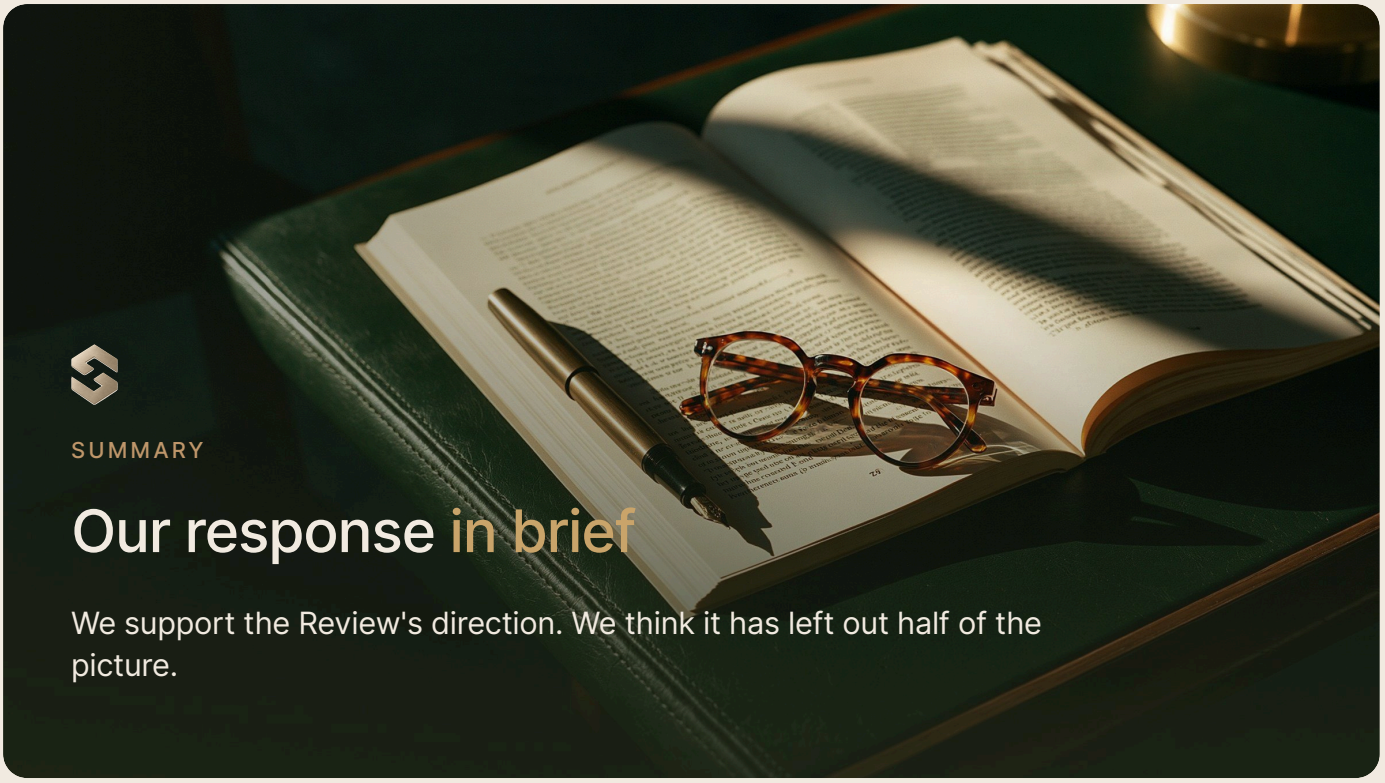


POSITION PAPER · OCTOBER 2026

The Review sees the system. It misses the whole person.

Sanctum Healthcare's response to the *Independent review into prevalence and support for mental health conditions, ADHD and autism* (final report, October 2026).

Dr Asad Raffi
Consultant Psychiatrist. Founder and Clinical Director, Sanctum Healthcare



SUMMARY

Our response in brief

We support the Review's direction. We think it has left out half of the picture.

The Independent Review led by Professor Peter Fonagy, with Professor Gillian Baird and Professor Sir Simon Wessely, is a serious and unusually candid piece of work. We support its central policy shift: help should not be locked behind a diagnosis.

But the Review explains rising demand almost entirely through social, educational and service-system factors. It largely leaves out the biological and behavioural factors that shape how ADHD and autism present, what they are mistaken for and what drives impairment. Those include sleep, iron and thyroid status, hormonal change across the lifespan, connective tissue and autonomic differences, emotional dysregulation, addictive behaviours and the physical health risks that shorten lives.

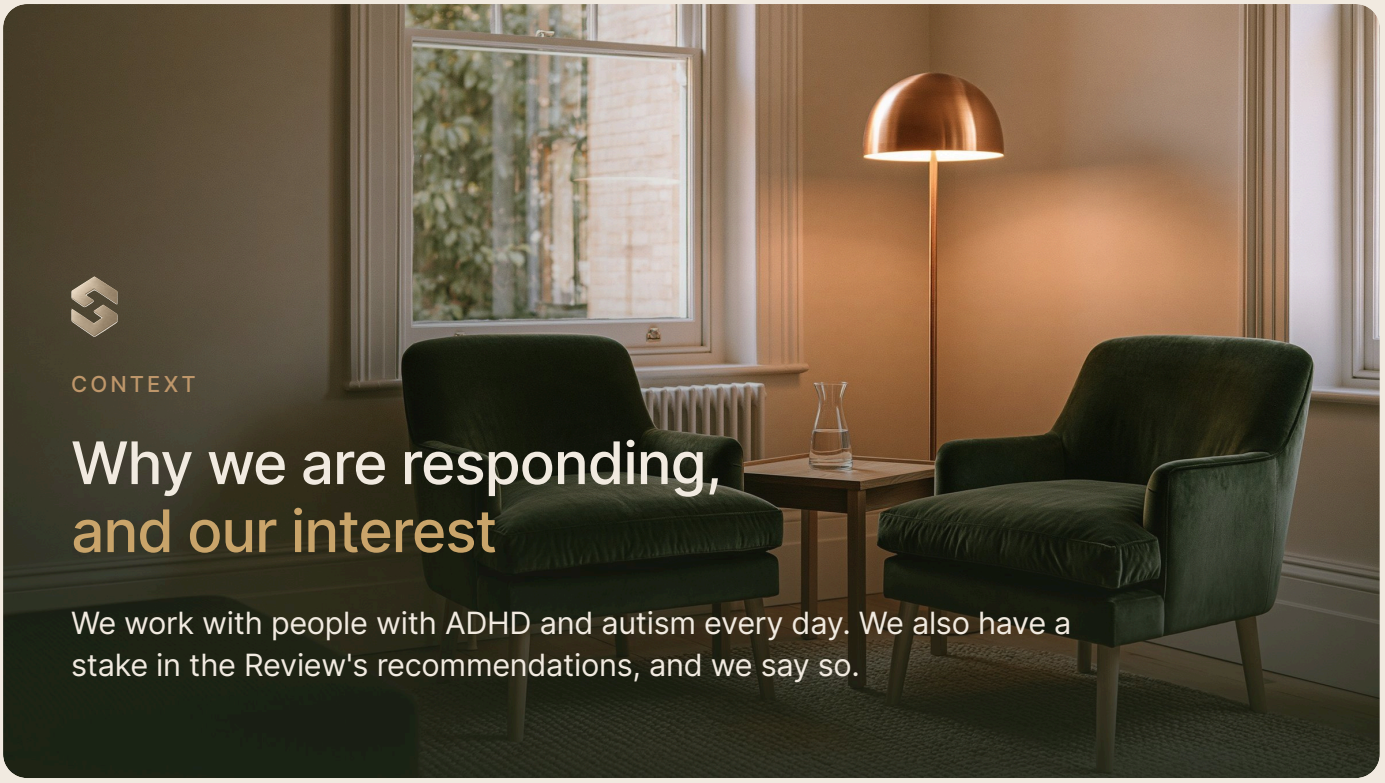
These omissions matter on the Review's own terms. It warns that misdiagnosis is a growing risk, that women and girls have been overlooked, that minority communities are under-served and that support should be matched to need. Each of those aims is weakened when the body is left out.

We also think the Review's headline on overdiagnosis goes further than its own data allow, particularly for ADHD. Section 2 sets out why.

TAKEAWAY

What we are asking for

1. Add a physiology and behaviour domain to the proposed needs framework (Annex A).
2. Set a national minimum standard for ADHD and autism assessment that covers sleep, substances and behavioural addictions, hormonal history, emotional regulation and relevant physical health.
3. Treat emotional dysregulation, sleep, substance use and physical health as treatment targets, with an annual physical health review for adults with ADHD.
4. Build women's health and life stage into assessment and treatment pathways.
5. Investigate the South Asian and Black diagnosis gaps, fund culturally valid assessment tools and correct the Review's error on autism recording in Black pupils.
6. Use the next national surveys to measure hormonal stage, sleep, physical health and addictive behaviours.
7. Extend the proposed model of care beyond age 25.



