



GP Webinar

ADHD and Autism: The Overlap

26th February, 2026

Introduction and welcome with:

Dr Jo Farrow
Medical Director
Psychiatry UK

Meeting Guidance

To help everyone get the most out of the session:

- **We have muted your microphone** to reduce background noise.
- **Please use the chat function** to ask questions or share reflections during the session.
- **Be respectful and considerate** of all participants and speakers.
- **Avoid sharing patient-identifiable information** during discussions.
- **Let us** know if you experience technical issues by posting in the chat.



Further Information and Resources

- A recording of today's webinar and a copy of the presentation slides will be available on our website:

Right to Choose for GPs: [Right To Choose \(For GPs\) | Psych-UK Limited.](#)

- The materials will also be shared in the **Summer 2026 edition of our quarterly GP newsletter.**

- If you would like to be added to our mailing list, please contact:

[sherif.al-marayati@psychiatry-uk.com.](mailto:sherif.al-marayati@psychiatry-uk.com)



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Speakers:



Dr Rachna Rajput – Consultant Psychiatrist
Deputy Clinical Lead Autism Service

Dr Daniel Berkeley - GP
Physical Health Clinical Lead

Anna Matty
Chief Commercial and Operating Officer

Beverley Nolker
Education, Advocacy & Empowerment Manager



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ADHD & Autism: The Overlap

Dr Rachna Rajput – Consultant Psychiatrist

Deputy Clinical Lead Autism Service



Session overview:

Understand the presentation of the co-occurrence of these two conditions.

Why it is relevant to GP's?

Common co-morbidities.

Risks associated.

Functional and physical health impact.

Why are we talking about Autism and ADHD (AuDHD) now?



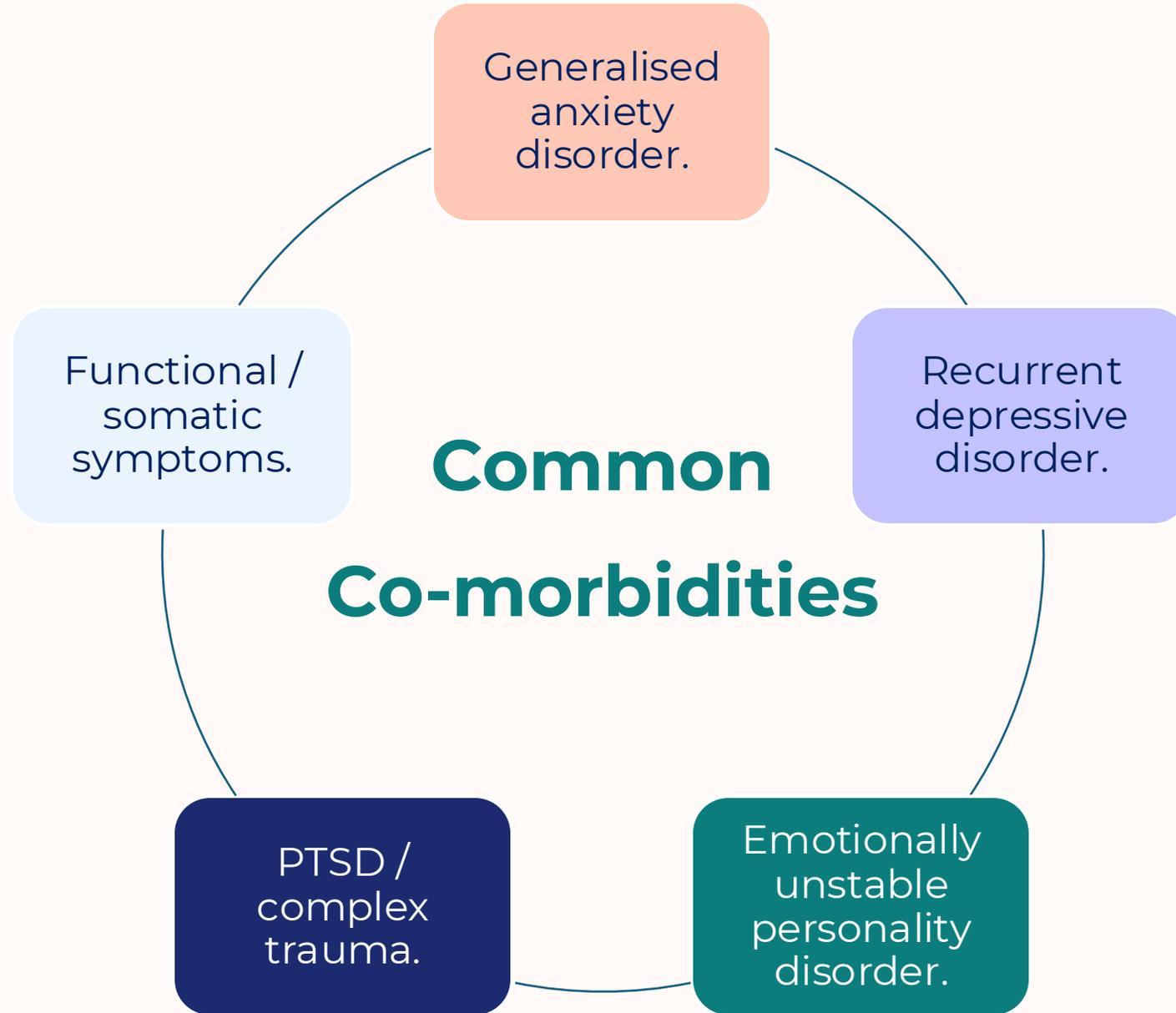
- Both conditions could not be diagnosed until 2013.
- Established guidance on identification and treatment of ADHD and autism as independent conditions.
- Awareness and understanding of both conditions when they **co-occur** is less established.



