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Q4 2026
OCT – DEC
EDITION

QUARTERLY

The Clinical & Neurodevelopmental Review

HEADLINE NEWS

959,662 POTENTIAL ADHD ASSESSMENT REFERRALS IN ENGLAND

NHS data reveals an unprecedented backlog, with referrals up 46.7% in a year and waiting times continuing to lengthen.

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Published by NeuroHaven
neurohaven.co.uk

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NEWS / ANALYSIS

959,662

The scale of England's ADHD assessment backlog



REPORT

Almost one million potential ADHD assessment referrals were open across England in June 2026, according to NHS figures released in August. Behind that extraordinary total are people who have already waited months or years to understand why everyday life can feel so difficult. For some, a diagnosis may eventually bring treatment; for others, the immediate need is simply to be heard and supported.

One figure cannot capture the different stories hidden inside this queue. Some people are trying to finish school; others are managing jobs, households and relationships while waiting for answers. The people behind the records include teenagers approaching exams, parents juggling shifts and childcare, and adults finally seeking an explanation for years of exhausting effort. Different lives, but the same question: when will help arrive?

The latest NHS England returns put the upper estimate at 959,662 open referrals across mental health and community services. The pressure reaches far beyond specialist clinics: GPs manage repeat appointments, families search for answers, and workplaces and schools try to offer help while formal assessments remain out of reach. The waiting list exposes how difficult it can be to get specialist care when demand outruns capacity.

An overdue assessment can carry a quiet cost. Someone may postpone a course, avoid applying for promotion or return repeatedly to their GP because they cannot work out why concentration and everyday organisation remain so difficult. Others may need urgent help with anxiety, low mood or sleep long before an ADHD appointment. Those needs do not disappear simply because a diagnostic pathway is busy.

THE NHS FIGURES

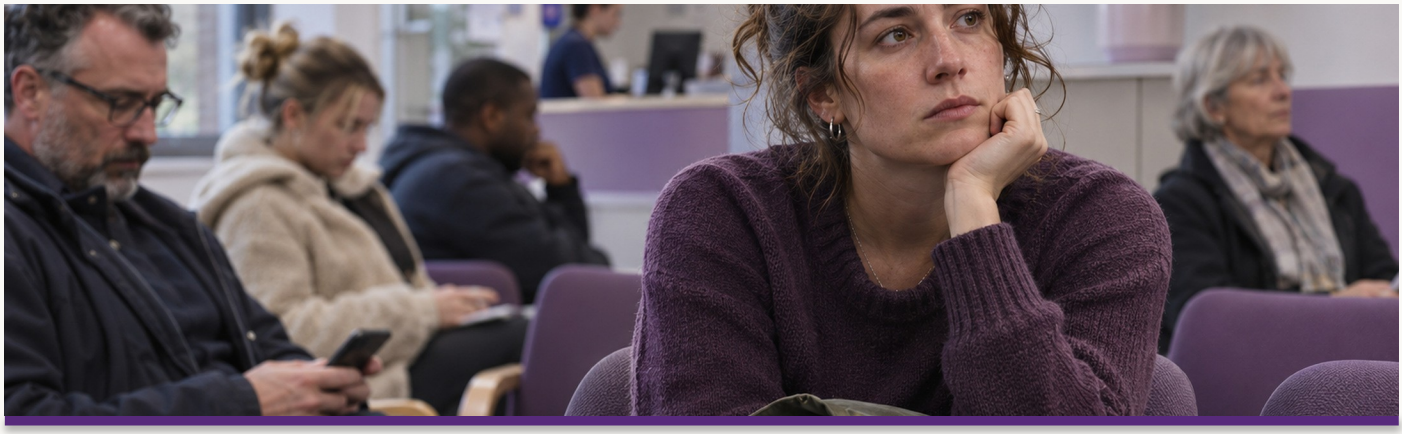
The estimate combines open referrals reported in mental health and community services. It is not a census of individual patients.

SOURCES NHS England ADHD Management Information, 27 Aug 2026

NEWS / ANALYSIS

Where England's ADHD referrals are recorded

The NHS records 780,430 open referrals in mental health services and up to 179,232 in community care.



REPORT

NHS England's August release counted 780,430 potential ADHD assessment referrals in mental health services in June 2026, plus as many as 179,232 in community health returns. Put together, they make the widely reported figure of 959,662. The figures reveal the scale of the pressure on assessment services and why appointment dates remain difficult to secure.

Mental health services account for more than four-fifths of the combined figure. The smaller community-services component matters because ADHD pathways differ around England, and referrals are not held in one uniform system. Some patients enter specialist mental health teams; others are recorded in community settings. Those local differences help explain why waiting times vary so widely around the country.

The numbers require some care. These are administrative records of open referrals, not a verified count of 959,662 different people. Some pathways may overlap, and being on an open referral list does not necessarily mean having had no contact with a service. None of that makes the backlog unimportant. It simply means the figure should be reported as an estimate of referral activity rather than a precise population count.

The figures also say little about what happens after people reach the front. Some referrals close following assessment; others may close for administrative reasons or because the patient moves, chooses another provider or cannot be contacted. When counting changes over time, reporting practices and the arrival of new providers can alter the totals. Waiting lists therefore need to be read alongside clinical outcomes, appointment capacity and patient experience.

TWO REPORTING STREAMS

780,430 mental health referrals, plus up to 179,232 community health referrals. Both figures relate to June 2026.

SOURCES NHS England ADHD Management Information, 27 Aug 2026

NEWS / ANALYSIS

New ADHD referrals rose sharply in a year

Another 37,105 potential referrals entered mental health services in June alone.



REPORT

The queue is still growing. In June 2026, mental health services recorded up to 37,105 new potential ADHD assessment referrals—46.7% more than in the same month a year earlier. Every referral brings work beyond the initial appointment: gathering childhood history, considering other explanations for symptoms, discussing support and, when appropriate, planning medication and follow-up.

One particularly important part of this story is the growing recognition of ADHD in women. For decades many girls were described as anxious, dreamy, conscientious or simply overwhelmed rather than recognised as having a neurodevelopmental condition. As awareness has improved, women who managed to conceal their difficulties through school and early adult life have started coming forward, sometimes for the first time in their forties or fifties.