CONTEXT

Why we are responding, and our interest

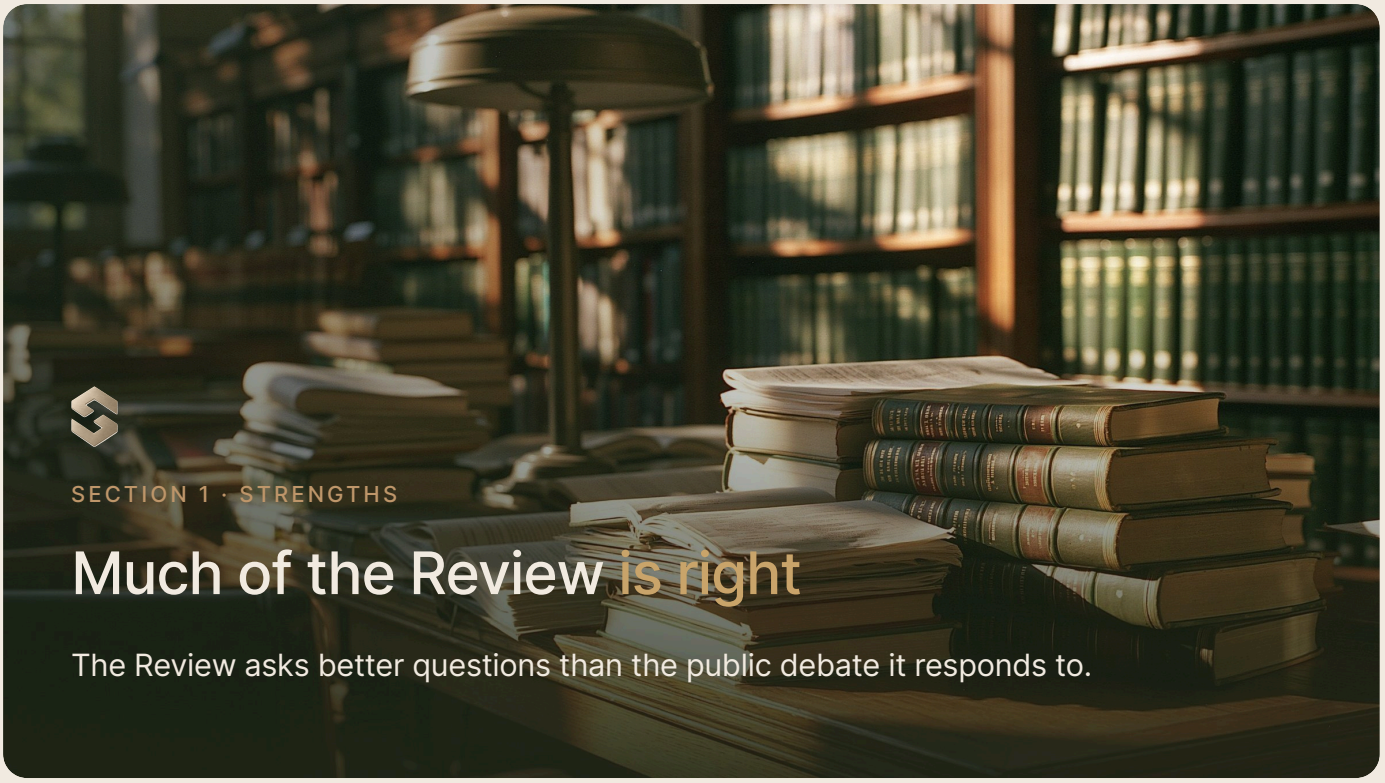
We work with people with ADHD and autism every day. We also have a stake in the Review's recommendations, and we say so.

Sanctum Healthcare is a CQC-registered independent service providing assessment and treatment for ADHD and autism in adults and children. Sanctum was originally set up to support people with ADHD and addiction, and we assess addictive behaviours as standard. Our clinical framework, the Brain Health Model, considers the brain and body together. Our not-for-profit arm, Sanctum Brain Health CIC, provides education and training.

We have read the full 599-page final report. Page references in this paper are to that report.

DECLARATION OF INTEREST

As an independent provider we have a direct interest in the Review's recommendations on the independent sector, including CQC regulation of assessment and data reporting. We address those briefly in section 1 and have kept our clinical argument separate from them. Sanctum does not carry out ICB-commissioned assessments.



SECTION 1 · STRENGTHS

Much of the Review is right

The Review asks better questions than the public debate it responds to.

It keeps a careful distinction between population prevalence, recorded diagnosis, demand for assessment and need. It treats diagnosis as a clinical intervention with benefits and harms, rather than asking simply whether there is too much or too little of it. Its central recommendation, a move from a diagnosis-dependent system to a needs-led plus diagnosis system, is right: people should be supported before, during and after assessment.

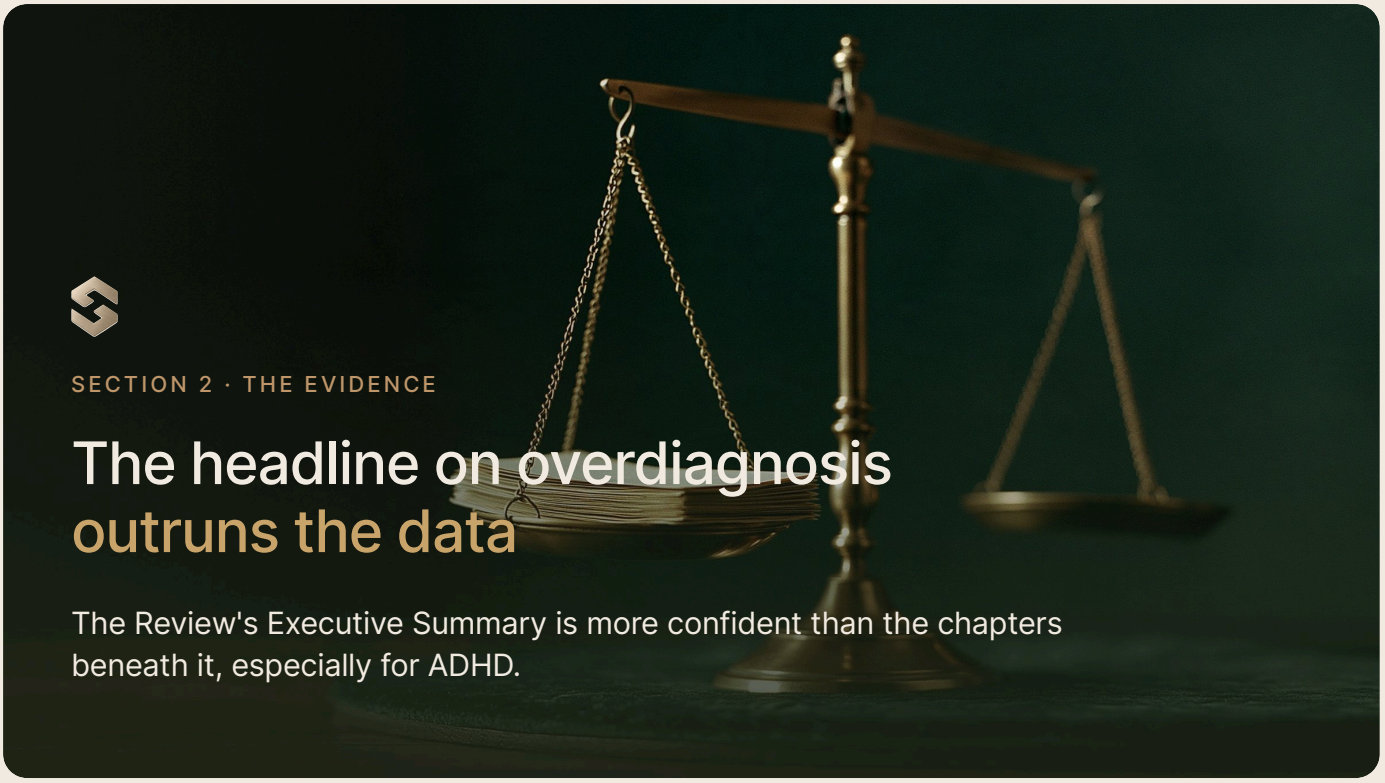
Its account of ADHD medication in Chapter 7 is balanced. It sets out the evidence on reduced accidents, substance misuse, suicidal behaviour and criminality and finds no evidence of widespread harm from increased prescribing (pp. 148 to 150). Its section on parenting and early intervention is strong and honest about effects shrinking under independent evaluation. It is candid about what is not known: there is no adult ADHD prevalence survey and no child diagnostic survey since 2017 (p. 42).

On the independent sector, the Review is right that rapid growth has outpaced oversight. Tariffs vary around fourfold between integrated care boards, and only about 10 of roughly 120 ADHD providers submitted data (p. 329). We support consistent standards, regulation and outcome reporting for all providers, NHS and independent alike.

TAKEAWAY

Our position

1. We support the move to a needs-led plus diagnosis system.
2. We support consistent standards, regulation and data reporting for every provider.
3. We support better national data, including regular prevalence surveys.



SECTION 2 · THE EVIDENCE

The headline on overdiagnosis outruns the data

The Review's Executive Summary is more confident than the chapters beneath it, especially for ADHD.

ADHD is compared with the wrong benchmark

The Executive Summary says recorded ADHD in young people is now "approaching and for some groups already exceeding" population estimates (p. 11). The example given is boys aged 12 to 17, at 5.1% (p. 131). But the benchmark is an estimate for boys and girls combined, aged 5 to 15: 3% in 2017, projected by the Review to about 3.8% now (p. 125).

Using the community sex ratio of about 2.3 to 1, an overall rate of 3.8% implies roughly 5.3% in boys and 2.3% in girls. The recorded rates for 12 to 17-year-olds are 5.1% and 2.7%. On the Review's own projection, recorded ADHD in adolescents matches the expected rate by sex. It does not exceed it. Chapter 12 says as much: recorded diagnoses "remain below community prevalence estimates in most age groups" (p. 267).

THE EVIDENCE

- Community ADHD sex ratio 2.3 to 1 in children, 1.6 to 1 in adults (Willcutt 2012).
- International DSM-5 estimates cited by the Review: 5 to 6% in children; NICE cites about 5% (p. 125).

A rising line is what a capacity-limited system produces

The Review argues that if diagnosis were simply catching up with true prevalence, the rate of increase would slow (pp. 61, 130). That only holds when assessment capacity is not the constraint. With more than 560,000 open ADHD referrals (p. 129), the number of new diagnoses each year is set by throughput, not by how many undiagnosed people remain.

Autism is a different story, but its benchmark is weak

For autism the gap is real: cumulative recorded prevalence is 6.3% in boys aged 6 to 11 (p. 155), against a population anchor of about 1.0 to 1.2% from the 2017 national child survey. That survey's measures were not designed for autism case-finding, and recent US surveillance with active case-finding finds 27.7 per 1,000 White and 36.6 per 1,000 Black eight-year-olds (CDC 2025). Both readings, threshold drift and an anchor set too low, deserve testing. The Review treats ADHD and autism in parallel, which blurs where the signal is.

Screening questionnaires are used as if they measured disorder

The Review reports that 57% of 16 to 24-year-olds with a common mental disorder screen positive for ADHD and 61% for autistic traits (p. 139), and that autistic-trait positives in this group rose from 20% to 61% since 2007 (p. 198). A tripling of a developmental trait in 17 years is not plausible. Distress inflating screening scores is the likelier explanation, and the same survey shows complaints of poor concentration roughly doubling (p. 81).

