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**Title: Attention-Deficit Hyperactivity Disorder (ADHD) –
ICD-11 Code 6A05**

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Introduction

Attention-deficit hyperactivity disorder (ADHD) is one of the most common neurodevelopmental conditions encountered across health, education and social care settings, with an estimated global prevalence of around 5% in children and 2–3% in adults (National Institute for Health and Care Excellence [NICE], 2018). Its classification has evolved considerably across successive diagnostic frameworks, and its placement within the neurodevelopmental disorders grouping of the eleventh revision of the International Classification of Diseases (ICD-11) reflects a broader shift toward understanding attentional and behavioural variation in developmental and functional terms, rather than as a fixed, uniform pathology (World Health Organization [WHO], 2024).

This report critically examines the classification and diagnosis of ADHD within ICD-11, before evaluating current treatment and rehabilitation approaches. It then explores ongoing debates surrounding the condition, with particular attention to the role of neurodivergence and reclassification, and concludes with recommendations for improving practice, policy and future research.

Classification and Diagnosis

The World Health Organization's ICD-11 defines ADHD as a persistent pattern of inattention and/or hyperactivity-impulsivity that emerges during the developmental period, is excessive for the individual's age and developmental level, and impairs functioning across multiple settings, e.g. home, school or work, with symptoms present for at least six months (WHO, 2024). ADHD is classified under code 6A05 within the neurodevelopmental disorders grouping, replacing the ICD-10 category of 'hyperkinetic disorders' (F90) and aligning more closely with the presentation-based model used in the DSM-5 (Gomez, Chen and Houghton, 2023). Five presentations are specified: predominantly inattentive (6A05.0), predominantly hyperactive-impulsive (6A05.1), combined (6A05.2), other specified (6A05.Y) and unspecified (6A05.Z).

A significant difference between ICD-11 and DSM-5-TR lies in diagnostic precision. DSM-5-TR retains a categorical, symptom-count model: at least six of nine symptoms must be present in the relevant domain (inattentive, hyperactive-impulsive, or both, for combined presentation) for children up to 16, falling to five of nine per domain from age 17. ICD-11, by contrast, relies on clinical judgement rather than a fixed symptom count to determine whether symptom pattern and severity are developmentally inappropriate and functionally impairing (Gomez, Chen and Houghton, 2023). This offers flexibility for adults whose

presentation differs from childhood-focused criteria but introduces subjectivity affecting diagnostic consistency between clinicians. Gomez, Chen and Houghton (2023, p. 141) frame this as a deliberate rejection of the ‘pseudo-precision’ of fixed symptom thresholds in favour of dimensional clinical judgement; however, they also note that no ICD-11-specific rating scale yet exists, so clinicians must rely on DSM-based instruments whose fit with ICD-11 remains unverified — a genuine gap in the evidence base.

In the UK, NICE guideline NG87 sets out the diagnostic pathway: children with persistent, at least moderate impairment should be referred to secondary care, and adults with suspected ADHD should be referred to a specialist in adult ADHD for formal assessment (NICE, 2018). Despite this pathway, NHS data indicate substantial under-recognition: around 2.5 million people in England are estimated to have ADHD, yet only 1.6% of males and 0.9% of females have a recorded diagnosis, and as of September 2025 up to 700,123 people were waiting for an ADHD assessment (NHS England Digital, 2025; NHS England, 2025).

The language used within ICD-11 is also significant. The term ‘disorder’ is retained throughout the classification, situating ADHD within a broadly medical framework that implies dysfunction requiring identification and treatment. This terminology is increasingly contested, a tension explored further in the discussion of current debates below.

Treatment and Rehabilitation

NICE (2018) recommends a multimodal approach to ADHD management, combining pharmacological and psychosocial interventions tailored to severity and preference. Stimulant medications, principally methylphenidate and amphetamines, are recommended as first-line treatment; a recent systematic review and network meta-analysis found stimulants among the few interventions with clear short-term benefit for core symptoms, with amphetamines outperforming methylphenidate, atomoxetine and modafinil (Ostinelli et al., 2025). Where stimulants are unsuitable, NICE (2018) supports non-stimulants such as atomoxetine or guanfacine, with monitoring of heart rate, blood pressure, weight and appetite.

However, the same review highlighted important limitations: evidence for medication’s effect on broader outcomes such as quality of life was weak, particularly in adults, and long-term evidence remains underdeveloped relative to the volume of short-term trial data (Ostinelli et al., 2025). This raises questions about whether rapidly expanding prescribing practice is adequately informed by evidence of sustained real-world benefit.