Why are more people coming forward? Greater awareness almost certainly plays a part, alongside changes in referral routes and data recording. Many adults are seeking help for difficulties they have lived with for decades. A rise in referrals is not the same as a sudden rise in the number of people with ADHD. Services must plan for new referrals as well as the hundreds of thousands already awaiting assessment.

There is evidence of that shift in the diagnostic records. NHS-linked OpenSAFELY analysis found that recorded ADHD diagnoses rose from 0.2% to 0.9% among females between 2016/17 and 2024/25; the corresponding figures in males rose from 0.7% to 1.6%. Greater Manchester research also reported particularly rapid post-pandemic increases among girls and young women. These studies do not tell us how many new referrals come from women. They do show that a population often missed in childhood is now being recognised far more often.

REFERRALS ARE STILL RISING

June 2026: up to 37,105 new potential referrals, 46.7% above June 2025. More people are entering a system already under strain.

SOURCES NHS England ADHD Management Information, 27 Aug 2026; NHS England OpenSAFELY ADHD analysis, Dec 2025; Fonagy interim report, Jun 2026

NEWS / ANALYSIS

A diagnosis is only the beginning

For many patients, assessment is followed by another wait for treatment and follow-up.



REPORT

A referral is only the first step. Before a diagnosis, services may need school records, family accounts, clinical interviews and a careful look at sleep, anxiety, mood or other possible causes of the difficulties. Afterwards, some patients need medication initiation, regular reviews and a clear plan for longer-term prescribing. Expanding assessment appointments without adding capacity elsewhere can simply move people from one waiting list to another.

Medication care is particularly easy to underestimate. Before prescribing, clinicians need to review physical health, current medicines, blood pressure, pulse and relevant risks. Finding the right dose may involve several appointments, discussion of adverse effects and adjustments that fit a person's working day. Even patients who find medication helpful may have a further wait before a stable repeat-prescription arrangement is agreed.

People should not have to wait for the end of that process to receive all forms of help. Someone struggling with depression, substance use, insomnia or an urgent safety concern may need treatment immediately, regardless of whether ADHD has been assessed. Assessment statistics tell only part of the story. Timely treatment, monitoring and continuity of care matter just as much.

The assumption that a GP will automatically take over prescribing can cause trouble. Shared-care arrangements are voluntary and local policies differ; some practices are unable or unwilling to accept them. Patients need honest information about costs, follow-up and who remains clinically responsible if shared care is declined. Assessment services that plan only as far as the diagnostic report leave an important part of care unresolved.

CARE AFTER DIAGNOSIS

Titration, monitoring and repeat prescribing require capacity of their own. Assessment is only one part of a treatment pathway.

SOURCES NHS England methodology; PHSO ADHD/autism report, Sep 2026

NEWS / ANALYSIS

Fonagy review calls for help before diagnosis

Support based on need, with access to specialist assessment when clinically necessary.



REPORT

Professor Peter Fonagy's independent review, published in October 2026, addressed rising mental distress and the pressures facing ADHD and autism services. Its central proposal was described as "needs-led plus diagnosis": offer useful help for real-world difficulties earlier, while keeping specialist assessment available where it is needed. A pupil who struggles to organise work, for example, should not necessarily have to wait years for reasonable adjustments.

The review arrives amid a genuine public argument. Some people worry that diagnostic labels have become too central to everyday support, while others fear that removing the requirement for diagnosis could make access to specialist care less secure. Parents describe years spent collecting evidence; adults describe jobs and relationships strained while they wait. Both groups have reason to ask what practical support can be offered now, rather than in two years' time.

Specialist diagnosis remains essential in many cases. A diagnosis may be essential for treatment decisions, understanding complex presentations and ensuring access to appropriate medication. The review does not make specialist assessment obsolete. Instead, it asks whether schools, employers and community services could do more before a person reaches the front of a diagnostic queue.

Needs-led approaches could start with simple things: reliable school adjustments, structured help at college, accessible workplace guidance and psychological support for distress. But those measures require staff, money and follow-through. If schools and community teams are asked to do more without extra staff or funding, the promise of earlier help may remain just that. The measure of reform should be what changes for the person asking for help.

A NEEDS-LED APPROACH

Schools, employers and community teams could offer earlier help while specialist assessment and treatment remain available.

SOURCES DHSC Independent Review into Mental Health Conditions, ADHD and Autism, 9 Oct 2026

NEWS / ANALYSIS

Support without a diagnosis: promise and risk

Practical support could begin sooner; specialist diagnosis must remain accessible.



REPORT

For someone losing sleep, missing deadlines or becoming overwhelmed by everyday demands, the chance to receive help without another year of waiting is welcome. Needs-led services might offer organisational strategies, sensory adjustments, mental health support or school accommodations based on difficulties already evident. They could also make it easier to prioritise people whose problems are most disabling.

Consider a school pupil whose concentration repeatedly collapses in a noisy classroom. A quieter workspace, shorter instructions or help planning assignments may be useful regardless of the eventual diagnostic outcome. An adult employee with similar difficulties might benefit from more predictable deadlines and written summaries of meetings. Support based on clearly described needs can be practical, inexpensive and immediate.

There is a legitimate concern that early support might eventually be used to ration specialist assessment. Generic advice cannot replace a proper evaluation when ADHD, autism or another condition needs specialist consideration. Clear routes back into assessment, transparent eligibility decisions and access to medication where indicated will matter as much as the policy itself.

There are limits to how far that approach can go. Persistent childhood-onset difficulties across different settings still deserve a proper assessment, particularly where medication is being considered or other psychiatric problems might be present. If a needs-led pathway has no transparent route to a specialist, people may find themselves receiving generic advice indefinitely. The pathway needs both: useful help now and timely specialist care when it is needed.

ACCESS IS THE TEST

Earlier adjustments are valuable only if people who need specialist assessment can still reach it.

SOURCES DHSC Fonagy review and government response, Oct 2026

NEWS / ANALYSIS

Private ADHD assessments face new scrutiny

Government plans could bring more independent diagnostic services within CQC regulation.



