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THE GREAT ADHD MYTH?

A clinical and evidential critique of Channel 4's documentary

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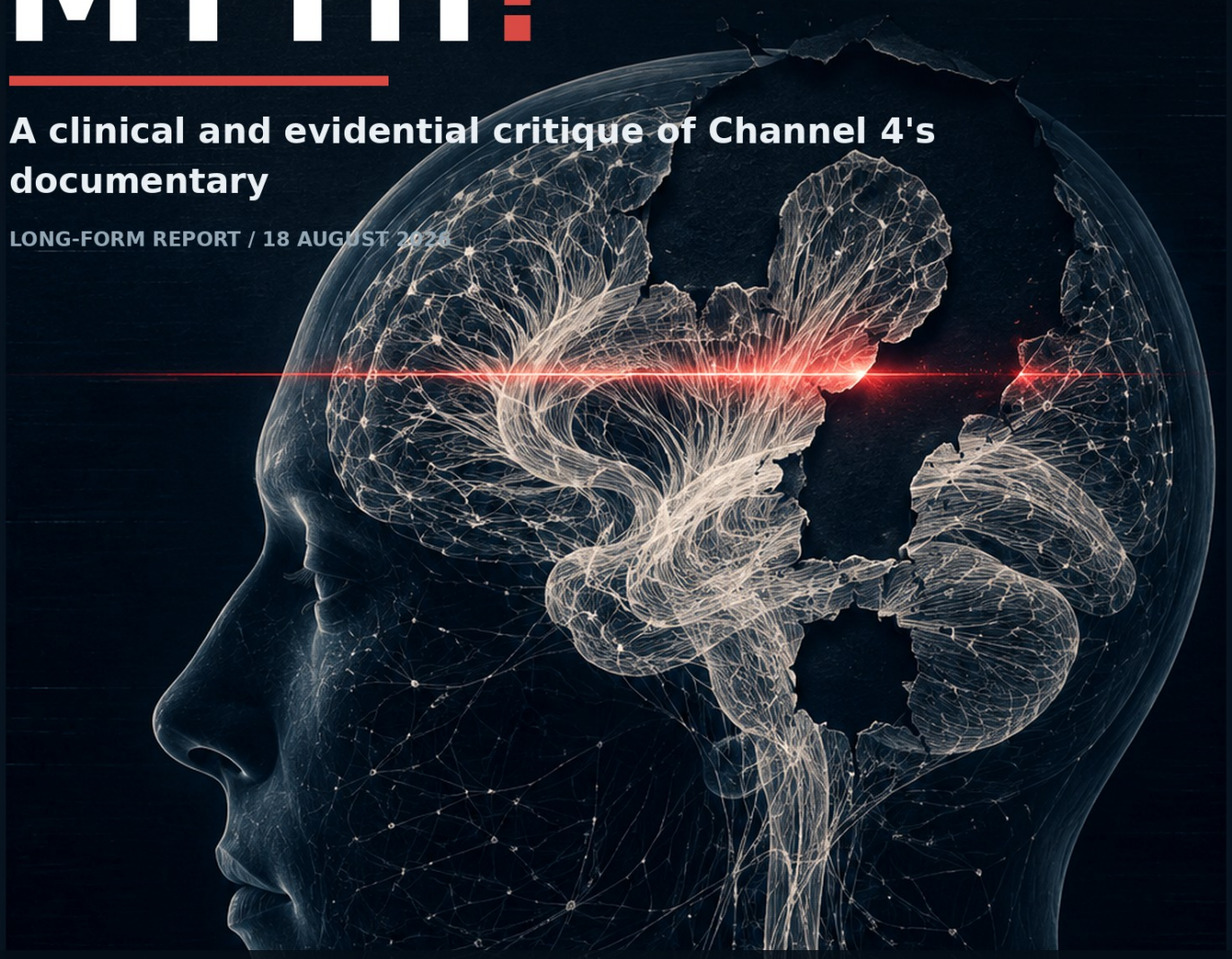

How a polemic mistakes failures in ADHD care for evidence that ADHD does not exist

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NAVIGATION FILE

Contents

Select a title to jump directly to that section. Page references match the displayed report folios and the PDF pages.

Editorial note. *This critique addresses public claims, professional credentials, declared commercial interests, production choices and the evidence shown on screen. It does not diagnose any contributor, speculate about private motives or apportion blame to a child or parent on the basis of an edited television programme. Where the documentary leaves competing explanations unresolved, they are identified as possibilities—not allegations.*

SECTION 01

Disbelief at another dangerous ADHD documentary

I watched Channel 4's *The Great ADHD Myth?* with mounting disbelief. After more than fifteen years assessing adults with ADHD—including many people whose lives have intersected with addiction—I found myself watching yet another dangerous television documentary flatten a complex, heterogeneous neurodevelopmental disorder into an hour of insinuation, staged "experiments" and false binaries.

My concern is not that ADHD should be protected from scrutiny. Quite the opposite. I would welcome serious investigation of variable diagnostic quality, unacceptably long NHS waiting lists, weak post-diagnostic support, the commercialisation of assessment, inconsistent shared-care arrangements, medication shortages, diversion, inadequate monitoring, and the failure of schools and workplaces to accommodate neurodevelopmental difference. I would also welcome an informed, ethically serious discussion about prescribing psychotropic medication to children. These are difficult and important questions.

But this programme did not examine those questions cleanly. It repeatedly collapsed three distinct debates into one:

- whether and when children should receive medication;
- why adult referrals, diagnoses and prescriptions have risen as recognition and diagnostic frameworks have changed; and
- whether ADHD is a genuine neurodevelopmental condition at all.

Evidence of failure in one domain was used to create doubt in another. A questionable private assessment was treated as evidence against the diagnosis. A child's complex response to stopping and restarting medication was treated as evidence against the underlying disorder. The absence of an individual diagnostic brain scan was allowed to slide into the suggestion that there is no neurobiology. Legitimate concerns about pharmaceutical profit were investigated while a commercial provider of "drug-free" programmes was presented without equivalent interrogation.

That is not merely imprecise. It is a category error repeated until it becomes a narrative.

The result was not a genuinely open, science-led inquiry. It was a conclusion looking for an investigation.

SECTION 02

The title had already loaded the dice

Channel 4's own press release asked whether ADHD was "a genuine neurodevelopmental disorder, or a social construct" and whether children were being given "mind-altering drugs" in the face of "uncertainty". It described a 60-minute Minnow Films production commissioned by Channel 4, presented by Dr Max Pemberton and built around rising referrals, medication and modern-life explanations such as screens, ultra-processed food and regimented schooling.[1]

A question mark does not neutralise a loaded premise. As ADHD UK put it before transmission, "A question mark is not a get-out-of-harm-free card."[24] The title did not ask whether some assessments are poor, whether services are safe, or whether some children would benefit from more environmental support. It invited a mass audience to revisit whether a recognised disability is real.

That matters because the scientific and policy baseline is not mysterious. ADHD is recognised by the World Health Organization, the NHS and NICE. A 2024 *Nature Reviews Disease Primers* review describes it as a common neurodevelopmental condition affecting children and adults, with a predominantly genetic aetiology involving common and rare variants.[3] The 2021 World Federation of ADHD International Consensus Statement generated 208 empirically supported conclusions, approved by 80 authors from 27 countries, from meta-analyses and very large studies.[4] A major genetics review estimated heritability at approximately 74 per cent while emphasising that ADHD is polygenic and that individual variants have very small effects.[5]

None of this makes ADHD simple. A disorder can be neurodevelopmental and socially mediated. Disability emerges partly through the interaction between a person and an environment. Diagnostic boundaries can be imperfect. Referral rates can rise without population prevalence rising. Medicines can benefit some people and harm or fail others. Those propositions coexist comfortably in mainstream clinical science.