AuDHD: why is it important?



- Frequent attenders.
- Under recognised and/or missed.
- High rates of mental health comorbidity.
- Significant impacts on functioning.
- Often underestimated in risk assessments.
- This session is about **patterns** not necessarily criteria.
- GP's to mainly to recognise, validate and refer on.



Risks associated with unrecognised Autism and ADHD



Self harm and suicidality.

Substance use disorders—alcohol, cannabis.

Gambling addictions.

Gaming addictions.

Internet/pornography addictions.

Compulsive spending.

These are often mis-labelled as poor choices rather than regulation attempts.

What might it look like in general practice?



Have tried multiple SSRI's

Usually cause a lot of side effects.



Partial or poor response to standard treatments.



Repeated sick notes

High rates of anxiety, depression, burnout and exhaustion.



Workplace crisis

Red flags- warranting referral



Strong family history of autism/ADHD.

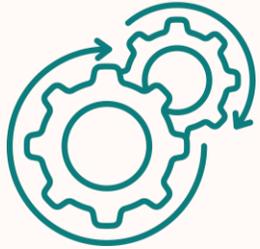
History of lifelong difficulties.

Multiple partial diagnoses.

Periods of over performance followed by collapse.



What strengthens referrals?



Functional impact information.



Childhood history.



Co-morbid mental health conditions.



Screening questionnaire like the AQ10.



Family neurodiversity.



Clinical information from mental health team - last clinic or discharge letter.

Contradictory behaviour in autism and ADHD



Craves routine,

Autism

but cannot maintain it

ADHD

Highly sociable,

ADHD

yet socially exhausted

Autism

Avoids change,

Autism

but seeks stimulation

ADHD

Examples:



Wants an organised workplace but repeatedly creates clutter due to executive dysfunction.



Appears outgoing and talkative, at an event, then crashes for days afterwards.

Core clinical features of AuDHD

Attention regulation: fluctuating extremes.



Clinical feature:

Alternation between **distractibility** and **intense hyperfocus**.

Difficulty regulating attention **voluntarily**.

Example:

I can't do day-to-day chores but I can work, uninterrupted, for eight hours in my area of interest.

Clinical relevance:

Comes across as inconsistent.

Core clinical features of AuDHD

Executive dysfunction with a need for structure.



Clinical feature:

ADHD – difficulties with planning, initiation and working memory.