REPORT

Alongside the Fonagy review, ministers signalled plans to bring all ADHD and autism diagnostic assessments into the scope of CQC-regulated activities. For independent clinics, including online providers, this could eventually change oversight and registration requirements. The announcement did not itself change the law: the detailed rules and implementation timetable still need to be set.

For patients, the difference between a lengthy report and a good diagnostic assessment is not the number of pages. A sound evaluation explains the history, how symptoms manifest today, whether the pattern began in childhood, why it causes impairment and which other possibilities were considered. It should be possible for another clinician to understand the reasoning and the plan for treatment.

Good assessments already require careful work: a developmental history, evidence that difficulties occur in more than one setting, assessment of everyday impact and attention to other explanations. Prescribing adds another layer of responsibility, from cardiovascular checks to reviews and safe handovers. Regulation may strengthen accountability, but its value will depend on how well it protects clinical standards without unnecessarily delaying access.

Independent providers vary greatly in size and structure, from single clinicians to national services handling thousands of referrals. A uniform regulatory framework may help clarify minimum expectations and routes for complaints, but details will matter: who must register, which activities fall within scope, and how existing CQC requirements interact with any new rules. These are questions for implementation, rather than settled facts as of this issue.

REGULATION UNDER CONSIDERATION

The government has proposed broader CQC oversight. The legal details and implementation dates have not yet been set.

SOURCES DHSC government response to Fonagy review, 9 Oct 2026

NEWS / ANALYSIS

When the ADHD pathway falls between services

An Ombudsman investigation describes the human cost of fragmented care.



REPORT

The Parliamentary and Health Service Ombudsman reviewed around 3,000 ADHD and autism complaints collected over six years, and examined 95 recent cases in depth. Its September report described uncertainty about referrals, unequal access between areas and confusion over who should take responsibility when NHS and independent services are involved. These problems are familiar to anyone who has tried to navigate assessment, diagnosis and ongoing care through different organisations.

The complaints show how easily responsibility becomes blurred. One service may complete an assessment, another may be asked to prescribe, and a third may be responsible for long-term monitoring. If they cannot agree on records, eligibility or shared care, the person seeking treatment is left to coordinate a system they do not control. The problem is not necessarily one bad appointment; it is the absence of an accountable pathway.

Choice is of limited value if a patient does not know who will prescribe after diagnosis, how follow-up will work or whether a new service will accept an existing assessment. Patients need to know which clinician or service is responsible at each stage. For patients, the experience of being repeatedly passed between teams can be as distressing as the original wait.

The Ombudsman's message reaches beyond ADHD. Autism assessments, mental health treatment and community support also suffer when commissioning arrangements are unclear. Patients should be able to find out who can refer them, what waiting times mean locally, whether an independent assessment will be accepted and whom to contact if the pathway breaks down. None of those questions should require detective work.

WHO IS RESPONSIBLE FOR CARE?

Assessment, prescribing and follow-up need named responsibilities, especially when patients move between NHS and independent providers.

SOURCES PHSO, Improving ADHD and Autism Services, Sep 2026

NEWS / ANALYSIS

£343 million for community mental health care

England plans 159 facilities; staffing and opening dates will determine their impact.



REPORT

In August, the government announced £343 million for 159 mental health facilities in England, including 100 community mental health centres and 59 mental health emergency departments. The aim is to make help easier to reach and, where appropriate, give people an alternative to a busy hospital emergency department during a mental health crisis. Better local access could make a considerable difference to patients and their families.

The ambition is to move more care out of overstretched emergency departments and into places people can reach before a crisis escalates. A neighbourhood service might combine urgent assessment, follow-up, links with social care and closer contact with primary care. Done well, that can make mental healthcare feel less like a series of disconnected buildings and more like one service that knows the patient.

Buildings alone will not shorten waits. Its value depends on the clinicians available, the hours it opens, how quickly people can be seen and how well it works alongside existing crisis and community teams. The most telling results will be fewer delays, better continuity and people receiving treatment before problems become emergencies.

There is also a workforce question behind every building announcement. A centre needs experienced nurses, psychiatrists, psychologists, therapists, support workers and administrative staff—not just a door and a sign. Existing teams cannot be hollowed out to populate new premises without risking poorer care elsewhere. The success of the investment will become clear in waiting times, continuity of care and whether people feel safe getting help close to home.

WHAT THE FUNDING COVERS

The £343 million announcement includes 100 community mental health centres and 59 emergency facilities.

SOURCES DHSC £343m community mental health announcement, 5 Aug 2026

NEWS / ANALYSIS

Mental health support reaches more schools

Nearly 11,800 schools and colleges were covered by support teams in mid-2026.



REPORT

Mental health support has become available in more schools and colleges across England. Department for Education figures released in June 2026 showed mental health support teams working across almost 11,800 schools and colleges, covering around 5.8 million pupils and learners. These teams can support early difficulties, advise staff and help families work out when more specialist input may be needed.

School mental health teams can reach pupils who would never choose to approach a clinic. They can help with early anxiety and low mood, work with families and guide staff on creating a more supportive environment. Some children may find it easier to talk to someone they have seen around school than to attend an unfamiliar hospital appointment. That low threshold matters, especially for those whose difficulties have been hidden.

School-based support is not a replacement for specialist CAMHS or a full ADHD or autism assessment. Children with more complex conditions, severe anxiety, eating disorders or significant risks may require services that are already stretched. Families need straightforward explanations of what school teams can offer, what they cannot and how to obtain specialist help without starting the whole process again.

Yet schools are also where neurodevelopmental differences can be misread as laziness, defiance or poor motivation. Teachers need to recognise when behavioural problems may reflect ADHD, autism, sensory overload or unmet learning needs. The relationship between school teams, educational psychologists, CAMHS and specialist neurodevelopmental services will determine whether pupils are identified early—or merely passed from one waiting list to the next.