The programme instead repeatedly encouraged a theatrical choice: brain disorder or social construct; authentic child or medicated child; nature or modern life; care or commerce. Reality is not arranged in those pairs.

SECTION 03

What the programme failed to explain about the brain

No diagnostic scan is not no neurobiology

The most startling scientific omission was the failure to distinguish two entirely different statements:

- there is no MRI scan that can diagnose ADHD in an individual; and
- there is no evidence of neurodevelopmental differences in groups of people with ADHD.

The first is true. The second is false.

Research MRI detects average differences between groups. Those differences are generally small, heterogeneous and overlapping. That makes them unsuitable as a stand-alone diagnostic test for an individual patient. It does not make them imaginary. Blood pressure distributions overlap between groups; height distributions overlap between sexes; neither fact abolishes a population-level difference. The same elementary statistical point applies here.

Large collaborative studies exist precisely because small effects require large samples. In the 2017 ENIGMA analysis, researchers compared 1,713 people with ADHD with 1,529 controls across 23 sites. They reported smaller volumes, on average, in the accumbens, amygdala, caudate, hippocampus and putamen, as well as lower intracranial volume. Effects were small and most pronounced in children; medication history did not account for them.[6]

A later ENIGMA cortical analysis included 2,246 participants with ADHD and 1,934 controls. In children, ADHD was associated with lower cortical surface area, principally in frontal, cingulate and temporal regions, with small effect sizes; adolescent and adult group results were less clear.[7] That developmental pattern is important. ADHD is a developmental condition, and a difference can attenuate, change form or become harder to detect with age without having been fictitious in childhood.

Diffusion MRI examines the movement of water through tissue and provides indirect information about white-matter organisation. A large youth mega-analysis reported lower fractional anisotropy in the inferior longitudinal and left uncinate fasciculi, with the strongest associations again small and of limited individual diagnostic value.[8] A 2023 systematic review and meta-analysis of 129 diffusion studies found widespread, mainly reduced fractional anisotropy across tracts including the corpus callosum, cingulum and frontostriatal pathways, while also documenting substantial heterogeneity and methodological limitations.[9]

Functional MRI studies add another layer: altered average activation during inhibition, attention, timing and reward tasks, and differences in large-scale resting-state networks. Longitudinal work has reported delayed maturation of cortical and intrinsic functional architecture in some young people with ADHD. The 2024 *Nature Reviews* synthesis does not claim a single ADHD brain signature; it reviews a distributed, developmentally changing and heterogeneous literature.[3]

This is how mature science speaks: small effects, overlapping distributions, inconsistent findings in some age groups, vulnerability to motion and sampling artefacts, and no clinically validated individual scan. The responsible conclusion is that imaging contributes to a convergent neurodevelopmental evidence base but is not a diagnostic biomarker. Even the US National Institute of Mental Health has explained why group-level findings requiring large samples are not ready for individual diagnosis.[11]

The programme appears to have converted "small, variable and not diagnostically decisive" into "not convincing" and then allowed viewers to hear "none". That conversion is especially difficult to understand because Professor Katya Rubia—the programme's one clearly identifiable high-level ADHD neuroimaging specialist—has an extensive research record in structural imaging, functional imaging, pharmacological imaging, PET, neurofeedback and brain stimulation in ADHD.[10] Before broadcast she warned: "My worry is that people will view the documentary and think that ADHD does not exist – that is not true."[44]

If her nuanced point was that no scan can confirm ADHD in one person, she was correct. If the edit made that sound like an absence of group-level evidence, the programme failed its audience. I cannot determine from the broadcast alone whether that was achieved by editing, questioning or compression. I can say that the scientific distinction was not conveyed with the clarity its importance demanded.

The missing neurochemical account: dopamine, noradrenaline and careful stimulant use

The neurochemical account was not merely underdeveloped; it was absent. The programme asked viewers to judge whether ADHD is biologically credible and whether stimulant treatment is justified without explaining the principal neuropharmacological framework through which those medicines are understood. That is a major editorial omission. It left the audience with an apparent choice between a visible abnormality on an ordinary scan and no meaningful biology at all.

Standard structural MRI does not measure dopamine or noradrenaline. Diffusion MRI estimates water diffusion through tissue; functional MRI measures blood-oxygen-level-dependent haemodynamic signals. Neither reads out a person's neurotransmitter "level". PET and SPECT studies using radioligands can estimate receptor or transporter availability and, in some designs, aspects of neurotransmitter release. These are technically demanding group studies, not routine diagnostic tests. A neurotransmitter mechanism therefore cannot be dismissed merely because it is not visible on the structural scan shown to a television audience.

Nor should ADHD be reduced to the slogan “low dopamine”. The better-supported model concerns dysregulated catecholamine signalling—dopamine and noradrenaline, or norepinephrine in US usage—across prefrontal, frontostriatal and reward networks. Studies of dopamine transporter and D2/D3 receptor availability have produced differing results across samples and methods. One PET study of treatment-naïve adults reported increased dopamine transporter binding in the right caudate; another reported lower D2/D3 receptor and transporter availability in reward and motivation regions.[13–14] A recent review concludes that altered dopamine signalling remains strongly implicated while rejecting a single, universal dopamine-deficiency model.[12]

The prefrontal cortex is central to sustained attention, working memory, inhibitory control, task initiation and goal-directed behaviour. Its performance depends on catecholamine signalling within an optimal range: too little can weaken the stability and signal-to-noise of prefrontal networks, while too much can also impair them. In animal experiments designed to produce clinically relevant drug exposure, low-dose methylphenidate preferentially increased extracellular dopamine and noradrenaline in the prefrontal cortex and improved prefrontal-dependent cognition; higher doses lost that advantage and could impair performance.[47–48] These experiments do not prove that every human with ADHD has the same transmitter abnormality. They do show why therapeutic dose, rather than the mere presence of a stimulant, matters.

Stimulant treatment is therefore pharmacologically purposeful, not an arbitrary attempt to sedate behaviour. Methylphenidate principally inhibits dopamine and noradrenaline transporters, increasing the availability of catecholamines already released. Lisdexamfetamine is a prodrug converted in blood to dexamfetamine, which both reduces reuptake and increases release of dopamine and noradrenaline.[49] The therapeutic aim is to optimise catecholamine signalling in prefrontal control systems and connected networks so that attention and executive control become more reliable. The drugs are not, however, anatomically delivered only to the frontal lobes: they circulate through the brain and body and can affect striatal, reward, motor and cardiovascular systems. That is precisely why dose, timing, preparation, comorbidity and individual sensitivity matter.

This is also why careful stimulant prescribing cannot be represented by one tablet and a camera crew. Drug action begins the day a dose is taken; stimulants do not require months of accumulation before any effect is possible. But identifying a useful treatment commonly requires a longitudinal titration process over weeks and sometimes months. NICE requires symptoms, impairment and adverse effects to be recorded at baseline and at each dose change, regular specialist review, and titration until there is meaningful functional improvement with tolerable adverse effects.[16] In practice that means agreeing target outcomes and monitoring pulse, blood pressure, appetite, weight, sleep, mood, anxiety, tics, emotional blunting and misuse or diversion risk; then adjusting the dose, timing, formulation or medicine as necessary. Benefits can become clearer or accumulate functionally as a person learns, works and regulates daily life more consistently, even though the pharmacological effect of each dose is acute.