NICE (2018) recommends a structured, ADHD-specific psychological intervention with regular follow-up, which may include elements of CBT rather than mandating it as a fixed first-line therapy; for pre-school children, a group-based parent-training programme is recommended first, reflecting caution around early medication use. Where used, CBT typically targets executive functioning difficulties such as planning, time management and organisation, but qualitative evidence suggests generic frameworks and therapists without ADHD-specific training can be poorly matched to ADHD's cognitive profile, causing disengagement (William et al., 2024) — effectiveness therefore depends on how well interventions are adapted to ADHD-specific needs.

ICD-11 is fundamentally a diagnostic and classification manual rather than a treatment guide: it identifies impairment across functional life domains but does not itself prescribe a rehabilitation pathway (WHO, 2024). Rehabilitation in UK practice is instead shaped by NICE guidance, education, employment support and equality legislation. ADHD is recognised as a disability under the *Equality Act 2010* where it has a substantial, long-term adverse effect on day-to-day activities, entitling individuals to reasonable adjustments such as flexible working or assistive technology, regardless of whether a formal diagnosis has been obtained (*Equality Act 2010*; Acas, 2025).

Educational rehabilitation deserves particular emphasis, given that academic impairment is one of the most consistent functional consequences of ADHD. Children with ADHD underperform relative to peers across standardised measures of academic achievement, evident from early schooling with long-term educational and occupational consequences (Loe and Feldman, 2007). This is not fully explained by core symptoms: longitudinal research has found that written expression ability specifically predicts adolescents' GPA and parent-rated academic impairment 18 months later, even after controlling for ADHD symptoms, medication status and reading ability (Molitor et al., 2016). Rehabilitation should therefore extend beyond symptom management to include targeted academic skill-building.

In practice, however, access to both pharmacological and rehabilitative support is markedly unequal. Only 26.6% of children and 15.6% of adults with an estimated ADHD diagnosis currently receive pharmacological treatment, and lengthy specialist assessment waiting lists delay access to any form of structured rehabilitation or accommodation (NHS England Digital, 2025). This gap between guideline recommendations and service delivery represents one of the most significant limitations of current provision.

Current Debates and Emerging Issues

A prominent debate concerns whether rising ADHD diagnosis rates reflect overdiagnosis or improved recognition of a previously overlooked condition. In the United States, adult ADHD diagnoses rose by approximately 123% between 2007 and 2016, and stimulant prescriptions increased by 30% between 2018 and 2022, prompting a joint warning from the FDA and DEA about diagnostic practice (Abdelnour, Jansen and Gold, 2022). Yet the same literature stresses that underdiagnosis and undertreatment remain serious concerns among adults and groups historically overlooked by frameworks built on young, male samples, so overdiagnosis and underdiagnosis appear to coexist rather than form one uniform trend (Abdelnour, Jansen and Gold, 2022).

In the UK specifically, this tension is compounded by service capacity and consistency problems rather than diagnostic criteria alone. NHS England's independent ADHD taskforce found that data on referrals, waiting lists and local diagnosis rates remain of poor quality across England, making it difficult to establish whether rising diagnosis reflects genuine need or inconsistent local practice; some Integrated Care Boards have since tightened referral criteria, while growing reliance on private and NHS 'right to choose' providers has introduced variation in diagnostic quality and shared-care prescribing arrangements (NHS England, 2025). This UK picture reframes the overdiagnosis/underdiagnosis debate as, in part, a problem of system capacity and regional inequality rather than diagnostic practice alone.

This debate is complicated by the evidence used to adjudicate it. Much of the data cited in support of overdiagnosis are administrative — prescribing rates and diagnostic codes — which cannot distinguish diagnostic inflation from improved detection (Abdelnour, Jansen and Gold, 2022). Norwegian registry evidence illustrates this directly: geographical variation in ADHD diagnosis rates far exceeded what variation in symptom levels could explain, suggesting diagnostic practice itself drives much of the variation (Widding-Havneraas et al., 2023). Read against this, ICD-11's move away from fixed thresholds seems a reasonable response to a heterogeneous condition rather than a weakness relative to DSM-5-TR; the more pressing problem is the lack of validated ICD-11-specific tools to apply that judgement consistently (Gomez, Chen and Houghton, 2023).