SUPPORT IN SCHOOLS

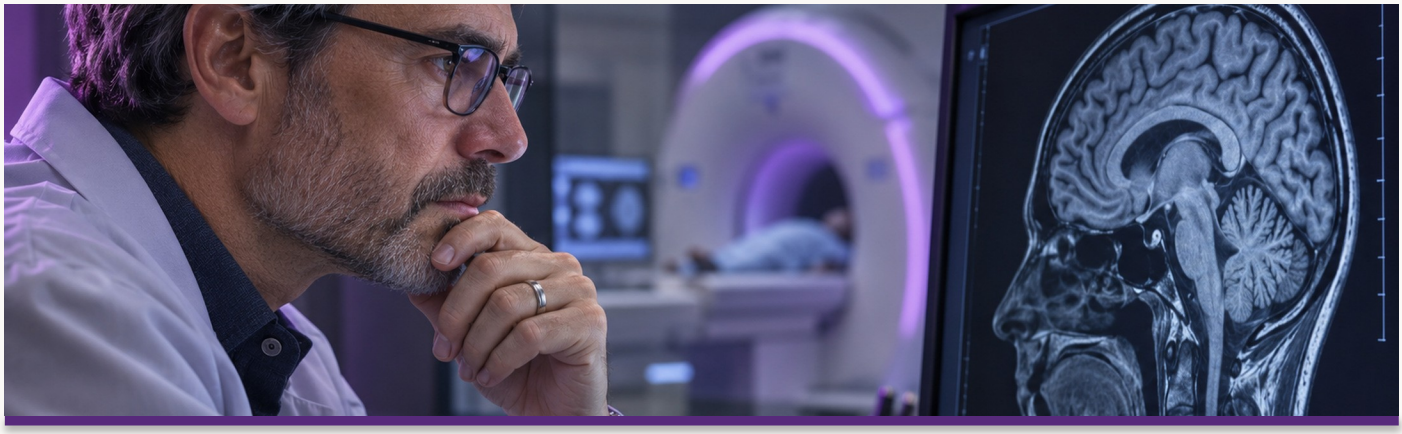
School teams can offer earlier help for common difficulties. More complex needs still require specialist services.

SOURCES DfE Mental Health Support Teams coverage statistics, Jun 2026

NEWS / ANALYSIS

Is the autism spectrum now too broad?

Professor Uta Frith has revived a debate about the usefulness of a single diagnostic label.



REPORT

Autism covers people with very different communication styles, sensory experiences, abilities and support needs. In August 2026, Professor Uta Frith argued that the spectrum has become so broad that some clinically important distinctions risk being lost. Her argument was not that autism is imaginary, but that a single term may tell us too little about the person sitting in front of the clinician.

The challenge reflects the success and difficulty of a broad spectrum concept. It helped clinicians move beyond narrow stereotypes and recognise people whose experiences were previously missed. At the same time, describing a person who needs round-the-clock support and a highly articulate adult living independently under the same label can obscure the practical differences that determine the care they need.

A careful assessment should make the individual picture clear: language, learning, daily living skills, social communication, sensory needs and mental health all matter. Two people can share the same diagnosis and need very different forms of support. The debate is likely to continue, but there is no reason to wait for a change in diagnostic terminology before making reports more personal and useful.

The discussion should not become a competition over who is 'really' autistic. Diagnostic reliability, communication, learning, adaptive functioning, mental health and context all need careful consideration. Better descriptions and meaningful subgroups might improve research as well as service planning. Detailed descriptions of functioning and support needs could improve both research and the allocation of services.

THE INDIVIDUAL PROFILE

Good assessment describes communication, daily living skills, sensory needs and mental health—not just the diagnostic label.

SOURCES Frith, Psychological Medicine, Aug 2026

NEWS / ANALYSIS

Centanafadine: a triple-reuptake ADHD treatment

US approval introduces a once-daily medicine acting on DAT, NET and SERT.



REPORT

The US Food and Drug Administration approved centanafadine, marketed as Simtriyo, in July 2026 for ADHD in adults and children aged six and over weighing at least 20 kg. Its pharmacology is unusual: it inhibits the transporters that take dopamine, noradrenaline and serotonin back into nerve cells. Blocking DAT, NET and SERT reduces reuptake and can prolong the presence of these neurotransmitters outside the cell.

In practical terms, reuptake inhibitors reduce the rate at which a neurotransmitter is cleared from the synaptic space. Dopamine is closely involved in reward, motivation and aspects of cognitive control; noradrenaline helps regulate alertness and attention; serotonin has a wider role in mood and many other functions. Centanafadine affects all three transporter systems, although its effects are not necessarily equal at each one.

That mechanism is scientifically interesting, but it does not tell us on its own how a medicine compares with familiar ADHD treatments. The FDA classifies centanafadine as a central nervous system stimulant. Clinicians will want to see how well it works in different groups of patients, how people tolerate it and whether it brings any meaningful advantage in daily life.

Its three-transporter mechanism differs from established ADHD medicines, but that alone tells clinicians little about comparative benefit. Clinicians need comparative trials, information about duration of benefit, adverse-effect rates and evidence across age groups and comorbid conditions. Its approval is a noteworthy step in ADHD pharmacology, not yet a reason to replace treatments that already have a substantial evidence base.

THREE TRANSPORTERS

The drug inhibits reuptake at dopamine (DAT), noradrenaline (NET) and serotonin (SERT) transporters.

SOURCES FDA Simtriyo prescribing information, July 2026

NEWS / ANALYSIS

Centanafadine: dosing, warnings and UK access

The FDA label sets out dosing and safety precautions; UK authorisation remains unconfirmed.



REPORT

Simtriyo is supplied as an extended-release capsule in 140 mg, 210 mg and 280 mg strengths. The US label starts adults at 210 mg once daily, with dosing adjusted according to response and tolerability up to 280 mg. The warnings deserve close attention: they include abuse, misuse and addiction, as well as suicidal thoughts and behaviour in children. Cardiovascular and psychiatric monitoring remain important, as with other treatments affecting these systems.

The US approval followed studies looking at symptom change against placebo, but real-life questions remain. Does the treatment provide coverage through school or a working day? How often do appetite, sleep or mood problems interfere with treatment? Are there patients who have not responded well to existing medicines who do better with this one? Those answers will have to come from clinical trials and experience after approval.