Against that background, Pemberton's single dose of lisdexamfetamine was not simply a weak experiment; it was presented without the central scientific context needed to interpret it. Feeling blunted after one dose may indicate that the dose, formulation or drug was unsuitable, that expectations influenced the experience, or simply that an individual without a treatment indication experienced an adverse effect. It cannot tell viewers what an appropriately diagnosed patient will experience after individualised titration. By omitting catecholamine theory and titration, the programme made rational, monitored psychopharmacology look like indiscriminate chemical suppression.

Medication response still does not prove a diagnosis or a single biochemical cause: stimulants affect people without ADHD, and benefit is not a laboratory test. But pharmacology, genetics, imaging, cognition, epidemiology, developmental course and treatment studies form converging—not identical—lines of evidence. The absence of a simple assay demonstrates that ADHD is a heterogeneous neurodevelopmental syndrome, not that its biology is imaginary. The programme did not simplify a difficult explanation. It omitted the central explanation against which its medication claims should have been judged.

SECTION 04

The presenter was not a neutral investigator

His expertise—and its limits

Dr Max Pemberton is a doctor and an NHS psychiatrist. Any critique suggesting that he is not currently practising would be inaccurate. In April 2026 he wrote that he worked in a specialist NHS first-episode psychosis service.[31] Public biographies identify him as a Daily Mail columnist, a former Daily Telegraph columnist of twelve years, a Reader's Digest columnist and a Spectator contributor.[32]

Those facts establish substantial clinical and media experience. They do not establish specialist expertise in adult ADHD assessment, child ADHD, developmental neurobiology, ADHD psychopharmacology or neuroimaging. I found no public record, in the sources reviewed, of an ADHD specialist clinic role or ADHD research programme. That does not mean he has never assessed ADHD; it means the programme should not have allowed the broad title "NHS psychiatrist" to substitute for precise expertise.

His journalism is also relevant—not because employment by a right-of-centre tabloid proves a personal party-political identity, which it does not, but because editorial culture shapes format. The Daily Mail and Spectator reward compressed, provocative and contrarian arguments. Pemberton is an experienced polemical journalist as well as a clinician. Viewers deserved to know that he had already published a firm position on ADHD. ADHD UK quoted his 2024 Spectator argument that ADHD was "wildly over-diagnosed", accompanied by claims about parental responsibility, screens and Ritalin.[24] Nineteen months later, the film presented him as setting out to discover the answer.

That prior commitment does not automatically invalidate his work. It does, however, create a clear risk of confirmation bias. Channel 4's marketing intensified that concern. Commissioning editor Tim Hancock promised a "science-led" approach while executive producer Liam Humphreys promised "startling revelations" that would make viewers think differently about medicating a generation.[1] An inquiry cannot honestly promise revelation and claim methodological neutrality at the same time.

The £1,200 diagnosis stunt proved almost nothing

Pemberton underwent a private 90-minute ADHD assessment, was diagnosed with combined-type ADHD and prescribed medication. He said he answered honestly and rejected the diagnosis. The sequence was framed as evidence that a knowledgeable, functional adult can be too easily diagnosed.[2]

It raises a legitimate question about assessment quality. It does not answer it.

Adult ADHD diagnosis is not a score on a checklist. It requires persistent symptoms, childhood onset, clinically significant impairment, evidence across settings, and consideration of alternatives and comorbidity. Under DSM-5 criteria, adults need five—not six—symptoms in a domain. Combined presentation requires both the inattentive and hyperactive-impulsive thresholds; predominantly hyperactive-impulsive ADHD does not require many inattentive symptoms. A robust assessment should examine developmental history, education, work, relationships, driving, substance use, sleep, mood, anxiety, trauma, autism, learning disorders and other explanations, usually with collateral evidence where feasible.[4,16,45]

The broadcast did not provide enough information to determine which of three explanations was correct:

- Pemberton met criteria and may have ADHD, significant ADHD traits, or an impairment history he does not interpret that way;
- the clinic produced a false-positive diagnosis because its process was inadequate; or
- the self-report was shaped, consciously or otherwise, by a psychiatrist who knew the criteria, the hypothesis and the purpose of filming.

Pemberton says he answered honestly. There is no evidence available to me that he lied, and it would be improper to allege that he did. But the programme's design cannot distinguish these explanations. He was investigator and subject; he knew the test; the process was not blinded; the production selected and paid the provider; and he treated his own rejection of the result as the external standard of truth.

If he answered honestly, his diagnosis is an unresolved clinical finding—not proof of overdiagnosis. If the process failed to establish childhood onset, impairment, pervasiveness or differential diagnosis, the programme should have shown those failures and obtained an independent reassessment. If answers were intentionally shaped, the sequence would show that a medically knowledgeable participant can game an unblinded assessment—not that ordinary patients are routinely misdiagnosed.

There is another temptation worth resisting. Pemberton appeared talkative, restless and, to some viewers, irritating. Hyperactivity can present in adults as inner restlessness, excessive talking, interrupting or difficulty remaining still. But television behaviour is also shaped by personality, performance, direction and editing. It would be hypocritical to condemn superficial diagnosis and then diagnose the presenter from an hour of television. The unanswered clinical question is a flaw in the experiment, not an invitation to armchair psychiatry.

One dose of lisdexamfetamine was not a treatment trial

Pemberton then took a single dose of lisdexamfetamine and described feeling "blunted", less talkative and irritated by the crew. The programme converted one unblinded subjective experience into a dramatic analogue for medicated children.

Lisdexamfetamine has acute same-day effects; it does not require months of drug accumulation before it can work. But safe and meaningful treatment is still a longitudinal clinical process. NICE states that ADHD medication should be initiated and titrated by a professional with training and expertise. Dose is adjusted against symptoms, functional outcomes and adverse effects; pulse, blood pressure, appetite, weight, sleep, mood and other risks are monitored; and the prescriber may change dose, timing or medicine.[16]

One dose cannot establish the best dose, tolerability over time, functional benefit, the balance of benefit and harm, or whether the treatment is indicated. It is not equivalent to the weeks or months of titration and monitoring through which clinicians and patients usually learn whether medication helps. Nor is a non-patient's reaction a diagnostic test: people with and without ADHD can experience stimulation, calmness, dysphoria, anxiety or emotional blunting depending on dose, expectation and individual biology.

The experience was relevant as an anecdote. Presenting it as evidence about a generation of children was scientifically out of place.

SECTION 05

The child at the centre: moving testimony, invalid experiment

The programme's emotional centre was ten-year-old Mason, who had taken lisdexamfetamine for approximately two years and said it took his "fun-ness" away. With medical oversight, he stopped medication for six weeks while the family introduced yoga, outdoor activity, sport, creative activity, no screen time, reduced sugar and ultra-processed food, and other lifestyle or holistic input. His mother, Shauna, described him as happier, funnier and more himself. At school, however, his inattention and disruptive behaviour increased. The end-credit update disclosed that he later restarted medication and that his schoolwork improved.[24,28]

Every part of that story matters.

A child who feels emotionally blunted deserves to be heard. Personality change, flattened affect, irritability or feeling unlike oneself are clinically important adverse experiences. They should trigger review of diagnosis, dose, timing, formulation, sleep, nutrition, comorbidity and alternative treatments —not dismissal. Medication is not successful merely because a classroom becomes quieter.

Equally, deterioration in education and function matters. "Being himself" and being able to learn are not moral opposites. Good care tries to preserve spontaneity, humour, appetite, sleep, relationships and self-respect while reducing disabling symptoms. The correct response to a medication that suppresses too much is individualised review, not a universal conclusion that medication suppresses the true child.