The impairment claim rests on the wrong group

The Executive Summary states that "those now presenting are no less affected than those identified before" (p. 15). The evidence offered is about undiagnosed adults who screen positive in a household survey (p. 139), not people presenting to services. The chapter's own counter-evidence points the other way: weakening links between ADHD diagnosis and educational outcomes in South London and Norway, and a Danish registry study showing differences between diagnosed children and controls narrowing as diagnosis doubled (p. 140).

Several headline figures rest on weak sources

The Review sets out a sound framework for grading evidence (Table 3.1) but does not visibly apply it to its headline claims. The figures on independent-sector spending come from a think tank report (Centre for Health and the Public Interest) and on independent-sector share from the providers' own trade body. The NEET figure for ADHD comes from a preprint. Several primary care analyses are cited as unpublished personal communications. The key Norwegian finding on harms of diagnosis is from a manuscript under review (p. 70). The claim that misdiagnosis is more likely where assessment is "not face to face" (p. 14) is not supported anywhere in the body of the report.

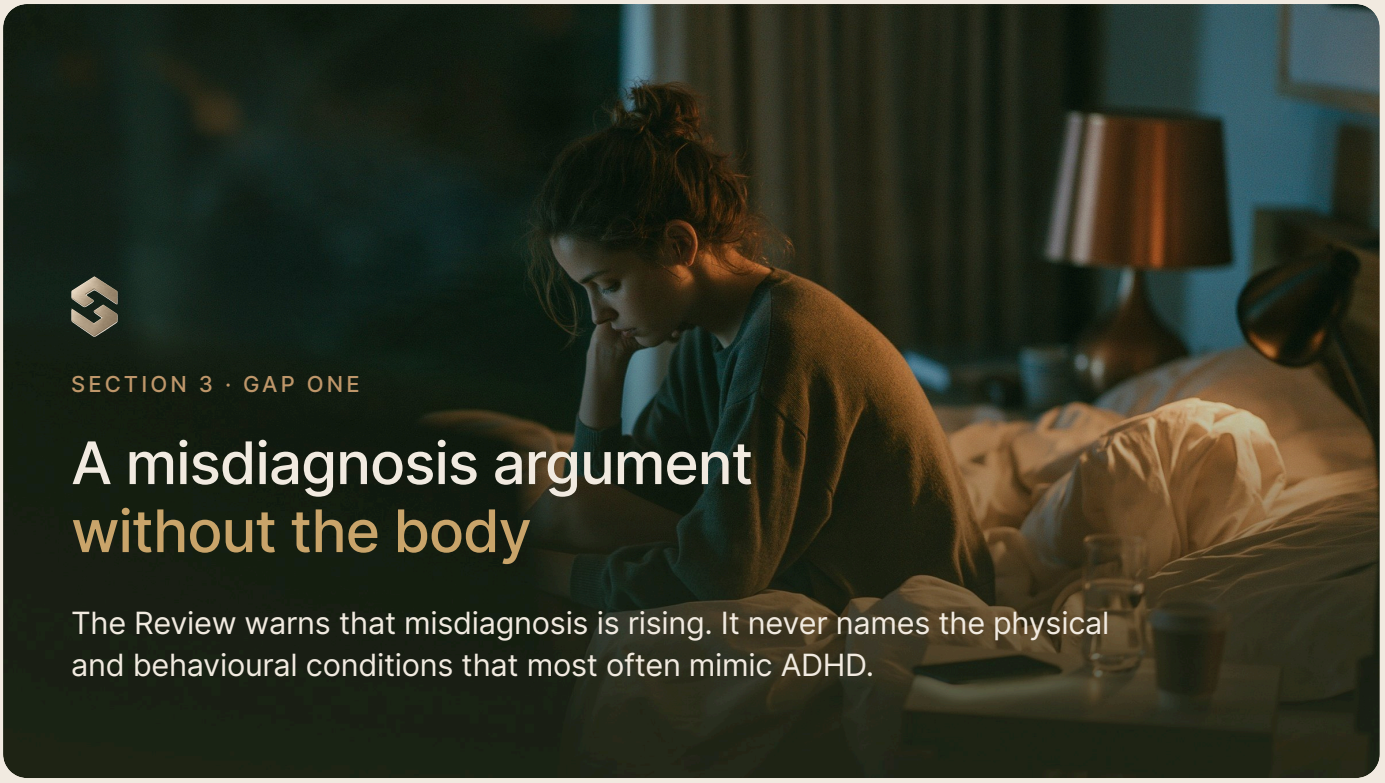
Adults with ADHD are under-served

Among people who identify with ADHD, the average recalled age at which difficulties began rose from 9.8 years in 2014 to 21.7 years in 2024 (p. 135). The Review cites the Dunedin cohort on late-onset ADHD but not Sibley and colleagues' 2018 study. In that study about 95% of people who first screened positive for late-onset ADHD were excluded on careful, repeated assessment, most often because their symptoms occurred only alongside heavy substance use. Chapter 19 narrows medication to improving "attention, concentration or productivity" (pp. 399, 423), contradicting Chapter 7. And the proposed model of care covers ages 0 to 25 only (p. 408), although adults make up most ADHD demand.

TAKEAWAY

Our reading

1. The data support real concern about autism thresholds and about assessment quality everywhere.
2. They do not show that ADHD is being overdiagnosed at scale, and the Review's own chapters say so.
3. Better national data, as the Review recommends, is the way to settle the question.



SECTION 3 · GAP ONE

A misdiagnosis argument without the body

The Review warns that misdiagnosis is rising. It never names the physical and behavioural conditions that most often mimic ADHD.

The Review is clear that attentional difficulties "may arise in anxiety, depression, trauma, sleep disturbance, substance misuse and many other conditions" (p. 146) and that comprehensive assessment is the safeguard. But it never says what comprehensive assessment must include, and its proposed standards for assessment (Recommendation 5) cover only co-occurring conditions, functioning, remote versus in-person assessment and assessor training.

Sleep and circadian rhythm

Sleep appears mainly as the route by which phones and social media harm young people (p. 241). The Review notes that insomnia, delayed sleep phase and restless legs are common in ADHD and autism (p. 202) but does not recommend sleep screening in assessment, and does not mention sleep apnoea, insomnia treatment or melatonin as a treatment.

THE EVIDENCE

- Delayed melatonin onset in 31 of 40 adults with ADHD and sleep-onset insomnia (Van Veen 2010; small study).
- Restless legs symptoms in 11 to 43% of children and 20 to 33% of adults with ADHD (Migueis 2023).
- Sleep-disordered breathing linked to ADHD symptoms (g 0.57), which improved after adenotonsillectomy (Sedky 2014).
- Autism: most have sleep problems; 13% have a diagnosed sleep-wake disorder (Lai 2019).

Iron and thyroid

The words iron, ferritin, anaemia and thyroid do not appear in the body of the report. Iron deficiency is linked to ADHD, restless legs and poor sleep, and it is common in menstruating young women: the group whose distress and ADHD diagnoses have risen fastest.

THE EVIDENCE

- Iron deficiency and ADHD: OR 1.64; ferritin lower in ADHD (Tseng 2018; Wang 2017).
- Maternal hypothyroidism: offspring ADHD OR 1.14, autism OR 1.41; low certainty (Ge 2020).

Hormonal change

Across 599 pages, menopause is mentioned once (p. 103) and hormonal change once (p. 180). There is nothing on the menstrual cycle, premenstrual dysphoric disorder, the postpartum period, perimenopause, contraception or HRT. A woman in her mid-forties presenting for the first time with new attentional problems, low mood and poor sleep is exactly where perimenopause is both a contributor and a source of diagnostic confusion. The Review has nothing to say about her.

THE EVIDENCE

- In one clinic sample of 209 women with ADHD, 45.5% reported PMDD symptoms and 57.6% of mothers scored above the screening threshold for postpartum depression (Dorani 2021; no control group).
- Falling oestradiol predicted worse ADHD symptoms; stimulant effects varied across the cycle (Roberts 2017; Justice and de Wit 1999). Evidence is preliminary, with no trial in women with ADHD.

Connective tissue, autonomic and immune differences

The Review records the Ehlers-Danlos association (p. 202) and lists POTS and hypermobile Ehlers-Danlos among conditions "often grouped under the umbrella of medically unexplained symptoms" without questioning that label, although both have established diagnostic criteria. It notes their overlapping fatigue, dizziness and poor concentration, then does not follow the point through to assessment. Inflammation, histamine and mast cell activation are not discussed. Evidence on these is still emerging and the right ask is research, not clinical mandates.

THE EVIDENCE

- People with Ehlers-Danlos: ADHD RR 5.6, autism RR 7.4 (Cederlöf 2016).
- Joint hypermobility: ADHD aOR 4.7 (Glans 2021); autism aOR 3.1 (Glans 2022).
- Autism: lower heart rate variability, g −0.52 (Cheng 2020). POTS prevalence: no reliable data.
- ADHD: asthma OR 1.53 (Cortese 2018); autoimmune disease IRR 1.24 (Nielsen 2017).