Adding serotonin reuptake inhibition does not automatically make a drug safer, nor does a novel mechanism turn it into a non-stimulant. An FDA approval also does not grant UK prescribing authorisation. As of the November 2026 cut-off for this edition, a matching UK approval was not established in our review.

Prescribing also takes place within national regulatory systems. UK clinicians cannot assume an American product is available through routine prescribing or that its US patient information replaces MHRA advice. If a UK submission is made, licensing, supply, local formulary decisions and clinical guidance will shape access. Until then, centanafadine remains a development to watch rather than an established option for UK patients.

UK PRESCRIBING STATUS

FDA-authorised in the United States; no corresponding UK authorisation confirmed at the editorial cut-off.

SOURCES FDA Simtriyo label, revised July 2026; DEA scheduling Oct 2026

NEWS / ANALYSIS

COMP360 psilocybin reaches US regulatory submission

Compass Pathways submitted an application for treatment-resistant depression in November.



REPORT

On 9 November 2026, Compass Pathways announced that it had completed its US application for COMP360, an investigational synthetic psilocybin treatment for treatment-resistant depression. The programme includes two positive phase III studies and more than 1,000 participants across its broader development work. The submission marks a shift from small, exploratory studies towards formal regulatory scrutiny.

Treatment-resistant depression can be devastating. People may have tried several antidepressants, psychological therapies and other interventions with little sustained relief. A treatment that produces meaningful improvement after a limited number of supervised sessions would therefore be important. The COMP360 programme is being watched closely because it has progressed beyond small exploratory trials into a larger clinical development pathway.

Regulators will now examine more than symptom scores. In psychedelic trials, people can often guess whether they have received active treatment, making expectations difficult to control. How long does benefit last? What psychological support is needed? Which patients should be excluded? And can specialist services offer treatment safely at scale? Those questions will shape whether promising trial results turn into useful care.

The clinical setting is central to the story. Psilocybin changes perception and emotional experience over several hours, so treatment requires appropriate preparation, monitoring and follow-up. Trial results cannot simply be translated into unsupervised use. Regulators will consider not only average symptom scores, but adverse events, eligibility, interactions with other medications and how services would manage patients who become distressed during treatment.

REGULATORY STATUS

The FDA application was submitted in November 2026. COMP360 remained investigational at publication.

SOURCES Compass Pathways COMP360 NDA announcement, 9 Nov 2026

NEWS / ANALYSIS

Beyond psilocybin: new treatments enter trials

LSD-derived and modified psilocin treatments are being studied for anxiety and depression.



REPORT

Psilocybin is not the only psychedelic-related treatment being studied. In 2026, late-stage announcements also drew attention to a lysergide-based treatment for generalised anxiety disorder and modified psilocin approaches to depression. The compounds differ in formulation, dosing and the clinical support provided during treatment. Comparing headline percentages across studies can give a misleading impression of which works best.

The newer compounds are also being developed with different treatment models. Some programmes focus on a single supervised dosing session; others explore use alongside antidepressants or structured psychological support. These details matter because the full intervention is not just a chemical molecule. The surrounding care, patient expectations and intensity of follow-up can affect the experience and may influence outcomes.

To judge the findings, researchers need to know how many people improved, how many entered remission, whether serious adverse events occurred, how durable benefits were and what other support patients received. Many announcements come from companies before independent scientists have examined the full results. Announcements can be encouraging, but conclusions depend on the full data and independent scrutiny.

There is a wider ethical issue too. Many people with severe depression or anxiety are understandably eager for alternatives after years of failed treatment. Reporting promising results is important, but so is protecting that hope from exaggeration. The responsible question is not which company produced the most dramatic headline, but what the complete data show about sustained functioning, safety and who is most likely to benefit.

READING THE TRIAL RESULTS

The meaningful comparisons are placebo-adjusted benefit, remission, adverse events and how long any improvement lasts.

SOURCES Late-stage sponsor trial releases, Sep–Nov 2026; UK psilocybin research

NEWS / ANALYSIS

Olanzapine, now in a once-monthly injection

A new US formulation could make long-term schizophrenia treatment easier for some.



REPORT

The FDA approved Weltruza, a once-monthly injection of olanzapine given under the skin, in October 2026. Its practical appeal is straightforward: fewer clinic visits for some patients and no routine post-injection observation or oral supplementation with this particular formulation. For people who find frequent appointments difficult, changes to how a medicine is delivered can matter enormously.

Long-acting medication is often described primarily in terms of adherence, but the human benefits can be broader. A person may have difficulty attending frequent appointments, remembering daily tablets or dealing with periods of worsening illness. Reducing the number of administrations can sometimes give back time and autonomy, particularly when the treatment is chosen collaboratively and side effects are acceptable.

The drug itself, however, is still olanzapine. Weight gain, changes in blood sugar and lipids, sedation and wider metabolic health remain important considerations. And approval in the US does not automatically mean availability in the UK. What matters clinically is whether the formulation improves adherence and quality of life compared with existing options.

The route of delivery also affects service planning. Nursing time, injection technique, refrigeration and follow-up arrangements can influence whether a new formulation is a genuine improvement in practice. A monthly injection is not necessarily the best option for every patient, and metabolic monitoring remains essential. Comparisons with established long-acting treatments will determine its practical place in care.

MONTHLY DOSING, FAMILIAR RISKS

Weltruza reduces injection frequency, but weight, glucose, lipids and sedation still need monitoring.

SOURCES FDA Weltruza approval and US prescribing material, Oct 2026

NEWS / ANALYSIS

Treating agitation at home: a new US option

Dexmedetomidine's expanded label raises questions about access and safety outside hospital.



REPORT

In November 2026, the FDA expanded approval for Igalmi, a sublingual dexmedetomidine film, to cover selected at-home treatment of agitation associated with schizophrenia, schizoaffective disorder and bipolar I or II disorder. For some patients, having a clear plan for managing an episode earlier could help avoid a frightening escalation to emergency care.

Agitation can be frightening for the person experiencing it and for their family. An early intervention that a patient has agreed with their treating team may help preserve dignity and avoid an unnecessary trip to hospital. This approach also reflects a wider move towards recognising that some episodes can be supported in the community, provided a reliable safety plan is already in place.