Autism – need for predictability and routine.

Example:

Patients feels calmer with routines but repeatedly fails to maintain them, leading to distress and self-criticism.

Clinical relevance:

High risk of burnout.

Core clinical features of AuDHD

Emotional dysregulation and sensory overload



Clinical feature:

Rapid emotional escalation (ADHD) combined with sensory hypersensitivity (ASD).

Example:

Emotional 'meltdowns' after noisy demanding environments.

Clinical relevance:

Frequently misdiagnosed as mood or personality disorder. SSRIs alone provide limited benefit.

Core clinical features of AuDHD

Social functioning: masking.



Clinical feature:

Autistic social-communication differences.
ADHD impulsivity or talkativeness → appears socially confident.

Example:

Patient appears articulate and engaging in consultations but reports severe exhaustion and shutdowns after social interactions.

Clinical relevance:

Leads to exhaustion, delayed diagnosis, especially in women. Professionals may underestimate burden.

Masking behaviours and Internalised symptoms



Anxiety.



Overwhelm.



Perfectionism.



Chronic self-blame.

Examples:

*Everyone else
seems to manage
normal life, but I
can't!*

*I am just not
coping!*

Long history of being labelled:

Sensitive!

Dramatic!

**Too
intense!**

Lazy!

Functional impact on physical health



IBS, migraines, chronic pain.

Sleep dysregulation.

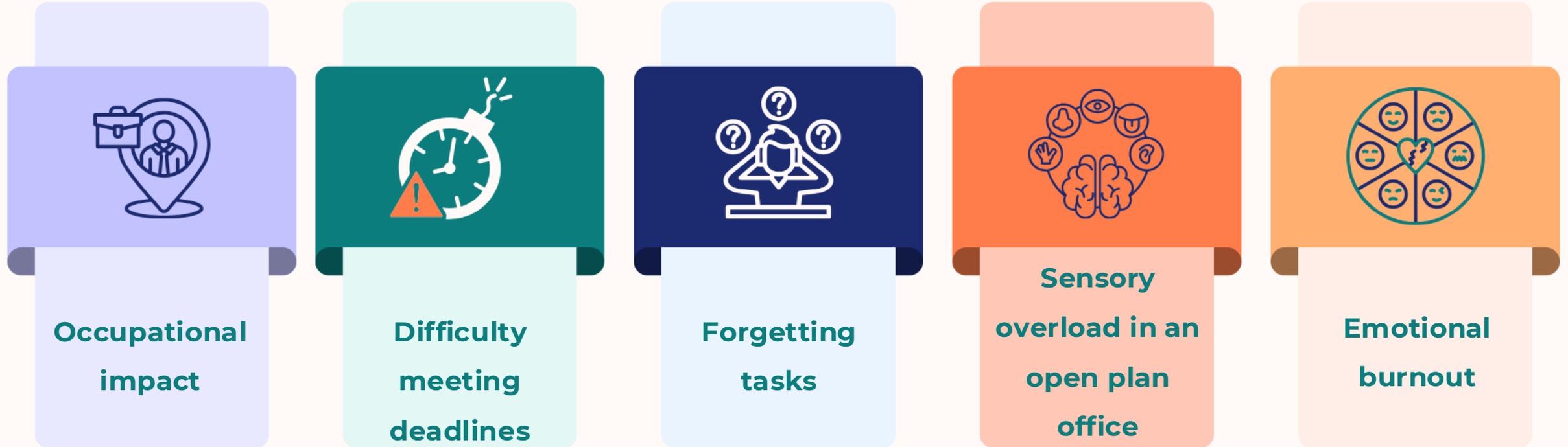
Poor interoception → delayed recognition of hunger, thirst, pain.

Somatization.

Examples:

Frequent presentations for stress-related physical symptoms.

Functional impact



Examples:

Needs multiple sick notes, labelled anxiety, or stress.

Excels in parts of job requiring creativity but fails repeatedly at admin or emails.

Diagnosis

Currently both autism and ADHD are assessed separately.