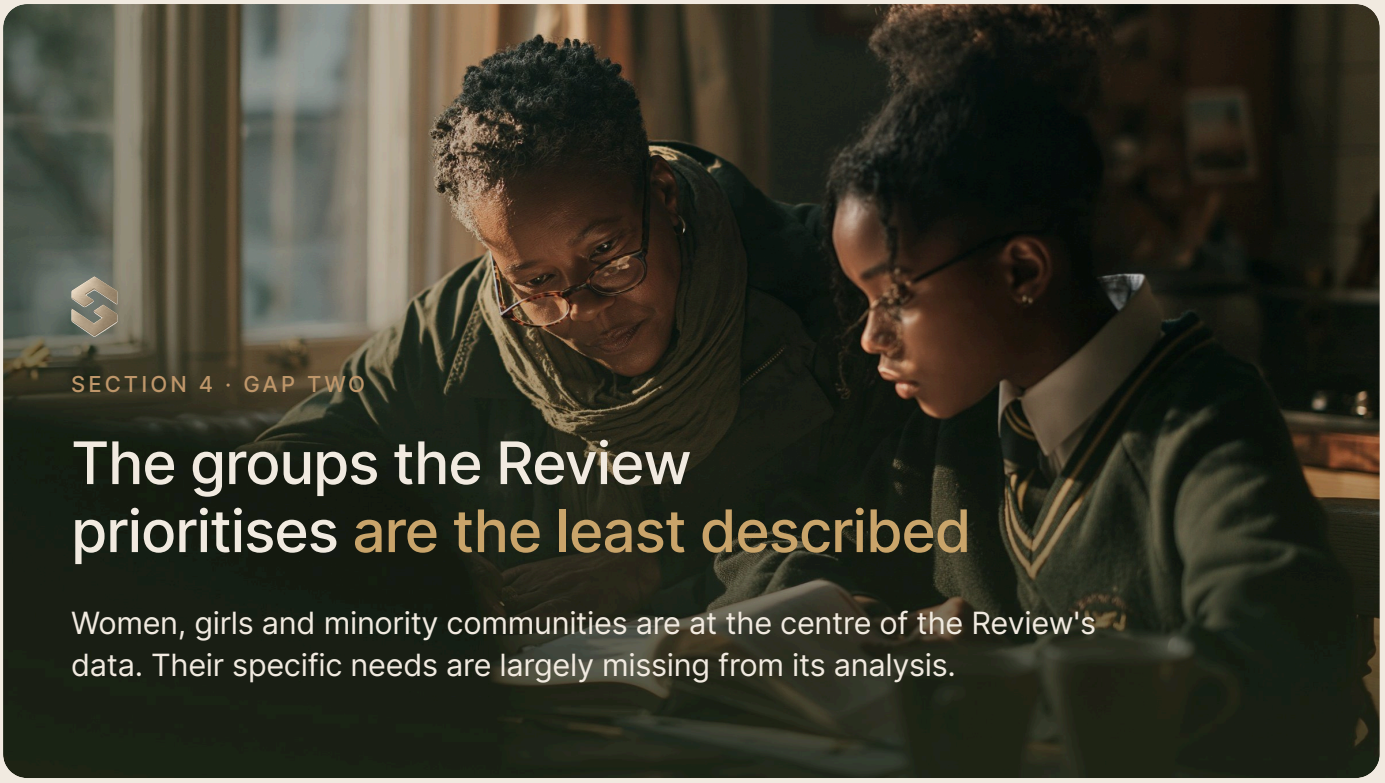
Substances, caffeine and screens

Intoxication and withdrawal from stimulants, cannabis, nicotine and caffeine can mimic or mask inattention, as can heavy phone use. The Review notes that ADHD is often missed in substance misuse services (p. 299) but sets no expectation that ADHD assessment covers substance use. Caffeine is not mentioned; nicotine appears only as a public health analogy.

TAKEAWAY

What this means

1. Before attention difficulties are attributed to ADHD, assessment should consider the common physical and behavioural mimics.
2. The Review asks for comprehensive assessment but never defines it. A national minimum standard should.



SECTION 4 · GAP TWO

The groups the Review prioritises are the least described

Women, girls and minority communities are at the centre of the Review's data. Their specific needs are largely missing from its analysis.

Women and girls

The Review's own data keep pointing at women. Common mental disorder among women aged 16 to 24 rose from 20.5% to 36.1% (p. 84). Recorded ADHD rose more than tenfold in females between 2017 and 2025, against threefold in males (p. 131). Recorded autism incidence in females now exceeds that in males from adolescence onwards (p. 169). The Review explains this through awareness, masking, social media and educational pressure. It does not consider hormones, pregnancy, life stage or the specific risks women with ADHD and autism face.

THE EVIDENCE

- Women are diagnosed with ADHD about 4 years later than men (mean 23.5 vs 19.6 years; Skoglund 2023).
- Teenage birth: 15.3% of women with ADHD vs 2.8% (OR 6.23; Skoglund 2019). Unplanned pregnancy 39 to 48% vs 10.6% (Owens 2017).
- Borderline personality disorder in ADHD: aOR 19.4 (Kuja-Halkola 2018). ADHD in 16 to 38% of clinical BPD samples (Weiner 2019).
- Eating disorders in ADHD: bulimia OR 5.71, binge eating OR 4.13 (Nazar 2016).
- Women with PCOS: autism aOR 1.55 (Cesta 2016). Maternal PCOS: offspring ADHD OR 1.42, autism OR 1.44 (Cao 2026).
- Sexual violence victimisation in ADHD: OR 1.84 (Arrondo 2023).

Each has practical consequences. Late diagnosis means years of treatment for the wrong problem. Early pregnancy raises questions about ADHD medication in pregnancy and the postpartum period that the Review does not address. The overlap with borderline personality disorder is a well-known source of misdiagnosis in women, yet how often autistic women are misdiagnosed with it has never been measured (May 2021). The Review notes that the link between eating disorders and ADHD has strengthened (p. 381) but does not consider what that means for prescribing an appetite-suppressing medication.

Minority communities

The Review reports recorded prevalence by ethnicity from primary care records. For ADHD: Mixed 2.0%, White 1.7%, Black 0.7% and South Asian 0.4% (p. 132). It concludes it cannot say why. Several things it could have said are missing.

The South Asian gap is very large. In Bradford, White British children were diagnosed with ADHD 5.3 times (boys) and 5.8 times (girls) as often as South Asian children (Warburton 2026). International evidence points to under-diagnosis rather than lower prevalence. Assessment tools behave differently across groups, and there are no UK norms by ethnicity for the main ADHD rating scales. Language matters too: pupils who speak another language at home are less likely to have autism recorded.

The Review also contains a factual error. It says autism-related special educational needs were "recorded less often" for Black pupils, citing 2.11% (p. 311). Its source shows Black pupils had the highest recorded autism prevalence of any group (Roman-Urrestarazu 2021).

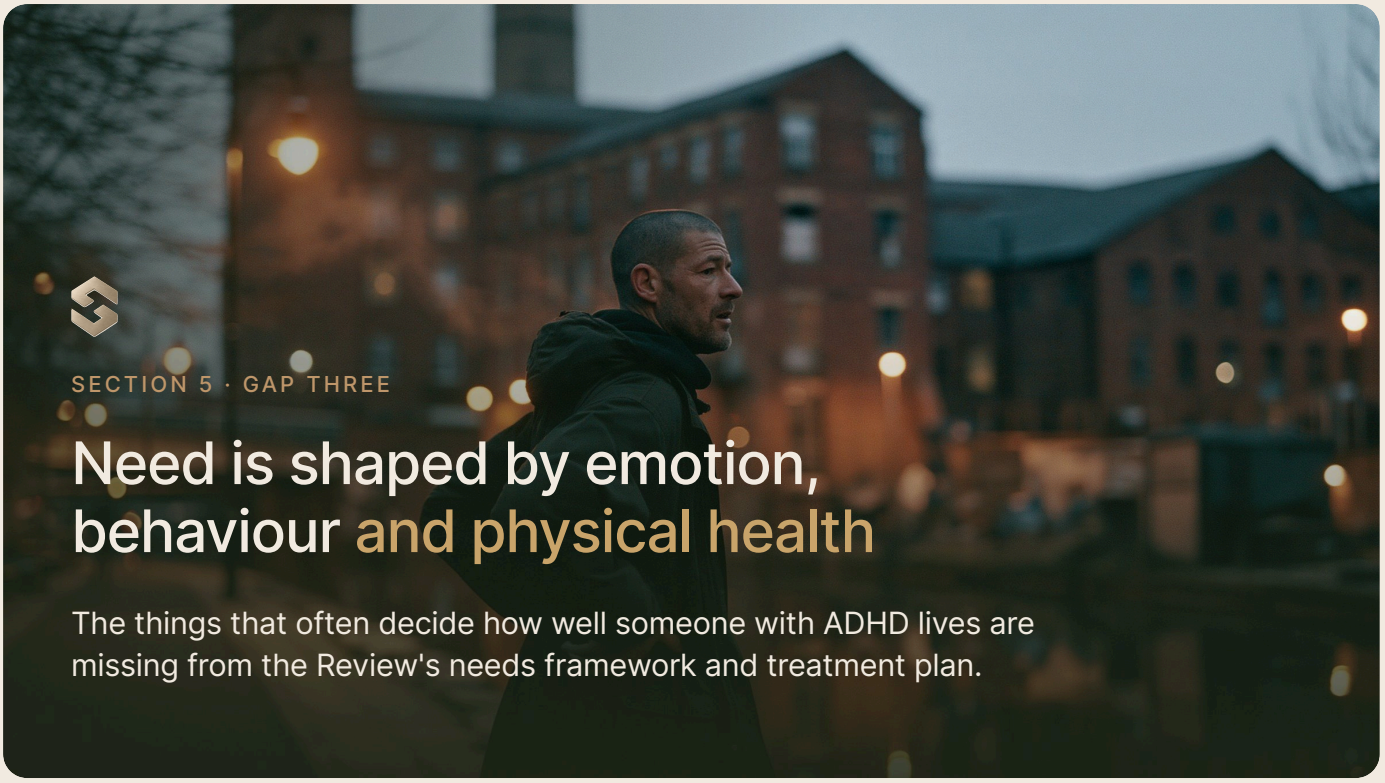
THE EVIDENCE

- US: Black children had 69% lower adjusted odds of ADHD diagnosis (Morgan 2013); similar pooled prevalence in Black and White children (Cénat 2022).
- Teacher ADHD ratings function differently by race (DuPaul 2020). Eight ADOS items differ for Black children, with little effect on total scores (Kalb 2022).
- Autism in English schools, compared with White pupils: Chinese 1.38, Black 1.26, Asian 0.83, Roma or Irish Traveller 0.42; other language at home 0.64 (Roman-Urrestarazu 2021).
- Intellectual disability in autistic eight-year-olds: Black 52.8% vs White 32.7%, suggesting autism without intellectual disability is missed (CDC 2025).
- Suspensions per 100 pupils: Gypsy or Roma 33.7, Mixed White and Black Caribbean 17.4, Black Caribbean 13.6, all pupils 9.3 (DfE).