Home treatment is not appropriate in every situation. Dexmedetomidine can cause substantial sedation, low blood pressure and a slow heart rate. Patients and carers need advice on when it can be used, what to watch for and when urgent assessment is needed. The development is notable because it changes where care might take place—not because it removes the need for clinical judgement.

Its prescribing restrictions are important. Sedation can impair judgment and mobility, while hypotension and bradycardia create risks for people with cardiovascular problems or interacting medicines. Families should never be left to interpret serious deterioration alone. Clear instructions, follow-up and access to urgent assessment are part of the treatment, not optional extras attached to the prescription.

AT-HOME SAFETY

Dexmedetomidine can cause sedation, low blood pressure and bradycardia. Treatment requires patient selection and clear escalation plans.

SOURCES FDA Igalmi expanded indication, 16 Nov 2026

NEWS / ANALYSIS

Digital support shows promise for perinatal anxiety

The RELAX trial examined early psychological support during pregnancy and after birth.



REPORT

A study reported by King's College London in November 2026 tested a self-directed digital intervention for anxiety during pregnancy and after birth. Published in *JAMA Network Open*, the RELAX trial found lower anxiety scores than usual care, with improvements in related symptoms such as repetitive negative thinking. The findings add to evidence that structured psychological support can be delivered beyond traditional clinic appointments.

Pregnancy and early parenthood can bring enormous changes in sleep, relationships and daily routine. For someone already prone to anxiety, uncertainty about the pregnancy or caring for a newborn may add to a sense of being overwhelmed. A private, flexible programme that can be used from home offers a different way to reach people who cannot easily attend regular appointments.

Digital care also has limits. Some people struggle with internet access, language barriers or the time and energy needed to work through a programme. Others need more intensive help than a self-guided intervention can provide. The strongest services make it easy to move from early support to specialist treatment when symptoms become more severe.

The strength of a digital intervention lies partly in its ability to support early, rather than only after severe symptoms have developed. But it cannot tell the whole story about a person's wellbeing. Some participants will need a clinician, a medication review or help with difficult social circumstances. Research should therefore measure not just short-term symptom scores but who uses the programme, who drops out and whether benefits last beyond the first weeks after birth.

DIGITAL SUPPORT IN PRACTICE

Digital programmes can widen access to early help, provided patients can also reach face-to-face and specialist care.

SOURCES King's College London; RELAX study, JAMA Network Open, Nov 2026

NEWS / ANALYSIS

Mental healthcare in 2027: what needs to improve

Waiting times, treatment access and continuity will show whether reforms are working.



REPORT

England enters 2027 with large waiting lists and significant changes promised for services. Patients will judge progress by whether they can get appointments and remain in care. Reporting needs to capture more than referrals: how long people wait, what support they receive in the meantime and whether treatment follows assessment. The move towards needs-led care could be valuable if it improves access without making specialist services harder to reach.

Across the stories in this edition, a common problem emerges: new ideas are moving faster than the services that would have to deliver them. Better recognition of ADHD creates assessment demand; a move towards needs-led care creates expectations for schools and community teams; new medicines require prescribing skills, monitoring and clear explanations. Healthcare improves when these pieces work together.

At the same time, new medicines and therapeutic approaches are entering the conversation. Centanafadine, psychedelic compounds, longer-acting antipsychotics and treatment for agitation at home each involve different evidence, safety and access questions. Clinical use, follow-up studies and routine outcome data will eventually show which treatments deserve a lasting place in practice.

It is worth being ambitious, but equally worth asking ordinary questions. Can a patient speak to a named clinician? Can families understand why they are waiting? Are outcomes measured after treatment rather than only at the point of diagnosis? Those are less glamorous than a drug launch or funding announcement, yet they are the things that will decide whether the coming year feels different to the people using services.

MEASURES TO WATCH IN 2027

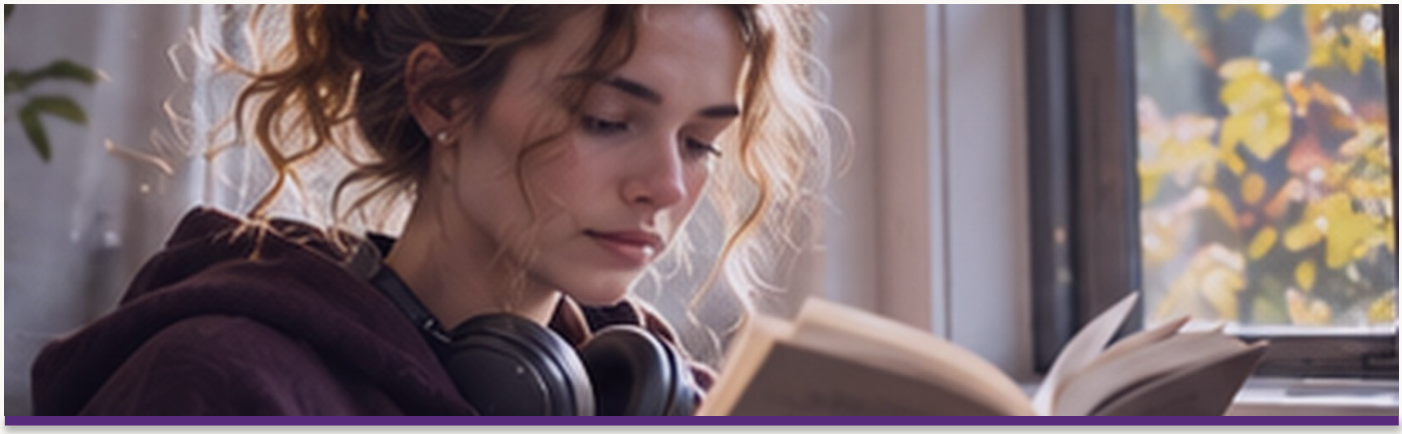
Assessment waits, access to medication and psychological care, continuity of prescribing, and outcomes reported by patients.