ADHD Assessment



Autism Assessment



Treatment of autism and ADHD



Education

Treatment currently involves education around both conditions and their co-occurring presentations.

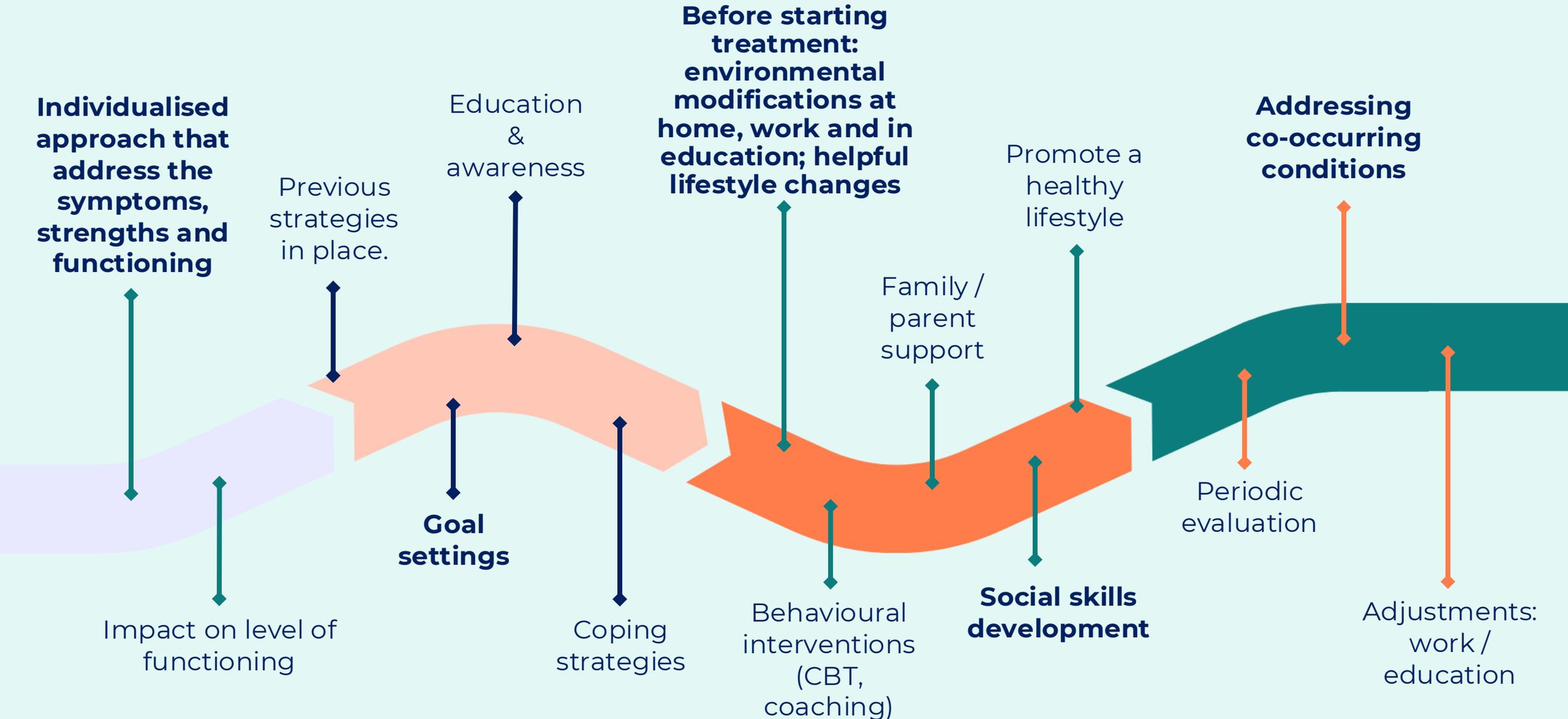
Diagnostic formulation

Includes protective, predisposing, precipitating and perpetuating factors.

Management

- Nuanced
- Multi agency approach works best.

Post-diagnosis care principles



ADHD Medications



Stimulants

Methylphenidate

Amphetamines

Action:

Increase the levels of neurotransmitters dopamine and norepinephrine in the brain.