TAKEAWAY

What this means

1. Women need assessment and treatment that take account of hormones, pregnancy and life stage.
2. Minority communities need culturally valid tools, adapted pathways and research into why the gaps exist.
3. Without these, the Review's commitment to under-served groups stays a statement of intent.



SECTION 5 · GAP THREE

Need is shaped by emotion, behaviour and physical health

The things that often decide how well someone with ADHD lives are missing from the Review's needs framework and treatment plan.

Emotional dysregulation

The Review records that emotional dysregulation predicts later impairment beyond ADHD symptoms (p. 141), and its lived experience partners describe it as the most disabling part of their ADHD and the part medication helped most (p. 149). Yet it never becomes part of how ADHD is assessed or treated. The Review lists portrayals of "mood instability" as characteristic of ADHD among the inaccuracies of social media content (p. 143).

Rejection sensitive dysphoria is not mentioned. It has no validated measure or prevalence data and is not a diagnostic entity. But it is one of the most widely used ADHD concepts in exactly the spaces the Review studies, and clinicians need guidance on it.

THE EVIDENCE

- Emotional dysregulation in 25 to 45% of children and 30 to 70% of adults with ADHD (Shaw 2014).
- Adults with ADHD vs controls: g 1.17 (Beheshti 2020).
- Autistic young people about 4 times as likely as the norm sample to have clinically raised emotional reactivity (Conner 2021).
- Rejection sensitive dysphoria: qualitative studies only (e.g. Ginapp 2023).

Addictive behaviours

The word addiction appears once in the body of the report, in a list of under-delivered therapies (p. 420). Gambling appears once, as a social determinant (p. 434). Gaming disorder, an ICD-11 diagnosis, is not mentioned. Provision for young people with substance misuse problems shrank while other mental health provision grew (p. 337). Impulsivity, reward sensitivity and using behaviour to manage emotion are the processes the Review itself calls transdiagnostic (p. 192), yet it does not connect them to addictive behaviour in ADHD.

THE EVIDENCE

- 23.1% of people with a substance use disorder have ADHD (van Emmerik-van Oortmerssen 2012).
- Childhood ADHD: nicotine dependence OR 2.82, cannabis use OR 2.78 (Lee 2011). Vaping initiation aOR 1.60 (McCabe 2025).
- Internet addiction OR 2.85 (Ho 2014). Gambling severity correlates weakly with ADHD symptoms, r 0.17 (Theule 2019).
- Loan defaults rise sharply in middle age in ADHD; financial distress linked to about four times the suicide risk (Beauchaine 2020).

Physical health and life expectancy

In the UK, life expectancy is 6.8 years shorter for men and 8.6 years shorter for women with diagnosed ADHD (O'Nions 2025). The Review mentions reduced life expectancy (p. 69) and asks for "proactive physical health review" (p. 400), but sets no standard. People with severe mental illness are offered an annual physical health check. Adults with ADHD are not.

Medication's effects on these outcomes belong in the treatment discussion. Chapter 7 covers them; Chapter 19 drops them.

THE EVIDENCE

- Obesity in adults with ADHD 28.2% vs 16.4% (Cortese 2016). Type 2 diabetes OR 2.29, largely explained by psychiatric comorbidity (Garcia-Argibay 2023).
- Adults with ADHD had raised risk of 34 of 35 physical conditions (Du Rietz 2021).
- On medication: road traffic crashes 38% lower in men and 42% lower in women (Chang 2017); suicide attempts RR 0.75 (Liu 2020); sexually transmitted infection HR 0.59 to 0.70 (Chen 2018).

Lifestyle

Physical activity is described as "one of the few individual-level protective factors supported by prospective evidence" (p. 347) but only as population prevention. Diet gets one sentence (p. 373). Nothing is said about exercise or nutrition as part of ADHD care, or about the myths a public information campaign (Recommendation 9) could correct.

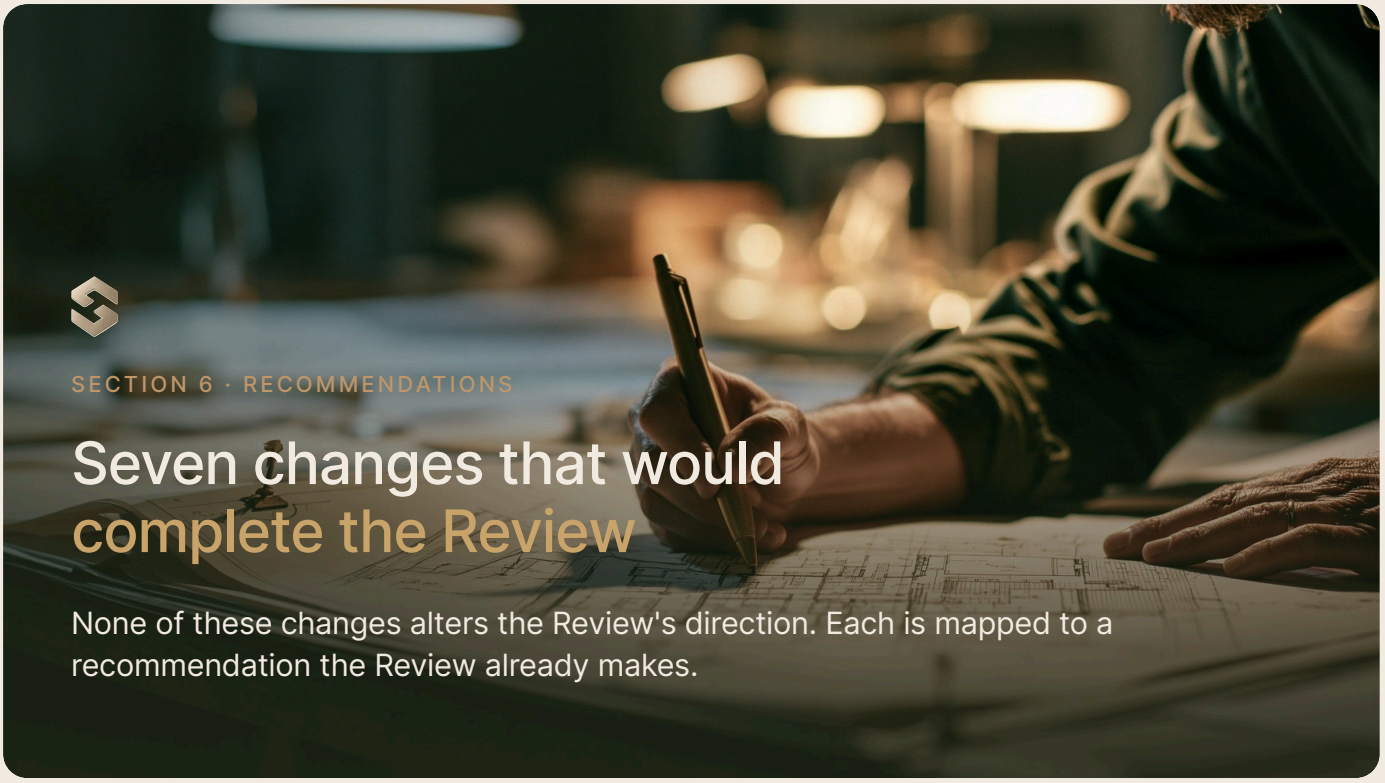
THE EVIDENCE

- Exercise: core ADHD symptoms SMD 0.50, executive function SMD 0.77; low certainty, mostly children (Zhu 2026).
- Omega-3: small benefit, g 0.38 (Chang 2018). Food colours: small effect, perhaps 8% of children sensitive (Nigg 2012).
- Sugar: no effect on behaviour (Wolraich 1995).

TAKEAWAY

What this means

1. Emotional regulation, addictive behaviours, sleep and physical health belong in the needs framework and the treatment plan.
2. Adults with ADHD should have a proactive physical health review, as people with severe mental illness do.



SECTION 6 · RECOMMENDATIONS

Seven changes that would complete the Review

None of these changes alters the Review's direction. Each is mapped to a recommendation the Review already makes.

1 **Needs framework (Recommendation 2, Annex A).** Add a seventh dimension, physiology and behaviour, covering sleep, physical health, hormonal stage, substances and behavioural addictions, emotional regulation and eating.

2 **Assessment standard (Recommendation 5).** Set a national minimum content for ADHD and autism assessment: structured screening for sleep disorders; substances including nicotine, caffeine and cannabis; behavioural addictions including gambling, gaming and spending; menstrual, perinatal and menopausal history; emotional dysregulation; eating behaviour; and proportionate physical health checks, including ferritin and thyroid function where clinically indicated.

3 **Treatment and follow-up (Recommendation 4).** Treatment plans should address emotional dysregulation, sleep, substance use and lifestyle. Adults with ADHD should be offered an annual physical health review. Chapter 19 should restore Chapter 7's account of what medication achieves.

4 **Women's health (Recommendations 3 and 4).** Build menstrual, perinatal and perimenopausal presentations into pathways, with national guidance on ADHD medication in pregnancy and after birth and joint working with women's health hubs.

5 **Equity (Recommendations 3 and 8).** Investigate the South Asian and Black diagnosis gaps, commission UK normative data for ADHD and autism tools across ethnic groups, fund culturally adapted pathways and correct the error on p. 311.

