concerns were raised about over-reliance on paperwork and the need for therapeutic interviews to support identity processing and post-diagnostic adjustment.

Digital Innovation

- Opportunities identified in the meeting included pre-assessment questionnaires, ambient voice technology, and AI-assisted triage.
- Concerns were raised about digital exclusion and the need for robust clinical governance.
- Remote monitoring and patient-held records (e.g. Patient Knows Best) were highlighted as ways to reduce clinician burden and improve continuity of care.

Workforce and Training

- A strong call was made for upskilling generalist clinicians, particularly psychiatrists and GPs, to diagnose and manage ADHD.
- The need for national training standards and integration of neurodivergence into medical curricula was emphasised.
- Nurse and pharmacist prescribers were seen as key to expanding capacity



Service Models and Integration

- Integrated pathways with autism services were seen as essential, given the high rate of co-occurrence.
- Several Health Boards (e.g. CTMUHB, HDUHB) are piloting joint pathways and shared administrative systems.
- The importance of aligning services across the lifespan, particularly during transition from child to adult services, was repeatedly stressed.

Equity and Access

- Concerns were raised about inequities in access, particularly for women, ethnic minorities, and individuals in the criminal justice system.
- The need for consistent national standards and data collection was highlighted to address postcode lottery effects.

Prescribing and Shared Care

- NICE guidelines requiring annual specialist reviews were seen as a barrier to discharge and sustainability.
- Participants advocated shared care agreements and red/amber/green prescribing protocols to enable safe GP prescribing.
- Examples were given of shared care protocols where GPs take over prescribing responsibilities after initial stabilization by specialists. This approach helps integrate ADHD management into primary care.
- The stigma around stimulant medications was identified as a barrier to primary care involvement.
- It was suggested that GPs could play a significant role in diagnosing and managing ADHD, particularly for non-complex cases. This includes the potential for GPs to handle annual reviews for stable patients.
- There is a need for training and supporting GPs to manage ADHD effectively. This includes developing pathways for GPs with extended roles (GPwER) and providing necessary education and training.

6. Good Practice examples

Throughout the discussion some notable examples of good practice were shared.



Integrated and Universal Service Models

- Cwm Taf Morgannwg University Health Board described a model where ADHD is treated as “everyone’s business” within mental health services. All clinicians, including junior doctors, nurse practitioners, and consultants -are trained to assess ADHD. This reduces bottlenecks and normalises diagnosis across services.
- The model includes a 28-day primary mental health assessment for all referrals, enabling early triage and redirection to appropriate service

Streamlined Assessment and Reporting

- Cwm Taf Morgannwg University Health Board uses a simplified, tabled format to document DIVA criteria, reducing the time spent on report writing. This approach was praised for being proportionate and efficient while maintaining clinical rigour.
- The Warrington model was shared where assessments are documented directly into GP systems, avoiding duplication and saving time.

Digital Tools and Remote Monitoring

- The use of remote monitoring tools (e.g. pulse oximeters, blood pressure monitors) and ambient voice technology can reduce clinician workload and improve efficiency. These tools have been trialled successfully in some Welsh Health Boards.
- “Patient Knows Best” was cited as a patient-held record system that enables shared access and reduces administrative burden.
- Cardiff and the Vale University Health Board highlighted the use of objective tools like the QbTest to guide ADHD medication decisions. The QbTest supports clinical assessment, while Patient-Reported Outcome Measures (PROMs) help identify comorbidities and differential diagnoses, ensuring a more comprehensive evaluation.



Shared Care and Prescribing Innovations

- Several Health Boards (e.g. Cwm Taf Morgannwg University Health Board, Aneurin Bevan, Cardiff & Vale) are developing or have implemented shared care agreements to enable GPs to continue prescribing ADHD medication after specialist initiation.
- GPs already issue the majority of stimulant prescriptions in Wales, suggesting a foundation for expanding shared care.