The six-week sequence changed almost everything at once. It removed screens, changed food, increased exercise and outdoor time, introduced structured activities, increased adult attention, involved professionals, created novelty and placed the family inside a national television production. It also withdrew medication. With no control, no stable baseline, no blinded ratings and multiple simultaneous changes, the programme could not attribute improvement or deterioration to any single component.

Channel 4 later called this an “observational study of one boy” and said an independent doctor, his GP, a medical risk company and three independent psychiatrists advised on the medication break.[24] That oversight is reassuring as far as immediate medical risk goes. It does not convert the exercise into causal evidence. Nor does it answer every ethical question about assent, long-term aftercare, educational risk, the child’s future digital footprint or the use of his treatment as prime-time proof.

The home footage appeared to show a screen-heavy environment before the intervention. It is reasonable to conclude that fewer screens, more structure, more shared activity and more parental support may have helped. It is not reasonable to condemn Shauna as a parent from an edited programme. The family received a concentrated package of time, expertise, motivation and production support that many exhausted families cannot access. The least sensational interpretation may be that intensive parenting and environmental support can reveal a child’s strengths while medication can still be necessary for sustained functioning.

That is not a defeat for holistic care. It is the case for multimodal care.

The programme’s own outcome is therefore its most awkward evidence. The child was happier in some respects off medication but struggled more at school; he restarted medication and schoolwork improved. ADHD UK’s post-broadcast verdict was blunt: “Their experiment disproved their conclusion.”[24] Strictly, a single case proves neither side. It does, however, contradict the documentary’s simple trajectory from medication to liberation.

I share the ethical instinct that prescribing to children requires particular care. I have not practised child psychiatry and would not pretend that adult ADHD expertise replaces it. For children under five, NICE prioritises parent-training and environmental modification and requires additional specialist safeguards before medication. For older children, guideline treatment depends on severity, impairment, age, informed preferences and response to environmental modifications; medication is not universally defined as a last resort.[16] A defensible debate would have shown those distinctions.

SECTION 06

The missing half of the story: girls and women

The near-erasure of female ADHD was not a minor omission. It removed one of the most important changes in contemporary understanding.

Girls are more likely to present with inattentive and internalised difficulties, less conspicuous classroom disruption, compensatory perfectionism or masking. They may be labelled anxious, depressed, disorganised, emotionally unstable or simply underperforming. Recognition often comes later, sometimes after a child is diagnosed, after educational demands exceed coping strategies, or during hormonal transitions. Women with undiagnosed ADHD can accumulate years of shame, relationship difficulty, occupational instability, eating problems, anxiety, depression and problematic substance use before anyone identifies the developmental pattern.[3]

This does not mean every distressed or distracted woman has ADHD. It means a historical male, hyperactive stereotype produced systematic under-recognition. Rising adult female referrals and prescribing may therefore represent, in part, correction of an old diagnostic blind spot rather than manufacture of a new disorder.

The English prescribing data itself demonstrates why a male-child narrative is inadequate. Boys dominate the younger groups, but by ages 20–24 the male and female counts are almost equal, and women outnumber men in the 25–44 age bands among identified community recipients of the broad ADHD-drug category.[19] Any programme claiming to explain the modern "rise of ADHD" while largely ignoring women has not explained the rise.

SECTION 07

Prescribing figures: what the numbers actually say

Channel 4 and ADHD UK appeared to contradict each other. Channel 4 said boys aged 10–14 were the largest prescribing group; ADHD UK said adults were the largest group overall. Both can be true because one describes a single five-year age-sex cell and the other aggregates all adults.

The latest NHS Business Services Authority report for England, covering 2025/26 and published in July 2026, identified 426,504 people receiving at least one community-dispensed item in British National Formulary section 4.4, "CNS stimulants and drugs used for ADHD". Of those with usable age data, 266,853 were adults aged 18 or over and 158,394 were children aged 17 or under. Approximately 241,000 identified patients were male and 185,000 female. Boys aged 10–14 were indeed the largest single age-sex cell, at 60,976; boys aged 15–19 were next, at 47,140.[19]

England, community dispensing 2025/26	Female	Male
Age 5–9	6,030	19,356
Age 10–14	20,831	60,976
Age 15–19	26,507	47,140

England, community dispensing 2025/26	Female	Male
Age 20–24	21,265	21,215
Age 25–29	24,517	20,900
Age 30–34	23,636	20,907
Age 35–39	19,942	16,275
Age 40–44	14,926	11,439

These figures require three caveats that sensational television rarely supplies.

First, the BNF section is broader than stimulants used for ADHD. It includes methylphenidate, dexamfetamine and lisdexamfetamine, but also non-stimulants such as atomoxetine and guanfacine and medicines with other indications, including modafinil, pitolisant and caffeine preparations. It is not an exact count of people prescribed stimulants specifically for ADHD.

Second, the dataset covers medicines dispensed in the community in England. It excludes private prescriptions, prisons and much secondary-care supply. Patient identification was approximately 92.4 per cent, so the unique-patient count is incomplete.

Third, growth in treatment is not automatically overtreatment. NHS England's independent ADHD Taskforce concluded that population prevalence has not risen, while referrals have increased in the context of under-recognition, under-diagnosis, under-treatment and service failure. It estimated population prevalence at roughly 3–5 per cent in children and 2–3 per cent in adults and showed that recorded English rates remained lower, particularly for girls and women.[17–18]

The 2025/26 data showed adult identified recipients rising more quickly than children. That should prompt examination of capacity, quality and safety; it should also be read alongside decades of missed adult cases. A queue can grow because clinicians have invented a disease, because public awareness has improved, because diagnostic access has expanded, because need was previously hidden, or through some mixture. Counting the queue alone cannot distinguish those explanations.

International numbers are not one comparable statistic

There is no honest single "international number" for male versus female or adult versus child stimulant prescribing. Countries publish different things: prescription items, unique public-insurance recipients, self-reported medication use, claims for selected payers, or all residents. Age bands, drugs, indications and years differ. The following examples are useful only when their denominators and definitions remain attached.

Jurisdiction and year	Measure	Sex/age pattern
Ontario, 2023	351,879 residents, 2.6% of the population, had past-year stimulant prescribing in a whole-population study	Highest in boys 10–14 at 7.8%; in adults, women exceeded men at 18–24 (6.7% vs 5.2%), 25–44 (3.8% vs 3.1%) and 45–64 (1.4% vs 1.1%)[21]
United States adults, 2023	Survey-estimated 15.5 million adults reported current ADHD; 33.4% used a stimulant in the previous year—approximately 5.2 million	Adult survey estimate; not a dispensing count and not directly comparable with England[22]
United States children, 2022	About 6.5 million children had current ADHD; 53.6% received any ADHD medication—approximately 3.5 million	Includes stimulant and non-stimulant medication; not an exact stimulant count[23]

The Ontario data are especially relevant to the programme's missing female story: incident stimulant prescribing rose steeply in young adult women between 2015 and 2023. That might reflect better recognition, changing demand, inappropriate prescribing, or several processes at once. It is a research question, not a ready-made morality tale.

SECTION 08

Who was invited to speak—and what perspectives did they bring?

Calling the contributors "oddballs" would be unfair and analytically weak. Several are distinguished professionals. The problem is not that they are foolish. It is that the programme assembled a particular set of intellectual and commercial standpoints, then presented their convergence as if it represented the field.