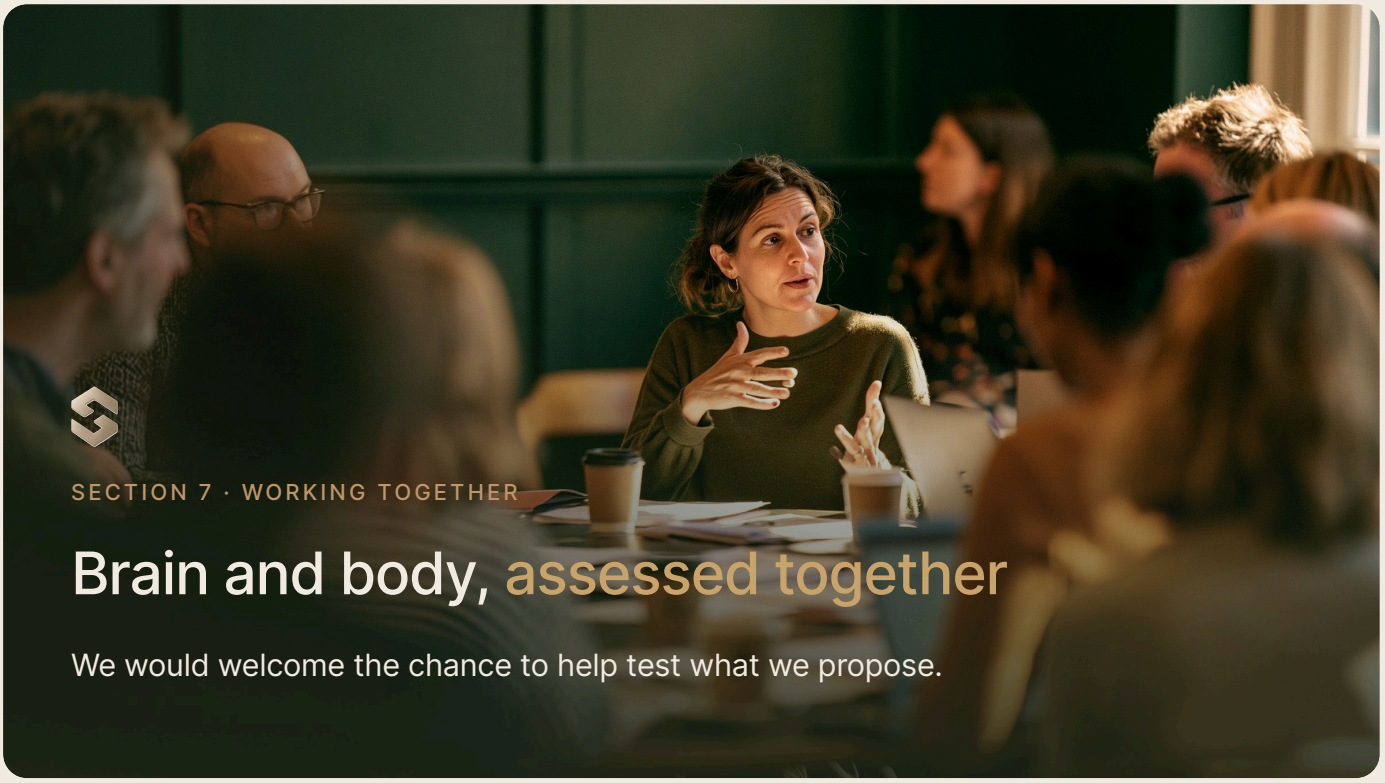
6 **Data, research and public information (Recommendations 8 and 9).** Include hormonal stage, sleep, physical health and addictive behaviour measures in the next national surveys. Prioritise research on hormonal effects on ADHD and stimulant response, iron, hypermobility and dysautonomia, mast cell activation and whether rejection sensitive dysphoria is a valid construct. Use the public information campaign to address sleep, substances and nutrition myths.

7 **Life course (Recommendations 3 and 10).** Extend the 0 to 25 model of care and the Annex A framework to adults, who make up most ADHD demand.

TAKEAWAY

The principle

- Diagnosis alone is an incomplete guide to need. So is a needs framework that leaves out the body.



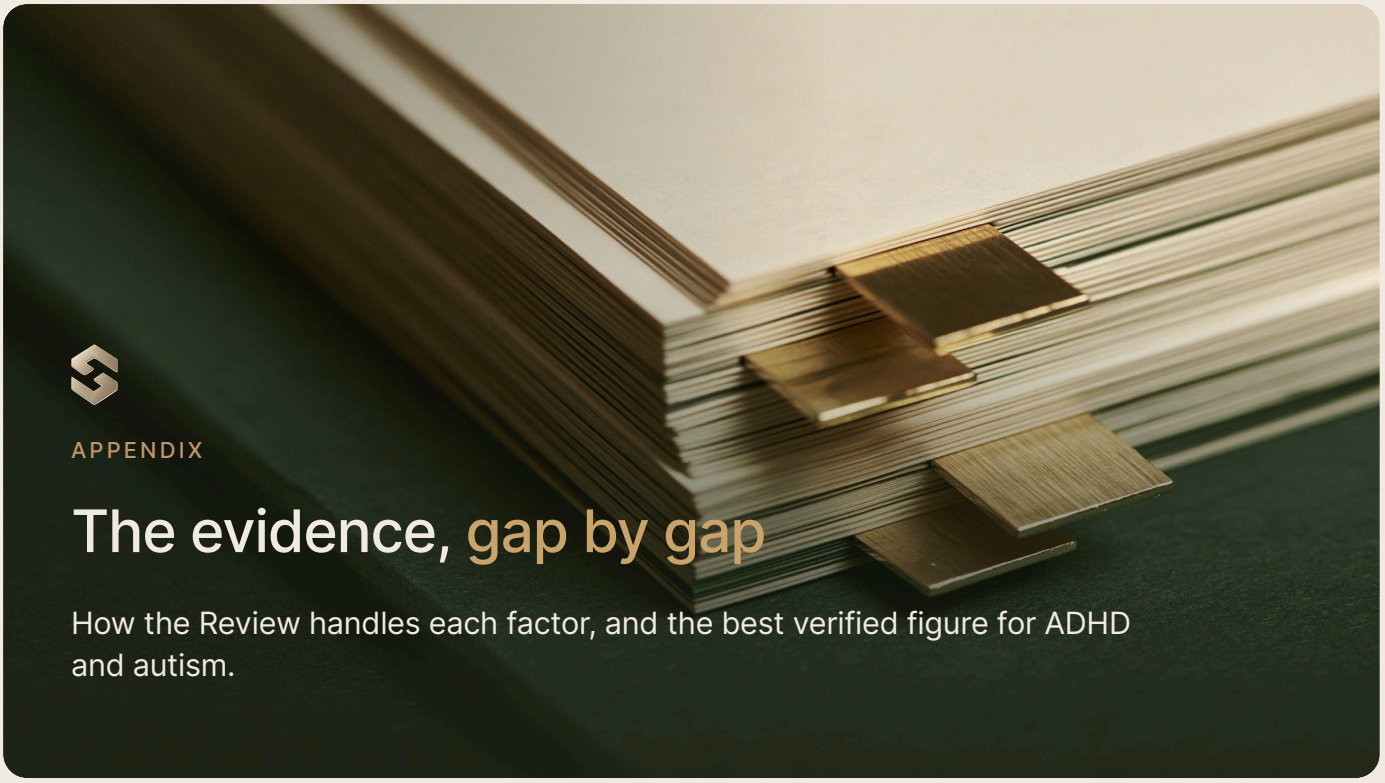
SECTION 7 · WORKING TOGETHER

Brain and body, assessed together

We would welcome the chance to help test what we propose.

The changes we propose are practical. Most can be built into assessment templates and care plans that services already use. The weaker parts of the evidence, on hormones, iron, dysautonomia and rejection sensitivity, call for careful research rather than new mandates, and we have labelled them that way throughout.

We would welcome working with the Department of Health and Social Care, NHS England, integrated care boards and the Review team to test a physiology and behaviour domain within the proposed needs framework, and to share what we learn.



APPENDIX

The evidence, gap by gap

How the Review handles each factor, and the best verified figure for ADHD and autism.

Strength: **Strong** = large registry or meta-analysis with consistent findings. **Moderate** = meta-analysis with heterogeneity, or a single large cohort. **Emerging** = small or single studies. **Weak** = observational or inconsistent. Figures checked against PubMed or official statistics in October 2026. Most figures are odds or risk ratios because that is how the research reports them; we have not converted them into percentages.

Sex, gender and hormones

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
True sex ratio	Recorded trends only	Community children 2.3:1; adults 1.6:1; clinic samples 3:1 to 16:1	Pooled 4.2:1; about 3:1 in high-quality screened studies	Strong	Willcutt 2012; Young 2020; Loomes 2017
Later diagnosis in women	General only	About 4 years later (23.5 vs 19.6)	Later, no reliable pooled figure	Moderate	Skoglund 2023
PMDD and postpartum depression	Absent	PMDD symptoms 45.5%; postpartum depression 57.6% of mothers	No data	Emerging	Dorani 2021
Menstrual cycle and oestrogen	Absent	Symptoms and stimulant effects vary with oestradiol; no trial in ADHD	No data	Emerging	Roberts 2017; Wynchank 2025
Teenage and unplanned pregnancy	Absent	Teenage birth 15.3% vs 2.8%; unplanned pregnancy 39 to 48% vs 10.6%	No data	Strong	Skoglund 2019; Owens 2017

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
Sexual and partner violence	Not addressed	Sexual violence OR 1.84; partner violence OR 1.78	88.4% of autistic women (self-selected survey)	Moderate	Arrondo 2023; Cazalis 2022
Borderline personality disorder	Co-occurrence only	aOR 19.4; ADHD in 16 to 38% of clinical BPD	Overlap 3 to 4%; misdiagnosis not measured	Moderate	Kuja-Halkola 2018; Weiner 2019; May 2021
Eating disorders	Partly	Bulimia OR 5.71; binge eating OR 4.13; anorexia OR 4.28	29% of people with anorexia above ADOS cut-off	Moderate	Nazar 2016; Inal-Kaleli 2024
Gender diversity	Brief (p. 111)	Similar to autism (figure not verified)	3.0 to 6.4 times as likely	Strong	Warrier 2020
PCOS	Absent	Maternal PCOS: offspring OR 1.42	Women with PCOS aOR 1.55; maternal PCOS offspring OR 1.44	Moderate	Cesta 2016; Cao 2026

Ethnicity

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
South Asian gap	Recorded rates only	Bradford: White British diagnosed 5.3 (boys) and 5.8 (girls) times as often; incidence 1.8 vs 0.3 per 1,000 person-years	Asian pupils 0.83 vs White	Moderate	Warburton 2026; Pettinger 2025; Roman-Urrestarazu 2021
Under-diagnosis vs prevalence	Not discussed	Black children 69% lower adjusted odds of diagnosis; similar pooled prevalence	–	Moderate	Morgan 2013; Cénat 2022
Autism in English schools	Misreported (p. 311)	–	Chinese 1.38, Black 1.26, Roma or Irish Traveller 0.42; other home language 0.64	Strong	Roman-Urrestarazu 2021
Autism with intellectual disability	Absent	–	Black 52.8% vs White 32.7%	Strong	CDC 2025
Tool bias	Absent	Teacher ratings function differently by race; no UK ethnic norms	8 ADOS items differ, little total effect; AQ higher in Indian samples	Moderate	DuPaul 2020; Kalb 2022; Freeth 2013
Exclusion	SEND only	Suspensions per 100: Gypsy or Roma 33.7; Black Caribbean 13.6; all 9.3; SEN support 28.9 vs 6.8	–	Strong	DfE