Workforce Development and Training

- Participants emphasised the importance of upskilling generalist clinicians. Cwm Taf Morgannwg University Health Board's model includes training for all staff in ADHD assessment, which has improved service resilience and reduced reliance on a small number of specialists
- The National Neurodivergence Team (NNT) was recognised for developing e-learning modules and resources to support workforce development across sectors.

Open Access Psychoeducation

- Cwm Taf Morgannwg University Health Board partnered with Valley Steps to deliver a 10-week psychoeducational course open to the public, removing barriers to support while awaiting diagnosis

7. Recommendations

Building on the momentum of the ADHD roundtable, the following actions were recommended:

1. **Develop a National Quality Statement for adult ADHD services**, setting consistent standards and outcome measures across the system.
2. **Pilot Integrated Neurodivergence Hubs in each of the health boards**, sharing successful models and best practice, providing a coordinated approach to care and support for individuals with ADHD and other neurodivergent conditions.



3. **Engage with NICE and the Four UK Nations to revise guidance** on specialist roles and prescribing responsibilities. This will help to ensure that community/general professionals are well-informed and supported in their roles.
4. **Expand Training and E-learning through the National Neurodivergence Team.** This should target GPs, psychiatrists, and allied professionals to enhance their understanding and management of ADHD.
5. **Implementation of Digital Triage and Monitoring Tools** to improve accessibility and clinical safety, ensuring that individuals receive timely and appropriate care.
6. **Strengthen Transition Protocols** to prevent young people from having to restart waiting lists upon entering adult services. This will ensure continuity of care and better outcomes for individuals transitioning from children to adult services.
7. **Explore Prison-Based Pilots** to address unmet needs and reduce reoffending linked to undiagnosed ADHD is a critical step. This will help to identify and support individuals within the criminal justice system who may have ADHD. A clinician from Cardiff and the Vale University Health Board advised that research suggests that up to 25% of the prison population may have ADHD
8. **Promotion of Public and Professional Awareness** is essential to challenge stigma and normalise neurodivergence as part of good mental health. This will create a more inclusive and supportive environment for individuals with ADHD.
9. **GPs and the GP contract need to be supported** with training, shared care protocols and ongoing contract negotiations to enable more efficient, community-based care.
10. **Simplex versus the complex**, managing complex assessment through triaging with simplex presentations considered by wider professionals.

8. Next Steps

The success of the Ministerial ADHD Roundtable as a method for exploring complex issues in an informed and collaborative environment is clear. It has resulted in renewed energy, shared ambition, tangible recommendations for improvement and identification of real-world good practice already shaping adult ADHD pathways in Wales.



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By building on these strengths and sustaining a spirit of collaboration it is recommended that a task and finish group is formed from selected membership of the ADHD Roundtable to scope the potential recommendations identified above and develop a clear and costed action plan.

By taking these steps, we can improve the quality and accessibility of adult ADHD services, ensuring that individuals receive the care and support they need. This comprehensive approach will enhance the overall outcomes for individuals with ADHD and contribute to a more inclusive society.



ANNEX 1 - Attendance List <redacted s40(2)>

ANNEX 2 - Current service models

The following is an overview of how Health Boards are developing their adult ADHD Pathway and services.

Aneurin Bevan University Health Board

Specialist stand-alone team, managed in Primary Care Mental Health Support Services. Specialist Nurse Consultant leads the service, some psychiatry input, moving to nurse prescribers. Referrals via GP into ADHD service. Aligning service with IAS, will be co-located, once established consider joint screening, pathways between services etc. Use of DIVA. Able to report more reliable and specific data.

Betsi Cadwaladr University Health Board

Little available information as not engaged with adult ADHD pathway group. Referrals are included in the total waiting for primary care assessment and then they go for a consultant assessment and diagnosis. Developing a proposal for adults.

Cwm Taf Morgannwg University Health Board

Clinical lead in post. Referral route via Primary Care to risk assess and support all patients referred, referrals are then managed via CMHT waiting list. Diagnostic and review capacity is variable across the localities due to variation in skill mix/staffing levels in Outpatient services. Improvements are in progress with focused work streams, with the use of advanced nurse practitioners to undertake assessments and treatment with oversight from Consultant for Staff Grade Doctor. Commissioned a third sector organisation to deliver psycho-education course.