SOURCES NHS England; DHSC; PHSO; FDA; trial publications through 17 Nov 2026

FOCUSED ARTICLE · ADHD IN WOMEN

ADHD in women: the years spent being missed

How inattentive symptoms, hard work and masking can conceal ADHD for years



ADHD IN WOMEN / FEATURE

A girl can get excellent marks and still spend every evening in tears over homework. She may lose things, misjudge time, rehearse conversations and work twice as hard as her classmates simply to look organised. Because she is quiet, helpful or academically successful, nobody thinks to ask what school costs her behind the scenes. For years, the most obvious route to an ADHD assessment was disruptive behaviour. Girls who kept the disruption inside often passed unnoticed.

The same pattern can follow a woman into adult life. She might be praised for being conscientious while working late into the night to catch up. She may seem capable at work but struggle with bills, appointments, shopping or relationships at home. The symptoms are not necessarily different from those seen in men: attention, impulsivity, restlessness and emotional regulation matter in everyone. What differs is how those difficulties are noticed, explained and compensated for.

Finding out later in life can bring relief and grief in equal measure. A diagnosis may explain a lifetime of missed appointments, unfinished projects and exhausting attempts to keep up. At the same time, it can prompt questions about missed opportunities and years of self-criticism. Being diagnosed later can change how someone understands years of effort, setbacks and self-doubt.

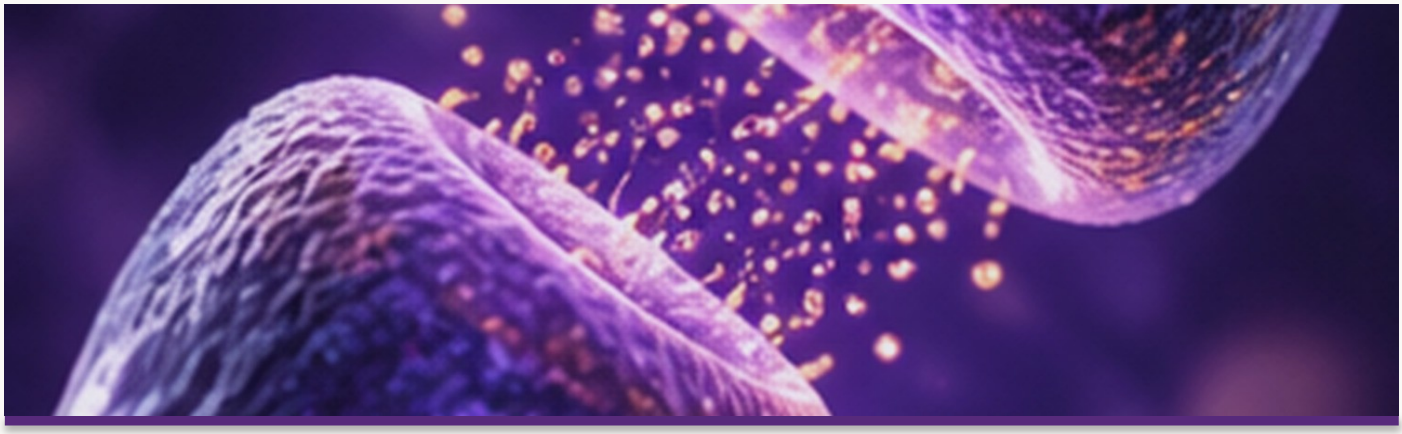
A good assessment looks backwards as well as at the present. Childhood reports, family memories, friendships, sleep, emotional responses and the hidden work behind good grades may all help. Clinicians also need to consider anxiety, mood disorders, autism, trauma and physical illness. The point is not to see ADHD everywhere, but not to miss it when someone has found ingenious ways to cope.

For families and partners, that understanding can change conversations. Forgetting a task can still be frustrating. But recognising difficulties with memory, starting tasks or judging time creates room for practical solutions rather than another argument about effort.

REFERENCES Littman, Dean, Wagenberg & Wasserstein (2021), doi:10.1521/adhd.2021.29.5.1

Oestrogen, dopamine and the female ADHD story

What is known about hormonal changes and why symptom patterns can shift



ADHD IN WOMEN

Some women describe weeks when managing ADHD seems almost straightforward—and others when their usual strategies suddenly stop working. Is it simply stress and sleep, or can changing hormones play a part? There is a biological basis for asking. Oestradiol influences brain systems involved in reward, working memory and cognitive control. Laboratory research shows that oestrogen can affect dopamine signalling, although the relationship varies with brain region, timing and existing dopamine activity. More oestrogen does not automatically mean more dopamine or better concentration.

In 2021, Ellen Littman, Jessica Moriah Dean, Benjamin Wagenberg and clinical neuropsychologist Jeanette Wasserstein drew attention to this question in *ADHD in Females Across the Lifespan and the Role of Estrogen*. Their paper brought together clinical observations and the biology of reproductive hormones. It helped give the topic serious attention, but it was not a clinical trial of hormone treatment for ADHD.

The evidence in people is still developing. A 2025 systematic review identified just 11 relevant studies of sex hormones and ADHD symptoms in females. Some suggested changes around puberty or the menstrual cycle, but the studies were small and used different methods. Surveys also show that many women notice a pattern—often finding symptoms more difficult in the days before menstruation—yet self-report cannot tell us how much is caused by hormone levels rather than poor sleep, pain, stress or changes in medication use.

The limitations of the evidence do not make women's experiences any less important. Asking someone to track sleep, mood, concentration and cycle timing over several months can reveal a pattern worth discussing. It may also show that something else is happening. Either way, women deserve a conversation based on their experiences, not an assumption that every symptom is hormonal.

For adolescents, the message is equally practical: a noticeable change around puberty or menstruation is worth raising, even when grades stay high.

REFERENCES Littman et al. (2021); ADHD and Sex Hormones in Females systematic review (2025), PMCID PMC12145478

Pregnancy, parenthood and ADHD

Hormonal change, broken sleep and new responsibilities can make coping harder



ADHD IN WOMEN

Pregnancy and early parenthood can turn a manageable routine upside down. Someone who used to catch up on Sundays may now have appointments, broken sleep, feeding schedules and constant practical decisions. People with ADHD may bring creativity, humour and quick thinking to this new life, but the relentless demands can expose difficulties that were previously kept under control. Sometimes symptoms feel worse even though the underlying ADHD has not changed very much.