Gender bias is a clear example of this unevenness. Girls and women are disproportionately underdiagnosed because ADHD symptoms in females more often present as inattentive and internalising rather than disruptive, making them less likely to be referred for assessment (Almekhlafi and Jain, 2023). Recent clinical research confirms gender-specific patterns in symptom and impairment endorsement, with women more frequently reporting inattentive

symptoms and impairments in self-esteem and social relationships (Platania et al., 2025). Delayed diagnosis in women has been linked to increased risk of internalising disorders, self-harm and long-term psychosocial impairment, underscoring that diagnostic frameworks are not gender-neutral in application even where gender-neutral in wording.

Central to this module's focus is the role of neurodivergence in reshaping how ADHD is understood. The neurodiversity movement, originating with sociologist Judy Singer in the 1990s, reframes conditions such as ADHD and autism as natural variation in human cognition rather than deficits requiring correction, positioning itself against a purely medical model defined primarily through impairment and dysfunction (Cascio, 2025). Commentators caution against treating this as binary: an exclusively strengths-based framing risks minimising the genuine impairment and distress many individuals with ADHD experience, while a purely deficit-based model risks pathologising ordinary cognitive variation and reinforcing stigma (Cascio, 2025).

This tension is reflected directly in debates over language. UK survey research with neurodivergent adults found a strong community preference for identity-first language and a rejection of terms such as 'disorder' and 'deficit', widely reported to imply deviation from an assumed norm and reinforce stigma (Pearson et al., 2026). ICD-11 nonetheless retains 'disorder' terminology, in part because diagnostic labels carry practical weight: they determine eligibility for NHS treatment, statutory educational support and legal protection under equality legislation. This creates a genuine tension between the clinical and administrative utility of diagnostic language and the lived preferences of the neurodivergent community it describes.

These debates have concrete implications for practice and policy. Clinically, they support a shift toward individualised, strengths-aware assessment rather than uniformly deficit-focused models. In policy terms, they intersect with disability rights: because *Equality Act 2010* protections do not require a formal diagnosis, services and employers are increasingly expected to respond to functional need rather than label alone (*Equality Act 2010*). Yet persistent waiting lists and unequal access to diagnosis mean many people cannot yet benefit fully from either pathway.

Recommendations

Several recommendations follow from this analysis. First, diagnostic services should adopt gender-informed and lifespan-sensitive assessment protocols, including specific training for clinicians, teachers and GPs on how ADHD presents differently in girls and women, to reduce the persistent gap in recognition (Almekhlafi and Jain, 2023; Platania et al., 2025).

Second, investment is needed to reduce ADHD assessment waiting times through an expanded specialist workforce, stepped-care pathways, and wider adoption of NICE-recommended digital aids such as QbTest for the 6–17 age range, which increases the likelihood of a timely diagnostic decision without improving accuracy itself, so should supplement rather than replace clinical assessment (Hollis et al., 2018; NICE, 2024; NHS England Digital, 2025).

Third, psychosocial interventions such as CBT should be more consistently adapted to the ADHD-specific cognitive profile, with mandatory ADHD-specific training for therapists delivering these interventions, rather than relying on generic CBT frameworks that service users report as poorly matched to their needs (William et al., 2024).

Fourth, future revisions of diagnostic classifications and clinical guidance should formally incorporate the perspectives of neurodivergent service users, particularly regarding terminology, to help reconcile the clinical utility of diagnostic language with community concerns about stigmatising labels (Pearson et al., 2026).

Finally, employers and educational institutions should apply *Equality Act 2010* duties proactively, ensuring reasonable adjustments are available regardless of formal diagnosis status, while researchers should prioritise longitudinal studies of treatment outcomes and quality of life over short-term symptom reduction alone (*Equality Act 2010*; Ostinelli et al., 2025).

Conclusion

ADHD is a common and complex neurodevelopmental condition whose classification in ICD-11 reflects an increasingly nuanced, functioning-focused understanding compared with earlier diagnostic frameworks. Nonetheless, significant tensions remain: diagnostic language continues to be contested by the neurodivergent community, recognition of the condition remains unevenly distributed across gender and other demographic lines, and access to evidence-based treatment and rehabilitation is constrained by service capacity rather than by a lack of clinical guidance. Addressing these issues requires diagnostic and treatment pathways that are individualised, gender-aware and responsive to lived experience, alongside sustained investment in assessment capacity and further research into long-term treatment outcomes. Only through this combination of clinical, legislative and cultural change can classification and provision for ADHD keep pace with contemporary understanding of the condition.

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