Dr Iona Heath

Iona Heath is a highly respected former inner-city GP, medical writer and former president of the Royal College of General Practitioners. She practised in Kentish Town from 1975 until retiring from clinical general practice in 2010 and has made important contributions to medical ethics, generalism and criticism of over-medicalisation.[33]

That history explains why she was relevant to questions of disease-mongering, commercialisation and the medical capture of ordinary distress. It does not make her a contemporary ADHD specialist. By the time of broadcast she had been out of clinical general practice for sixteen years—a period spanning DSM-5, NICE's 2018 ADHD guideline, ICD-11 implementation, major genetic and imaging collaborations, expansion of adult services and a transformation in knowledge about female ADHD.

The chronology is especially important. Heath retired from clinical practice in 2010; her presidency of the RCGP continued until 2012. DSM-5 was published in 2013. Its ADHD revision reduced the symptom threshold from six to five for older adolescents and adults, moved the childhood-onset requirement from symptoms before age seven to several symptoms before age twelve, added lifespan examples to help clinicians recognise adult presentations, and removed the DSM-IV exclusion that had prevented ADHD being diagnosed alongside autism spectrum disorder. These were not cosmetic edits. They reflected a substantial shift toward understanding ADHD across the lifespan and recognising overlap between neurodevelopmental conditions.[46]

None of that proves that Heath stopped reading or failed to update her knowledge after retirement. It does, however, make the programme's evidential choice more questionable. A distinguished generalist who had left clinical practice before these revisions was given space to make a categorical claim about ADHD in 2026, without viewers being shown whether her position incorporated the post-2013 diagnostic framework and without a current ADHD specialist being given equivalent authority to test it.

Her categorical on-screen position that ADHD was not a medical condition was not merely provocative; it contradicted her former College. The RCGP immediately clarified that her remarks were not made on its behalf and stated: "The College recognises ADHD as a neurodevelopmental condition and supports evidence-based care".[25]

The responsible editorial choice would have been to identify her as a distinguished retired generalist and critic of medicalisation, then place her view against current specialist guidance. The programme instead allowed former presidential status to imply institutional and subject-matter authority that the RCGP itself rejected.

Dr Sami Timimi

Sami Timimi is a consultant child and adolescent psychiatrist and psychotherapist with substantial clinical experience. He is not an irrelevant outsider. He is also a longstanding and explicit contributor to critical psychiatry who has argued that psychiatric diagnoses are shaped by culture and has published *Rethinking ADHD: From Brain to Culture* and critiques of autism diagnosis.[34]

That standpoint is intellectually legitimate and should be heard. But it is not a neutral sampling of the field. Timimi is an established advocate in the dispute the film purported to investigate. A balanced documentary would have paired him with a child ADHD clinician working within NICE guidance, made the disagreement explicit, and tested both positions against systematic evidence. Presenting a known critic as though the camera had happened upon professional doubt obscures rather than illuminates the debate.

Professor Dinesh Bhugra

Dinesh Bhugra is an eminent psychiatrist: emeritus professor of mental health and cultural diversity at King's College London, former president of the Royal College of Psychiatrists, former president of the World Psychiatric Association and former president of the British Medical Association.[35] His expertise in cultural and social psychiatry makes him well placed to discuss how diagnostic concepts travel across cultures, how services and commerce shape distress, and how institutions can commodify care.

He is not primarily an ADHD neuroscientist, neurogeneticist or specialist diagnostic-methods researcher. His authority supports scrutiny of culture and industry; it cannot by itself settle whether ADHD has a neurodevelopmental basis. Nor should he be casually labelled "anti-psychiatry". The editorial problem is that the programme used high-status expertise from an adjacent field to reinforce a conclusion about a specialised evidence base without adequately presenting that evidence base.

Sarah Warley

Sarah Warley was presented as a "neurophysiological psychologist" and is the founder of The Key Clinic. The clinic advertises personalised, drug-free programmes for ADHD, autism, dyslexia, dyspraxia, dyscalculia and mental-health difficulties, including nutrient testing and proprietary programmes.[36]

This created the programme's clearest undeveloped conflict of interest. A commercial provider of alternatives to medication may have useful experience and sincere convictions; it also has a financial interest in public demand for non-drug assessment and treatment. The film scrutinised the pharmaceutical industry's incentives while apparently failing to apply the same lens to the market for supplements, tests, therapy packages and "drug-free" programmes.

Viewers needed specific information: What professional title is regulated? What are Warley's clinical qualifications and current registrations? What is the evidential status of each intervention? What do packages cost? Are outcome claims based on controlled, peer-reviewed studies, independent audits or parent feedback? What proportion of clients improve, do not improve or discontinue? How are adverse effects and delayed access to evidence-based care monitored?

Public material associates Warley with an Oxford psychology degree and training in approaches such as INPP, nutrient protocols and auditory integration. I found no clearly stated medical degree or clinical psychology doctorate in the sources reviewed. That is not proof of incompetence or misconduct. It is precisely why the programme should have given viewers an exact credential and regulatory disclosure rather than an impressive-sounding, potentially ambiguous title.

The Key Clinic says 96 per cent of parents who provided feedback reported improvement. That is a customer-feedback statistic, not a randomised comparison, and the denominator of respondents is not the denominator of all clients.[36] The programme should have interrogated it as vigorously as it interrogated drug companies.

Professor Katya Rubia

Katya Rubia is professor of cognitive neuroscience at King's College London and, among the named contributors, the clearest specialist in ADHD brain research. Her published profile covers developmental structural and functional neuroimaging, cognitive testing, pharmacological imaging of ADHD medications, PET in adults, neurofeedback, stimulation and cognitive training.[10]

Her inclusion could have anchored an accurate explanation: ADHD is not diagnosable by an individual scan; average group differences exist; effects are small and heterogeneous; development matters; and imaging is one piece of convergent evidence. Instead, the broadcast left many viewers with the opposite impression. The specialist voice was present, but the specialist framework was not.

Mason, Shauna and the school

Mason and his mother provided lived experience, not generalisable scientific evidence. Their contribution was emotionally real and clinically informative about trade-offs. The teacher's observations added a second setting, which is important in ADHD. But the family should not have been made to carry the evidentiary burden of a national argument about whether ADHD exists.

The programme appears not to have included a broad range of adults with ADHD, women diagnosed late, people harmed by delayed diagnosis, people who benefit from medication without losing personality, people who cannot tolerate medication, or families using combined environmental and pharmacological care. Lived experience was selected around the experiment rather than sampled around the disorder.

The public credits and reporting reviewed for this article do not name every teacher, clinic employee, crew member or healthcare professional who appeared briefly. I have therefore limited individual scrutiny to the named public contributors and credited decision-makers. Private individuals should not be reverse-identified merely to satisfy the illusion of completeness.

The missing experts

An hour cannot contain everyone, but the absences followed the argument. There was no clearly identified mainstream adult ADHD psychiatrist, child ADHD specialist practising current guideline care, ADHD neurogeneticist, psychopharmacologist, female-ADHD expert, addiction-and-ADHD clinician, or methodologist to audit the private assessment and the six-week intervention.

Not all the selected contributors share one ideology. Heath is a generalist critic of over-medicalisation; Timimi is a critical psychiatrist and social-construction critic; Bhugra is a cultural psychiatrist; Warley sells non-drug programmes; Rubia is a neuroscientist. Yet the edit weighted the first four toward a medicalisation-sceptical narrative and did not let the strongest specialist evidence determine the frame.