Brain and body

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
Sleep and circadian	Partly	Delayed melatonin onset (31 of 40); restless legs 11 to 43% children, 20 to 33% adults; sleep-disordered breathing g 0.57	Sleep-wake disorder 13%; problems in most	Moderate	Van Veen 2010; Migueis 2023; Sedky 2014; Lai 2019
Iron	Absent	Iron deficiency OR 1.64	No difference	Moderate	Tseng 2018; Wang 2017
Thyroid	Absent	Maternal hypothyroidism OR 1.14	OR 1.41	Weak	Ge 2020
Obesity and metabolic	Listed	Adult obesity 28.2% vs 16.4%; type 2 diabetes OR 2.29	Child obesity 17%, RR 1.58	Strong	Cortese 2016; Garcia-Argibay 2023; Sammels 2022
Hypermobility and EDS	One line	In EDS RR 5.6; hypermobility aOR 4.7	In EDS RR 7.4; hypermobility aOR 3.1	Moderate	Cederlöf 2016; Glans 2021; Glans 2022
Dysautonomia	Named once	No prevalence data	Lower heart rate variability g −0.52	Emerging	Cheng 2020
Allergy and autoimmune	Listed	Asthma OR 1.53; eczema OR 1.32; autoimmune IRR 1.24	Food allergy 11.3% vs 4.3%	Strong	Cortese 2018; Schans 2017; Nielsen 2017; Xu 2018
Inflammation and mast cells	Absent	IL-6 higher (fragile)	Maternal infection OR 1.30; mast cell data emerging	Emerging	Misiak 2022; Jiang 2016
Epilepsy	Listed	In epilepsy OR 3.47	12.1%	Strong	Brikell 2018; Lukmanji 2019
Gut	Listed	–	GI symptoms OR 4.42	Moderate	McElhanon 2014
Migraine	Absent	OR 1.32	–	Moderate	Salem 2018
Alexithymia	One word	About 22% (small study)	49.9% vs 4.9%	Strong (autism)	Kinnaird 2019; Edel 2010
Physical multimorbidity	General	Raised risk for 34 of 35 conditions	–	Strong	Du Rietz 2021
Life expectancy (UK)	No figures	6.8 years shorter (men), 8.6 (women)	–	Strong	O'Nions 2025

Emotion and mood

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
Emotional dysregulation	Not in definition	25 to 45% children; 30 to 70% adults; g 1.17	About 4 times norm (youth)	Moderate	Shaw 2014; Beheshti 2020; Conner 2021
Rejection sensitive dysphoria	Absent	No validated measure or prevalence	–	Weak	Ginapp 2023
Bipolar	Not linked	7.95% of adults with ADHD; 17.1% of people with bipolar have ADHD	–	Strong	Schiweck 2021
Anxiety and depression	Screens only	Anxiety OR 5.0; depression OR 4.5	–	Strong	Hartman 2023
Suicide	General	Attempts OR 2.37; death OR 6.69; stimulants RR 0.75	Death RR 2.85; lifetime attempts 15.3%	Strong	Septier 2019; Liu 2020; Santomauro 2024; Huntjens 2023

Addictive behaviours and lifestyle

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
Substance use disorder	Co-occurrence	23.1% of people with SUD have ADHD; adults OR 4.6	Risk doubled without ADHD	Strong	van Emmerik-van Oortmerssen 2012; Hartman 2023; Butwicka 2017
Nicotine and vaping	Absent	Dependence OR 2.82; vaping aOR 1.60	–	Strong	Lee 2011; McCabe 2025
Cannabis and alcohol	General	Cannabis OR 2.78; alcohol use disorder OR 1.74	–	Moderate	Lee 2011
Caffeine	Absent	Evening caffeine 2.5 times as likely (adolescents)	–	Weak	Cusick 2020
Gambling	One word	r 0.17	–	Moderate	Theule 2019
Internet, gaming, social media	Population only	Internet addiction OR 2.85; gaming r 0.30; social media r 0.36	Problematic internet use r 0.26	Moderate	Ho 2014; Koncz 2023; Ding 2025; Muris 2025

FACTOR	IN THE REVIEW	ADHD	AUTISM	STRENGTH	SOURCE
Spending and debt	Impairment only	Defaults rise in middle age	–	Moderate	Beauchaine 2020
Accidents and sexual risk	General	Injury OR 1.53; crashes lower on medication; STI HR 3.36	–	Strong	Ruiz-Goikoetxea 2018; Chang 2017; Chen 2018
Exercise	Prevention only	Core symptoms SMD 0.50	–	Emerging	Zhu 2026
Diet	One sentence	Omega-3 g 0.38; food colours small; sugar no effect	–	Moderate	Chang 2018; Nigg 2012; Wolraich 1995

REFERENCES

Sources

Titles are abbreviated. Page numbers in the text refer to the Review's final report. Photography is illustrative, generated with Midjourney, and does not show patients or real people.

Fonagy, Baird and Wessely 2026. Fonagy P, Baird G, Wessely S. Independent review into prevalence and support for mental health conditions, ADHD and autism: final report. October 2026.

Arrondo 2023. Arrondo et al. ADHD and interpersonal and sexual violence. Psychological Medicine. doi.org/10.1017/S0033291723001976

Beauchaine 2020. Beauchaine et al. ADHD, financial distress and suicide in adulthood. Science Advances. doi.org/10.1126/sciadv.aba1551

Beheshti 2020. Beheshti et al. Emotion dysregulation in adults with ADHD: a meta-analysis. BMC Psychiatry. doi.org/10.1186/s12888-020-2442-7

Brikell 2018. Brikell et al. The contribution of common genetic risk variants for ADHD to epilepsy. Biological Psychiatry. doi.org/10.1016/j.biopsych.2017.08.006

Butwicka 2017. Butwicka et al. Risks of substance use in autism spectrum disorder. J Autism Dev Disord. doi.org/10.1007/s10803-016-2914-2

Cao 2026. Cao et al. Maternal PCOS and offspring neurodevelopmental disorders: meta-analysis. BMC Psychiatry. doi.org/10.1186/s12888-026-08047-4

Cazalis 2022. Cazalis et al. Evidence that nine autistic women out of ten have been victims of sexual violence. Front Behav Neurosci. doi.org/10.3389/fnbeh.2022.852203

CDC 2025. Shaw et al. Prevalence of autism spectrum disorder among children aged 8 years. MMWR Surveill Summ 74(2). www.cdc.gov/mmwr/volumes/74/ss/ss7402a1.htm

Cederlöf 2016. Cederlöf et al. Ehlers-Danlos syndrome and neurodevelopmental disorders. BMC Psychiatry. doi.org/10.1186/s12888-016-0922-6

Cesta 2016. Cesta et al. Polycystic ovary syndrome and psychiatric disorders. Psychoneuroendocrinology. doi.org/10.1016/j.psyneuen.2016.08.005

Chang 2017. Chang et al. ADHD medication and motor vehicle crashes. JAMA Psychiatry. doi.org/10.1001/jamapsychiatry.2017.0659

Chang 2018. Chang et al. Omega-3 fatty acids in youth with ADHD: meta-analysis. Neuropsychopharmacology. doi.org/10.1038/npp.2017.160

Chen 2018. Chen et al. Sexually transmitted infection in ADHD and the effect of medication. J Am Acad Child Adolesc Psychiatry. doi.org/10.1016/j.jaac.2017.09.438

Cheng 2020. Cheng et al. Heart rate variability in autism: meta-analysis. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2020.08.007

Conner 2021. Conner et al. Emotion dysregulation in autistic youth. Autism Research. doi.org/10.1002/aur.2450

Cortese 2016. Cortese et al. ADHD and obesity: meta-analysis. Am J Psychiatry. doi.org/10.1176/appi.ajp.2015.15020266

Cortese 2018. Cortese et al. ADHD and asthma: meta-analysis and register study. Lancet Psychiatry. doi.org/10.1016/S2215-0366(18)30224-4

Cusick 2020. Cusick et al. Caffeine use and sleep in adolescents with and without ADHD. J Pediatr Psychol. doi.org/10.1093/jpepsy/jsaa033

Cénat 2022. Cénat et al. Prevalence of ADHD among Black, White, Latino and Asian youth: meta-analysis. J Clin Child Adolesc Psychol. doi.org/10.1080/15374416.2022.2051524

DfE. Department for Education. Pupil exclusions by ethnicity; suspensions and permanent exclusions in England. www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/pupil-exclusions/latest/

Ding 2025. Ding et al. Problematic social media use and ADHD symptoms: meta-analysis. J Psychiatr Res. doi.org/10.1016/j.jpsychires.2025.07.009

Dorani 2021. Dorani et al. Prevalence of hormone-related mood disorder symptoms in women with ADHD. J Psychiatr Res. doi.org/10.1016/j.jpsychires.2020.12.005

Du Rietz 2021. Du Rietz et al. Physical conditions in adults with ADHD. Lancet Psychiatry. doi.org/10.1016/S2215-0366(21)00171-1

DuPaul 2020. DuPaul et al. Invariance of ADHD symptom ratings by race. J Abnorm Child Psychol. doi.org/10.1007/s10802-020-00618-7

Edel 2010. Edel et al. Alexithymia, emotion processing and social anxiety in adults with ADHD. Eur J Med Res. doi.org/10.1186/2047-783x-15-9-403

Freeth 2013. Freeth et al. The Autism-Spectrum Quotient across cultures. J Autism Dev Disord. doi.org/10.1007/s10803-013-1808-9

Garcia-Argibay 2023. Garcia-Argibay et al. ADHD and type 2 diabetes: meta-analysis and register study. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2023.105076