Cardiff & The Vale University Health Board

The referral pathway is via routine CMHT referral route through GP. ADHD referrals are screened and processed through the usual multi-disciplinary team process across 6 CMHT's. It is believed that at least some CMHTs are considering implementing strict access criteria to manage demand. This is likely to mean that only the most chronic individuals will be accepted for diagnosis. Referrals are discussed at MDT, placed on CMHT waiting list allocated on a treat in turn basis to the next available clinician. Assessing staff devote 1 in 10 clinics to ADHD assessments. The service offered is diagnosis and medication.



CVUHB have invested through NDIP in a small specialist team to pilot new ways of working and agree a consistent approach. Good progress has been made in identifying appropriate clinical pathway. However, demand, lack of resources etc. has made it impossible to implement on service model across the Health Board.

Hywel Dda University Health Board

In HDUHB referrals are made to a specialist consultant psychiatrist who is solely employed to assess ADHD. He works currently in partnership with a non-medical prescriber (Band 7) to complete the medication and titration services offered. Aligning IAS and ADHD services closely, looking to pool resources and expertise. Significant demand and capacity issues.

Powys Teaching Health Board

Developed a stand-alone specialist ADHD team. Developing alignment with IAS admin and managerial support will be across IAS and ADHD, both waiting lists will be held within the IAS. Both ASC and ADHD assessors will be trained in ASC and ADHD awareness to identify possible co-occurring conditions. The referral process between both assessment pathways will then be developed to consider the efficiency of both processes, e.g. joint working.

Swansea Bay University Health Board

Referral route is via GP into CMHT's, triaged and added to CMHT general outpatient list, treat in turn, no dedicated ADHD staff as such. The initial assessment is 1 hour and a further 2 x 1-hour appointments are needed to complete the DIVA questionnaire to confirm diagnosis. Increasing number of patients seeking a private diagnosis but they require an NHS diagnosis to obtain medication from the NHS is resulting in some people feeling like they are being made to wait again. An audit by one Consultant



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over 4 months shows 40% of all new referrals into clinics are for an ADHD diagnosis. Proposal to improve pathway and consider alignment with IAS.



ANNEX 3 - Current demand

Currently there is no means to ascertain the demand for adult ADHD services in Wales. Estimating demand and capacity of ADHD services is challenging, particularly where referral processes are embedded in routine CMHT outpatient appointments, the data cannot be extracted from Health Board systems.

During the scoping exercise Health Boards provided a very rough estimate of their current position. These are best guesses; no comparison or benchmarking can be drawn from this data as services are in very different positions, with different staffing structures and levels, different approaches, very limited resources, prescribing challenges, demand and complexity of cases.

Health Board	Estimated waiting No.	Estimated waiting time	Estimated average referral rate	Other available information
ABUHB	3,960	2 years	around 300 per month	Additional 250 private diagnosis awaiting review for medication
BCUHB	N/A	Not available	Not available	Challenges in extrapolating data from general CMHT referrals
C&VUHB	1,300	12 – 24 months	Not available	Challenges in extrapolating data from general CMHT referrals so figure is believed to be significantly higher
CTMUHB	3,308	18 months – 5 years locality dependent	55 – 70 per month locality dependent	Capacity variable across localities in CMHTs. Improvements are in progress with focused work streams.
HDUHB	3,710	5 years	100 – 130 referrals per month	Service reduced staffing capacity approx. 1,400



				assessments requiring admin/triage processes
PTHB	456	16 months	60 referrals per month	Increased need for medication reviews reducing capacity to offer diagnostic assessments.
SBUHB	971 currently under pathway stages,	Longest wait is 5.5 years (290 weeks)	unclear	Challenges in extrapolating data from general CMHT referrals so figure likely to be significantly underrepresented

Table: illustrates our understanding of waiting times at October 2024.