SECTION 09

Production, editorial responsibility and funding

The public credits identify the following key production roles:[1]

Person or organisation	Public role	Relevant public background	Proper accountability question
Channel 4	Commissioning broadcaster	Publicly owned, commercially funded public-service broadcaster	Title, promotion, compliance, due accuracy, harm and disability remit
Tim Hancock	Commissioning editor	Longstanding Channel 4 factual commissioner; public biography highlights “sledgehammer” documentaries, splashy singles and controversial formats	Why was polemical framing commissioned as “science-led”?
Minnow Films	Independent producer	Award-winning factual production company	Research standards, contributor balance, child welfare, edit and disclosure
Liam Humphreys	Executive producer	Minnow head of constructed factual; former Channel 4 head of factual entertainment; credits include major constructed-factual and reality formats	Why were “startling revelations” promised before evidence was shown?
Leah Green	Senior producer	Publicly listed senior-producer/development credits; little detailed biography available in the sources reviewed	What research, fact-checking and specialist advice governed the film?
Xavier Alford	Director	BAFTA-winning factual director, with credits including *Locked In: Breaking the Silence* and *Drugsland*	How did direction and edit distinguish testimony, experiment and scientific conclusion?
Dr Max Pemberton	Presenter	NHS psychiatrist and experienced national newspaper columnist	Prior position, subject expertise, self-experiment and conflicts between presenter and investigator roles

These are not allegations about private beliefs. I found no sound public basis for assigning party-political positions to Hancock, Humphreys, Green or Alford, and their politics are not required to explain the film. Their documented professional centre of gravity is factual television and constructed narrative, not ADHD science. That is not disqualifying—documentary makers routinely cover fields outside their training—but it makes rigorous specialist advice, transparent methods and editorial challenge more important.

Pemberton's association with right-of-centre publications is a relevant editorial fact, but it does not prove that he personally is "right wing". The defensible criticism is narrower: his established polemical position and media environment were not adequately disclosed, and the programme used the authority of psychiatry while adopting the methods of contrarian factual entertainment.

Who paid for it?

The available public record identifies Channel 4 as commissioner and Minnow Films as producer. I found no disclosed pharmaceutical sponsor, private clinic sponsor, charity funder or named third-party grant for the programme. Channel 4 describes itself as a publicly owned but commercially funded public-service broadcaster that raises market revenue, including advertising, and reinvests surpluses in programming commissioned from independent producers.[37]

The most accurate answer is therefore that the film appears to have been financed as a Channel 4 commission produced by Minnow Films, within Channel 4's commercial public-service model. Public credits do not reveal the production budget, contractual terms or a separately earmarked source of money. It would be wrong to invent a hidden pharmaceutical, political or alternative-health funder without evidence. The commercial incentive that can be identified is ordinary broadcasting: controversy attracts attention. That is an inference from the format and marketing, not proof of improper payment.

SECTION 10

The formal warnings Channel 4 received—and how it answered

ADHD UK

ADHD UK wrote to Channel 4 before broadcast, addressing chief executive Priya Dogra and chief content officer Ian Katz and copying the commissioning editor, Channel 4 board and Minnow Films. It argued that the title manufactured doubt about an established condition; cited the World Federation consensus, heritability evidence and the long clinical history of ADHD-like impairment; identified Pemberton's prior published position; challenged the age framing of prescription data; requested a preview and right of reply; sought disclosure of medical-ethics oversight; and asked for on-air support signposting.[24]

Its strongest methodological point was that a "science-led" investigation should not promise its conclusion in advance. Its strongest human point was that stigma changes behaviour: people may abandon assessment or treatment, parents may doubt children, and employers may doubt staff.

ADHD UK is an advocacy charity, not a neutral regulator, and its campaigning interest should be visible. But the scientific claims it cited are independently testable. Advocacy does not make evidence disappear.

After broadcast, the charity focused on the end-credit outcome: Mason restarted medication and his schoolwork improved. It complained to Ofcom and invited viewers to report impact. That response was forceful and understandably angry; it also accurately identified the tension between the programme's liberation narrative and its own follow-up.

Channel 4

Channel 4's pre-broadcast reply made four substantive arguments. It said the film did not dispute the lived difficulties of people diagnosed with ADHD; invoked its remit to challenge the status quo and air alternative views; said the question-mark title was intended to stimulate debate rather than state a conclusion; and called Mason's sequence an "observational study of one boy". It also detailed immediate medical oversight and correctly defended the statement that boys aged 10–14 were the largest single 2025/26 age-sex prescribing cell.[24]

Those points deserve acknowledgement. The age-cell figure was correct. Medical oversight appears to have been extensive. Public-service broadcasting should challenge consensus. Editorial independence does not require giving an advocacy body a preview.

But none answers the central complaint. Alternative views still require due evidential weight. A question can mislead when the answer is established at the level implied. "Study of one" is not a shield if the entire narrative and promotion use that one case to support a general proposition. Medical risk review addresses immediate safety; it does not validate causal inference, contributor balance, long-term welfare or the edit. Editorial independence is not independence from accuracy.

The Royal College of General Practitioners

The RCGP's response was concise and highly significant. It separated Iona Heath's personal view from the institution and affirmed ADHD as a neurodevelopmental condition requiring evidence-based care.[25] The clarification demonstrates why former office-holding must not be used as a proxy for current institutional consensus.

Amnesty UK's Disabled People's Human Rights Network

A pre-broadcast blog by Jenny, a committee member of Amnesty UK's Disabled People's Human Rights Network, argued that the framing risked portraying diagnosed people as mistaken, misled or unnecessarily medicated; criticised fear-laden language; stressed that diagnosis is not a casual checklist; and called for an amendment, safeguarding and equality assessment, meaningful ADHD voices and fair scientific weight.[26]

This should be described accurately: it was a network blog by a committee member, not necessarily a corporate policy statement by Amnesty International. Its relevance lies in disability-rights analysis. The programme asked whether a recognised disability was real while Channel 4 publicly presents disability inclusion as central to its remit.

Global ADHD Advocacy Network

The Global ADHD Advocacy Network said it welcomed scrutiny of services, waiting lists, quality and treatment decisions but opposed the "manufacture of doubt" about a recognised disability. It cited consensus, heredity, imaging and the NHS Taskforce and encouraged formal complaints.[27]

The Network is an advocacy organisation and also offers training and services, which should be disclosed just as commercial context should be disclosed for other contributors. Again, the status of the messenger does not settle the evidence; its cited propositions can be checked against primary sources.

NHS England's independent ADHD Taskforce

The most important institutional response was not written about the programme at all. NHS England's independent ADHD Taskforce had already examined the national problem in far greater depth. Its conclusions cut across the documentary's frame:

- there is no evidence that population prevalence in children has risen over time;
- referrals have risen in the context of historic under-recognition and under-treatment;
- English recorded diagnosis remains below expected population prevalence, particularly in females;
- some independent and NHS assessments may be poor, so national quality standards and regulation are needed;
- medication can be highly effective for people meeting full criteria but should sit within stepped, holistic care;
- schools, employers and justice services should provide needs-based support without making people wait for diagnosis; and
- long waits and a two-tier system create serious inequality.[17–18]

That is the adult conversation the documentary should have had. It is possible simultaneously to defend ADHD's validity, expose service failure, demand better diagnostic quality, support environmental change and prescribe cautiously.