Ge 2020. Ge et al. Maternal thyroid dysfunction and offspring neurodevelopmental disorders: meta-analysis. J Clin Endocrinol Metab. doi.org/10.1210/clinem/dgaa555

Ginapp 2023. Ginapp et al. The lived experiences of adults with ADHD. PLoS One. doi.org/10.1371/journal.pone.0292721

Glans 2021. Glans et al. Generalised joint hypermobility in adults with ADHD. J Psychiatr Res. doi.org/10.1016/j.jpsychires.2021.07.006

Glans 2022. Glans et al. Joint hypermobility in autistic adults. Front Psychiatry. doi.org/10.3389/fpsyt.2021.803334

Hartman 2023. Hartman et al. Psychiatric comorbidity in adult ADHD: meta-analysis of large datasets. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2023.105209

Ho 2014. Ho et al. Internet addiction and psychiatric comorbidity: meta-analysis. BMC Psychiatry. doi.org/10.1186/1471-244X-14-183

Huntjens 2023. Huntjens et al. Suicidal ideation and behaviour in autism: meta-analysis. Crisis. doi.org/10.1027/0227-5910/a000922

Inal-Kaleli 2024. Inal-Kaleli et al. Autism in anorexia nervosa: meta-analysis. Int J Eat Disord. doi.org/10.1002/eat.24307

Jiang 2016. Jiang et al. Maternal infection during pregnancy and autism: meta-analysis. Brain Behav Immun. doi.org/10.1016/j.bbi.2016.06.005

Justice and de Wit 1999. Justice, de Wit H. Acute effects of d-amphetamine during the menstrual cycle. Psychopharmacology. doi.org/10.1007/s002130051033

Kalb 2022. Kalb et al. ADOS-2 measurement invariance by race and ethnicity. JAMA Netw Open. doi.org/10.1001/jamanetworkopen.2022.9498

Kinnaird 2019. Kinnaird et al. Alexithymia in autism: meta-analysis. Eur Psychiatry. doi.org/10.1016/j.eurpsy.2018.09.004

Koncz 2023. Koncz et al. ADHD and gaming disorder: meta-analysis. Clin Psychol Rev. doi.org/10.1016/j.cpr.2023.102343

Kuja-Halkola 2018. Kuja-Halkola et al. Codevelopment of ADHD and borderline personality disorder. Mol Psychiatry. doi.org/10.1038/s41380-018-0248-5

Lai 2019. Lai et al. Prevalence of co-occurring mental health diagnoses in autism: meta-analysis. Lancet Psychiatry. doi.org/10.1016/S2215-0366(19)30289-5

Lee 2011. Lee et al. Childhood ADHD and later substance use: meta-analysis. Clin Psychol Rev. doi.org/10.1016/j.cpr.2011.01.006

Liu 2020. Liu et al. ADHD medication and suicidal behaviour: meta-analysis. Pharmacoepidemiol Drug Saf. doi.org/10.1002/pds.5110

Loomes 2017. Loomes et al. The male-to-female ratio in autism: meta-analysis. J Am Acad Child Adolesc Psychiatry. doi.org/10.1016/j.jaac.2017.03.013

Lukmanji 2019. Lukmanji et al. Epilepsy in autism: systematic review. Epilepsy Behav. doi.org/10.1016/j.yebeh.2019.07.037

May 2021. May et al. Autism and borderline personality disorder: meta-analysis. Autism Research. doi.org/10.1002/aur.2619

McCabe 2025. McCabe et al. ADHD symptoms and e-cigarette initiation. JAMA Netw Open. doi.org/10.1001/jamanetworkopen.2024.58834

McElhanon 2014. McElhanon et al. Gastrointestinal symptoms in autism: meta-analysis. Pediatrics. doi.org/10.1542/peds.2013-3995

Migueis 2023. Migueis et al. Restless legs syndrome and ADHD: systematic review. Sleep Med Rev. doi.org/10.1016/j.smrv.2023.101770

Misiak 2022. Misiak et al. Inflammatory markers in ADHD: meta-analysis. Prog Neuropsychopharmacol Biol Psychiatry. doi.org/10.1016/j.pnpbp.2022.110581

Morgan 2013. Morgan et al. Racial and ethnic disparities in ADHD diagnosis. Pediatrics. doi.org/10.1542/peds.2012-2390

Muris 2025. Muris et al. Autism and problematic internet use: meta-analysis. Clin Child Fam Psychol Rev. doi.org/10.1007/s10567-025-00524-8

Nazar 2016. Nazar et al. ADHD and eating disorders: meta-analysis. Int J Eat Disord. doi.org/10.1002/eat.22643

Nielsen 2017. Nielsen et al. ADHD and autoimmune diseases. J Am Acad Child Adolesc Psychiatry. doi.org/10.1016/j.jaac.2016.12.010

Nigg 2012. Nigg et al. Restriction diets and artificial food colours in ADHD: meta-analysis. J Am Acad Child Adolesc Psychiatry. doi.org/10.1016/j.jaac.2011.10.015

O'Nions 2025. O'Nions et al. Life expectancy and years of life lost in UK adults with diagnosed ADHD. Br J Psychiatry. doi.org/10.1192/bjp.2024.199

Owens 2017. Owens, Hinshaw SP. Unplanned pregnancy in women with childhood ADHD. J Consult Clin Psychol. doi.org/10.1037/ccp0000217

Pettinger 2025. Pettinger et al. Neurodevelopmental diagnoses in Born in Bradford. Dev Med Child Neurol. doi.org/10.1111/dmcn.16396

Roberts 2017. Roberts et al. Ovarian hormones and ADHD symptoms across the cycle. Psychoneuroendocrinology. doi.org/10.1016/j.psyneuen.2017.11.015

Roman-Urrestarazu 2021. Roman-Urrestarazu et al. Race, ethnicity, social disadvantage and autism in English schools. JAMA Pediatrics. doi.org/10.1001/jamapediatrics.2021.0054

Ruiz-Goikoetxea 2018. Ruiz-Goikoetxea et al. ADHD, injuries and the effect of medication: meta-analysis. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2017.11.007

Salem 2018. Salem et al. ADHD and migraine: meta-analysis. Eur Child Adolesc Psychiatry. doi.org/10.1007/s00787-017-1045-4

Sammels 2022. Sammels et al. Autism and obesity in children: meta-analysis. Obesity Facts. doi.org/10.1159/000523943

Santomauro 2024. Santomauro et al. Suicide mortality in autism: meta-analysis. Psychiatry Res. doi.org/10.1016/j.psychres.2024.116150

Schans 2017. Schans et al. ADHD and atopic diseases: meta-analysis. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2017.01.011

Schiweck 2021. Schiweck et al. Comorbidity of ADHD and bipolar disorder: meta-analysis. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2021.01.017

Sedky 2014. Sedky et al. ADHD and sleep-disordered breathing: meta-analysis. Sleep Med Rev. doi.org/10.1016/j.smrv.2013.12.003

Septier 2019. Septier et al. ADHD and suicidal behaviour: meta-analysis. Neurosci Biobehav Rev. doi.org/10.1016/j.neubiorev.2019.05.022

Shaw 2014. Shaw et al. Emotion dysregulation in ADHD. Am J Psychiatry. doi.org/10.1176/appi.ajp.2013.13070966

Sibley 2018. Sibley et al. Late-onset ADHD reconsidered with comprehensive repeated assessments between ages 10 and 25. Am J Psychiatry. doi.org/10.1176/appi.ajp.2017.17030298

Skoglund 2019. Skoglund et al. ADHD and teenage motherhood. JAMA Netw Open. doi.org/10.1001/jamanetworkopen.2019.12463

Skoglund 2023. Skoglund et al. Sex differences in age at ADHD diagnosis. J Child Psychol Psychiatry. doi.org/10.1111/jcpp.13920

Theule 2019. Theule et al. ADHD and gambling: meta-analysis. J Atten Disord. doi.org/10.1177/1087054715626512

Tseng 2018. Tseng et al. Iron status in ADHD: meta-analysis. Scientific Reports. doi.org/10.1038/s41598-017-19096-x

van Emmerik-van Oortmerssen 2012. van Emmerik-van Oortmerssen K et al. ADHD in substance use disorder populations: meta-analysis. Drug Alcohol Depend. doi.org/10.1016/j.drugalcdep.2011.12.007

Van Veen 2010. Van Veen et al. Delayed circadian rhythm in adults with ADHD and chronic sleep-onset insomnia. Biol Psychiatry. doi.org/10.1016/j.biopsych.2009.12.032

Wang 2017. Wang et al. Iron status in ADHD: meta-analysis. PLoS One. doi.org/10.1371/journal.pone.0169145

Warburton 2026. Warburton et al. ADHD diagnosis by ethnicity in linked Bradford school and primary care records. Arch Dis Child. doi.org/10.1136/archdischild-2025-329285

Warrier 2020. Warrier et al. Elevated rates of autism in transgender and gender-diverse individuals. Nature Communications. doi.org/10.1038/s41467-020-17794-1

Weiner 2019. Weiner et al. ADHD and borderline personality disorder in adults. Neuropsychiatr Dis Treat. doi.org/10.2147/NDT.S192871

Willcutt 2012. Willcutt EG. The prevalence of DSM-IV ADHD: meta-analytic review. Neurotherapeutics. doi.org/10.1007/s13311-012-0135-8

Wolraich 1995. Wolraich et al. The effect of sugar on behaviour or cognition in children: meta-analysis. JAMA. doi.org/10.1001/jama.1995.03530200053037

Wynchank 2025. Wynchank et al. Female sex hormones and ADHD: narrative review. J Clin Med. doi.org/10.3390/jcm15010121

Xu 2018. Xu et al. Food, respiratory and skin allergies in children with autism. JAMA Netw Open. doi.org/10.1001/jamanetworkopen.2018.0279

Young 2020. Young et al. Females with ADHD: expert consensus statement. BMC Psychiatry. doi.org/10.1186/s12888-020-02707-9

Zhu 2026. Zhu et al. Exercise interventions for ADHD: umbrella review. Psychiatry Res. doi.org/10.1016/j.psychres.2026.117267

Sanctum Healthcare · Manchester | London | Cheshire