Short acting & Long acting.

Side-effects:

Insomnia, appetite suppression, increased heart rate and BP anxiety, irritability, psychosis, headaches.

Non-stimulants

Atomoxetine (SNRI)

Guanfacine (alpha 2 adrenergic agonist.)

Clonidine (alpha-agonist.)

Take weeks for the effects.

Effective as alternatives for individuals who do not respond well to stimulants or have undesirable side-effects or addictions.





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Physical Health Considerations when treating ADHD

Dr Daniel Berkeley GP

Physical Health Clinical Lead



ADHD medications and physical safety



Safety

Our medicines are generally very safe and most people can take them.

They do however require careful monitoring during titration.



Heart

Our medicines are pro-arrhythmic and increase cardiac strain.

There are certain situations where using them is not safe.



Information

At Psychiatry UK we assess each patient's physical safety for titration.

To do this we may ask you for information about your patient to help us make a safe decision.

How do we assess this?



Physical
Health
questionnaires



Questions
during their
assessment.



Self submitted
BP, heart rate
and weight.



Questionnaires
about alcohol and
drug use.



Request a
medical
summary from
yourselves.



Sometimes
asking for more
information
from yourselves
such as
specialist letters.

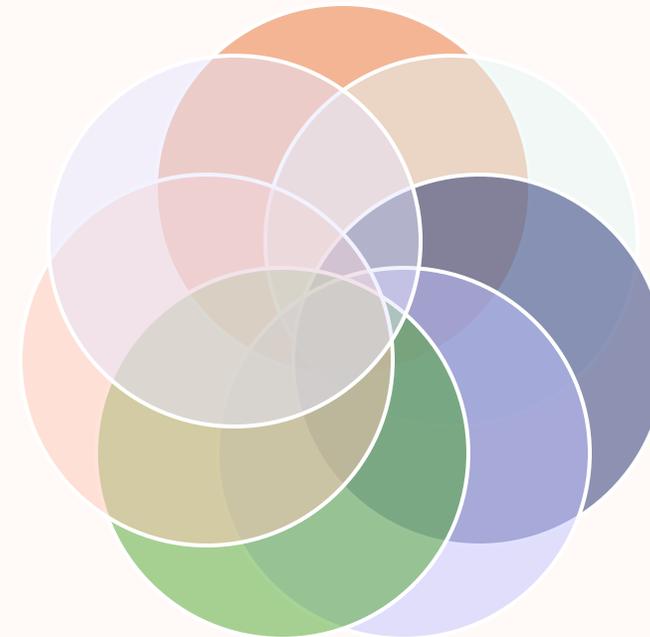


Requesting
ECGs when
recommended
by NICE
guidelines.



Some arrhythmias

- AF, untreated Wolf Parkinson White, VT
- Unless had successful ablation



Untreated Closed Angle Glaucoma

Heart Failure

Ischaemic stroke

NSTEMI/STEMI

HOCM

Significant ischaemic heart disease

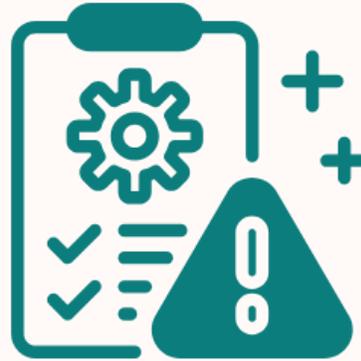
When is it not safe to go ahead?



Other factors that prevent safe treatment



Ongoing drug or alcohol dependence.



Heart rate on average over 100.



BMI under 18.5 (with some exceptions).



Blood pressure on average over 140/90.



High risk of serotonin syndrome.

People on more than two drugs with that risk.



In summary...



Most people can safely take our medicines.

We assess safety carefully, before and during titration.

We may sometimes ask you for more information to help us make safe decisions – thank you for helping us with this.

We may sometimes have to discharge a patient if we cannot treat them safely – we only do this if we feel the risks of treatment are significant.



Making a referral to PUK

Anna Matty

Chief Commercial and Operating Officer



Thank you – any questions?