SECTION 11

The public reaction was polarised—not a simple rejection

The reaction was divided. ADHD organisations, clinicians and disability advocates expressed alarm about stigma, false equivalence and medication fear. Online communities contained anger from people who felt their impairment and treatment had been delegitimised. The RCGP publicly distanced itself from Heath's position. ADHD UK escalated to Ofcom.[24–27]

Some reviewers were more receptive. *The Guardian* television review called the film controversial, acknowledged that its sceptical stall was set out immediately and described Pemberton's assessment as a "stunt", yet found the film's answers convincing and its lifestyle and school proposals compassionate.[28] That review is useful evidence of the programme's persuasive power: a well-made narrative can make reasonable interventions seem to validate an unreasonable overarching premise.

Other coverage was more sceptical. Reporting in *The Guardian* distinguished poor private assessments and the commodification of diagnosis from the existence of ADHD. Dr Marios Adamou, founder of the UK Adult ADHD Network, warned that the concept can be stretched or used as identity while also affirming biological evidence and ongoing underdiagnosis. Private-sector representatives argued that standards should apply to NHS and independent providers alike.[29] *The Times* review characterised the programme as polemical and insufficiently balanced while recognising that it raised important questions.[30]

The fairest summary is not that "everyone hated it" or "the programme proved its case". It successfully stimulated debate, as Channel 4 intended, but did so through a framing that many informed viewers regarded as harmful and scientifically unbalanced. The controversy is partly evidence of polarisation; it is also evidence that the programme chose the most inflammatory possible doorway into a legitimate subject.

SECTION 12

The real issues it should have investigated

Diagnostic quality without diagnostic nihilism

There are poor ADHD assessments. A brief checklist, no childhood history, no evidence of impairment, no collateral information, no differential diagnosis and an automatic prescription do not meet good standards. Financial incentives can distort private practice; throughput and waiting-list pressure can distort NHS practice. The answer is auditable standards, transparent qualifications, regulatory oversight and continuity—not declaring the disorder a myth.[18]

A collapsing service model

Millions may meet criteria, but specialist capacity is grossly inadequate. People wait years, then face fragmented titration, shortages, shared-care refusals and little psychological or occupational support. Those able to pay move faster; those with greatest complexity, poverty, addiction, criminal-justice involvement or unstable housing often wait longest. The programme focused on whether demand was legitimate rather than why the system cannot assess need safely.

The consequences it ignored: addiction, police custody and prisons

The programme also failed to examine the population in which missed ADHD is often most costly: people with addiction and those drawn into the criminal-justice system. That omission is particularly striking because important UK evidence was already available. A study published on 10 December 2025 offered voluntary ADHD and autism screening to detainees at six Metropolitan Police custody centres. Data collection took place over eight weeks in 2024, not in December 2025. Of 303 eligible arrestees, 216 consented; among 199 without a known ADHD diagnosis who completed ADHD screening, 100—50 per cent—scored above the modified Adult ADHD Self-Report Scale threshold warranting further assessment. Nearly 60 per cent of those arrested for drug offences either reported an existing ADHD diagnosis or screened positive.[50]

Those are arrest-and-screening data, not proof that half of all arrested people in London have ADHD. A screening instrument is deliberately more inclusive than a diagnostic assessment; the sample was small, overwhelmingly male, self-selecting and drawn from six custody centres. The result requires replication and formal diagnostic follow-up. Nevertheless, it is a powerful signal of unmet need at the first point of police contact, and it directly challenges a programme more interested in whether comfortable, articulate adults can obtain a private diagnosis than in who remains unidentified until crisis.

London evidence did not begin at the police-custody door. McCarthy and colleagues conducted face-to-face assessments with 240 men in a London Category C prison using standardised instruments for ADHD, autism and intellectual disability. Eighty-seven screened positive for at least one neurodevelopmental disorder or difficulty. The later Metropolitan Police paper summarises the study's two-stage ADHD assessment as identifying 54 of 240 prisoners—23 per cent—as meeting ADHD criteria. Prisoners screening positive for a neurodevelopmental condition were more likely to have been homeless before prison, unemployed and single, and more than 80 per cent had been convicted or imprisoned previously.[50,54] This was one male prison and cannot be treated as a prevalence survey of every London jail. It nevertheless supplies the specifically London prison evidence that the programme failed even to discuss.

The prison evidence is older and substantial. In one Scottish study, 96 of 390 men at Porterfield Prison—24.6 per cent—met ADHD criteria using the DIVA-2 interview; only 18 of those 96 reported a previous diagnosis and only 15 had ever received medication.[51] A related study of 387 male British prisoners found that ADHD was associated with use of a greater number of substances, greater severity of alcohol-use disorder and alcohol dependence, and more stimulant-cocaine, amphetamine and methadone use. Crucially, persistence along substance-use pathways was better explained by co-occurring conduct disorder and antisocial personality traits, which warns against treating ADHD as the sole cause.[52]

Another Scottish study of 198 prisoners found that frequent heroin use in the year before imprisonment was the strongest predictor of total offending, while ADHD symptoms still contributed independently; for violent offending, ADHD symptoms were the strongest statistical predictor, followed by alcohol dependence.[53] This supports the clinical impression that substance dependence can be an important route through which untreated impulsivity, reward dysregulation, poor planning and social adversity translate into offending. It does not prove that ADHD causes crime, that people with ADHD are inherently criminal, or that addiction explains most crime. Trauma, poverty, exclusion, conduct disorder, antisocial personality disorder, intoxication, withdrawal and many other factors interact.

That distinction is exactly why serious journalism was needed. The association between ADHD, addiction and offending is real, clinically important and potentially modifiable, while the causal pathways are complex. Observational evidence also reports lower criminality and substance-misuse risk during periods of ADHD medication, although such studies do not prove that medication alone prevents offending.[39] A balanced programme would have examined diagnosis and treatment in addiction and prison services, diversion safeguards, non-stimulant options, psychological treatment and continuity after release. Instead, it staged a single-dose experiment in its presenter and largely ignored the people for whom under-recognition may carry the gravest consequences.

Overcrowding, unmet neurodevelopmental need and the public purse

The omission becomes harder to defend when placed beside what inspectors report in London prisons. At HMP Brixton in 2024, 66 per cent of prisoners were sharing cells designed for one. Around 140 men were being released each month, yet inspectors found no accredited offending-behaviour programmes and inadequate preparation for release. About 450 prisoners were receiving substance-misuse support, while 42 per cent said illicit drugs were easy to obtain.[55] At HMP Wandsworth, 80 per cent of prisoners were sharing single cells and most spent more than 22 hours a day locked up; inspectors described severe overcrowding alongside drugs, violence, rising self-harm and seven self-inflicted deaths in the preceding year.[56]

Those conditions are not caused by ADHD, and diagnosing ADHD will not manufacture prison capacity or abolish crime. Nor do the inspection reports establish ADHD-specific effects. The more careful inference is that an overcrowded, idle, stressful and drug-exposed environment is especially ill-equipped to identify or manage attention dysregulation, impulsivity, emotional instability, executive dysfunction and addiction. It may also obstruct the education, psychological work, medication monitoring and release planning from which prisoners with those needs could benefit. The programme's failure was not simply to omit an interesting comorbidity. It ignored a setting in which neurodevelopmental impairment, addiction and institutional failure collide.

This is where the absence of joined-up thinking becomes financially indefensible. Official figures record 85,858 people in prison in England and Wales on 30 June 2026, including 15,386 on remand.[57] The Ministry of Justice reports £4.926 billion of prison resource expenditure in 2024–25 and an average annual cost of £56,618 per prisoner.[58] That is prison expenditure alone, not the additional public cost of policing, courts, legal aid, probation, emergency health care, homelessness, disrupted families or lost employment. It would be false to attribute that bill to ADHD, or to promise that diagnosis would make it disappear. But it is equally false economy to treat earlier assessment, addiction care and continuity of treatment as optional expenditure while accepting repeated crisis, custody and imprisonment as unavoidable downstream costs.

The capacity problem is not receding. The government's central projection reaches 100,600 prisoners by March 2030, with a projected range of 98,000 to 103,600.[59] Against that background, every department can appear to save money by passing a person onward: education fails to recognise a child; health services ration adult assessment; addiction services treat the substance but miss the neurodevelopmental driver; police and courts process the crisis; prison healthcare starts again with incomplete records; and release returns the person to a long waiting list, unstable housing or interrupted medication. The cost has not been saved. It has moved to another budget, usually at a later and more expensive point.

Joined-up policy would mean validated screening at police and prison reception followed by proper diagnostic assessment—not pretending that a screen is a diagnosis. It would require interoperable records and clear responsibility across NHS community teams, liaison and diversion, prison healthcare, probation and addiction services; access to psychological and pharmacological treatment with proportionate diversion safeguards; and release plans that protect medication continuity, clinical follow-up, housing and employment support. Outcomes and spending should be evaluated across the whole pathway, including reoffending and recall, rather than within isolated departmental ledgers. This is not an argument that ADHD treatment is a cure for prison overcrowding. It is an argument that repeatedly paying the high price of late failure while starving earlier, evidence-based intervention is neither clinically coherent nor fiscally serious.

Education that confuses compliance with learning

The programme was right that rigid schooling can disable children whose attention, movement, sensory or learning profiles differ. Schools frequently miss ADHD, autism, dyslexia, developmental coordination disorder/dyspraxia, dyscalculia and tic disorders including Tourette syndrome. Support should be needs-led: movement breaks, reduced distraction, clear instructions, task chunking, assistive technology, literacy and numeracy support, sensory adjustment, predictable routines and relationally informed behaviour policies.

But school reform and treatment are not mutually exclusive. A humane school may reduce impairment without eliminating it. Medication should not be used merely to make a child convenient; neither should it be withheld to make a philosophical point while the child falls behind.

Screens, sleep, exercise and food

Screens can displace sleep, exercise, face-to-face interaction and sustained activity. Chaotic routines and ultra-processed diets can worsen functioning. Exercise, outdoor time, sleep regularity and supportive parenting benefit most children and may meaningfully reduce ADHD impairment. These are not discoveries that abolish ADHD. They are components of good health and multimodal care.

The causal direction is also complicated. Children with ADHD may seek rapid, high-reward digital stimulation and struggle to disengage; exhausted parents may use screens to contain family stress; sleep disruption may worsen symptoms that further increase screen use. “Screens cause ADHD” is much less defensible than “screen patterns and ADHD can interact”.

Medication: neither chemical cosh nor magic answer

Stimulants have among the largest short-term symptom effect sizes in psychiatry, but averages do not determine individual care. Appetite suppression, sleep difficulty, cardiovascular effects, irritability, anxiety, tics and emotional blunting require monitoring. Some people do better on a different dose, formulation or non-stimulant; some choose not to take medication. Medication should target impairment and agreed goals, not social conformity.[16,18]

At the same time, undertreated ADHD is not benign. It is associated with educational and occupational failure, accidents, relationship difficulty, substance misuse, self-harm, suicide and premature mortality. A UK primary-care study estimated a marked reduction in life expectancy among adults with diagnosed ADHD—approximately 6.8 years for men and 8.6 years for women, while stressing that estimates reflect modifiable risks and limitations of recorded diagnosis.[38] A large Swedish observational target-trial emulation associated ADHD medication with lower rates of suicidal behaviour, substance misuse, transport accidents and criminality; observational associations are not randomised proof, but they are incompatible with portraying treatment as mere behavioural suppression.[39]

In addiction practice, the consequences of missed ADHD are visible: impulsive self-medication, unstable routines, repeated treatment failure, shame and preventable risk. Stimulant prescribing in substance-use populations requires careful assessment, formulation choice, monitoring and diversion safeguards. Avoiding diagnosis is not automatically the safer option.

SECTION 13

Does ADHD need reclassification?

I believe the programme missed a genuinely radical scientific question. ADHD overlaps extensively with autism, dyslexia, developmental coordination disorder, dyscalculia, tic disorders, language difficulties and other neurodevelopmental presentations. Comorbidity is common. Traits are dimensional. Genetic studies show shared polygenic liability across diagnostic categories, and imaging research finds both shared and distinct network differences. The boundaries in current manuals are useful but not laws of nature.[3]

That supports research toward a broader neurodevelopmental framework: profiles of attention, executive control, reward, language, motor coordination, learning, sensory processing and social cognition, mapped across development and impairment rather than forced into isolated boxes.

It does not yet support the claim that all neurodevelopmental conditions are one disorder caused by a single dopamine–noradrenaline pathway. Catecholamine regulation is central to ADHD pharmacology and aspects of executive function, but autism, dyslexia, dyspraxia, dyscalculia and Tourette syndrome involve partly overlapping and partly distinct genetic and neural mechanisms. A unifying hypothesis is worth testing; it is not established fact.

The more intellectually ambitious critique of current diagnosis is therefore not “ADHD is a myth”. It is that our categories may be too coarse for the heterogeneous neurodevelopmental realities they attempt to describe. That argument strengthens the case for careful phenotyping and individualised support. It does not erase disability.

SECTION 14

Conclusion: aim the camera at the right target

The Great ADHD Myth? raised one indispensable ethical question: how do we ensure that children are not medicated too early, too automatically or simply to fit an inflexible environment? It also touched real problems—commercialised diagnosis, variable assessment, screens, school design, family stress and the need for non-pharmacological support.

Its failure was to use those valid concerns as a solvent for the condition itself.

It did not adequately distinguish the absence of an individual scan from the presence of group-level neurodevelopmental evidence. It omitted the dopamine–noradrenaline account through which stimulant treatment is principally understood, then treated one dose of lisdexamfetamine as a meaningful experiment. It largely erased girls and women. It ignored striking evidence from addiction services, police custody and prisons, where under-recognition can carry the greatest costs, and never asked why the public purse pays repeatedly for late crisis while earlier assessment and continuity remain fragmented. It presented a presenter with a prior published position as an investigator discovering his conclusion. It changed multiple variables in one child, then built a national narrative around the result—only for the end credits to report that he restarted medication and his schoolwork improved. It scrutinised pharmaceutical commerce while giving a commercial non-drug provider much less scrutiny. And it assembled medicalisation critics without giving proportionate space to current mainstream ADHD practice and research.

Most damagingly, it confused failures of ADHD care with evidence against ADHD.

I do not want a television culture in which medication is beyond criticism. I want better diagnosis, better parenting support, better schools, better monitoring, better alternatives, stronger regulation and more honest conversations about uncertainty. I want children to remain recognisably themselves. I want adults—especially women and people with addiction histories—not to spend decades being told that severe, patterned impairment is laziness, weak character or a fashionable identity.

A question mark is punctuation, not scientific balance. “No diagnostic scan” is not “no neurobiology”. More referrals are not proof of more prevalence. A bad assessment is not proof of a bad diagnosis. A bad medication experience is not proof that treatment is a cosh. A child enjoying six weeks of intensive support is not proof that ADHD is socially invented.

The national scandal is not that Britain has suddenly invented ADHD. It is that recognition has outpaced a system capable of delivering careful, equitable and multimodal care. That system deserves unsparing investigation. So do commercial clinics, pharmaceutical companies, alternative-treatment providers, schools, commissioners and broadcasters.

Channel 4 had the platform to make that film. It chose a myth instead.

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