Hormones change dramatically during pregnancy and after birth. Yet studies directly measuring those changes alongside ADHD symptoms are much rarer than public discussion suggests. Some surveys report more difficulties after childbirth, but it is hard to separate hormonal effects from sleep deprivation, anxiety, depression, interrupted treatment and the sheer workload of caring for a baby. Not everyone experiences the same pattern.

Medication decisions are another source of anxiety. Some people stop treatment abruptly when trying for a baby, believing there is nothing to discuss. Others worry about staying on medication. The evidence and risks differ according to the medicine, dose and individual circumstances; untreated ADHD can also have consequences. Planning a pregnancy, considering breastfeeding or reviewing treatment should involve a properly informed clinical conversation.

Support at home can be refreshingly practical: a shared calendar, predictable handovers, fewer steps between deciding and doing, and protected sleep wherever possible. Partners can help by understanding that remembering an intention is not always the same as carrying it out.

New parents also need clinicians to recognise when something more is happening. Postnatal depression, anxiety and other perinatal mental health conditions require assessment in their own right. Not every change in concentration or mood should be attributed to ADHD.

REFERENCES ADHD hormonal-life-stages survey, PMID 41330200; 2025 systematic review PMCID PMC12145478

ADHD and the realities of perimenopause

Wasserstein's research describes the challenges many women report in midlife



ADHD IN WOMEN

For some women, the hardest period of ADHD arrives in their forties or fifties. Tasks that once felt routine can become strangely difficult. Names disappear mid-sentence, appointments slip and mental fog makes a busy day feel overwhelming. Perimenopause may be part of the picture: sleep disruption, hot flushes, mood changes and shifting responsibilities can all affect attention. But a new problem with concentration in midlife is not, by itself, evidence of childhood-onset ADHD.

In 2023, Jeanette Wasserstein, Gerry Stefanatos and Mary Solanto reported findings from a survey of 3,117 women, with analysis focused on 2,653 participants aged 46 or over. In this self-selected group, mostly made up of women already diagnosed with ADHD, 61% said ADHD had affected their lives most strongly between ages 40 and 59. Many described overwhelm, forgetfulness and difficulty keeping on top of everyday demands.

The accounts are powerful, but the survey cannot prove that falling oestrogen caused the changes. Participants were recruited through a specialist readership and were recalling events retrospectively. The survey has helped bring a neglected experience into clinical discussion. It also asks clinicians to look beyond the familiar picture of a hyperactive schoolchild when they meet a woman struggling in midlife.

A useful consultation considers the whole picture: longstanding ADHD symptoms, disrupted sleep, anxiety, depression, thyroid problems, pain, medication changes and menopausal symptoms. Menopause treatment may be appropriate for menopausal health; ADHD treatment should be reviewed on its own merits. Hormone replacement therapy is not an established ADHD treatment.

What researchers now need is the kind of study that follows women over time, measures hormones and sleep, and tests whether symptom changes track the menopausal transition.

REFERENCES Wasserstein, Stefanatos & Solanto (2023), doi:10.1017/S1355617723010846; Littman et al. (2021)

What better care for women might involve

The next step is better research and treatment decisions shaped by individual history.



ADHD IN WOMEN

Female ADHD has gained overdue attention, but public awareness is moving faster than the evidence in some areas. Clinicians are better at recognising quiet inattention, internal restlessness and the exhausting effort of keeping up appearances. We still have surprisingly little robust research on how medication response changes through the menstrual cycle, pregnancy or menopause. Research needs to reflect what women report in clinic, while testing which explanations stand up to closer investigation.

Better diagnosis starts with a life story rather than a checklist alone. When did the difficulties begin? How did they affect friendships, school, work or home life? What systems helped hide them? Why did things become harder at a particular age? Good grades or a successful career should not automatically rule out ADHD, and a moving personal story should not automatically confirm it. Sleep disorders, trauma, anxiety, mood conditions, autism and physical illness still need consideration.

Longer-term care could become more personal too. Instead of asking only whether someone feels “better” once a year, services might record how sleep, mood, demands at home and medication response change across different life stages. Research could benefit enormously from including adolescents, pregnant and postpartum women, and older women—groups often left out of drug trials.

Wasserstein and colleagues helped make the lifespan perspective hard to ignore: hormones, social expectations and changes in responsibility may all shape how ADHD is experienced. The unanswered task is to work out which factors matter most, for whom, and when.

There is also an intriguing implication for men. Oestradiol is not a hormone found only in women; men make it from testosterone. If the biology matters for attention, should we also ask how hormonal changes might affect men already living with ADHD? It is a separate question, worth investigating without assuming findings in women apply directly to men.

REFERENCES Littman et al. (2021); Wasserstein et al. (2023); 2025 systematic review PMCID PMC12145478

CURIOSITY CORNER

Testosterone, oestradiol and an unanswered ADHD question

Could changes in male hormones alter symptoms in people with longstanding ADHD?



CURIOSITY CORNER / RESEARCH

Research into female ADHD has finally brought hormones into the conversation. Oestradiol can influence brain systems involved in attention, motivation and cognitive control. That raises a question researchers have barely explored in men. Men produce oestradiol too, largely by converting testosterone through an enzyme called aromatase. Testosterone also acts directly through androgen receptors. If hormones influence cognition, several pathways could be involved.

Of course, difficulty concentrating in middle age is common—and often has nothing to do with ADHD. Poor sleep, obstructive sleep apnoea, low mood, alcohol, medication, obesity and chronic illness can all make thinking feel harder. ADHD itself begins in childhood. But for a man with longstanding ADHD, could a changing hormonal environment make familiar symptoms more difficult to manage? That is a narrower and more interesting question than whether low testosterone “causes” ADHD.

For now, the clinical evidence consists largely of a few observations. In 2022, Rogne and Hassel described three men aged 24, 37 and 43 whose ADHD symptoms reportedly improved while receiving testosterone gel. Their total testosterone levels, 12–16 nmol/L, were within the reported reference range; two had relatively low testosterone-to-SHBG ratios. The men described changes in concentration, restlessness, sleep and impulse control.

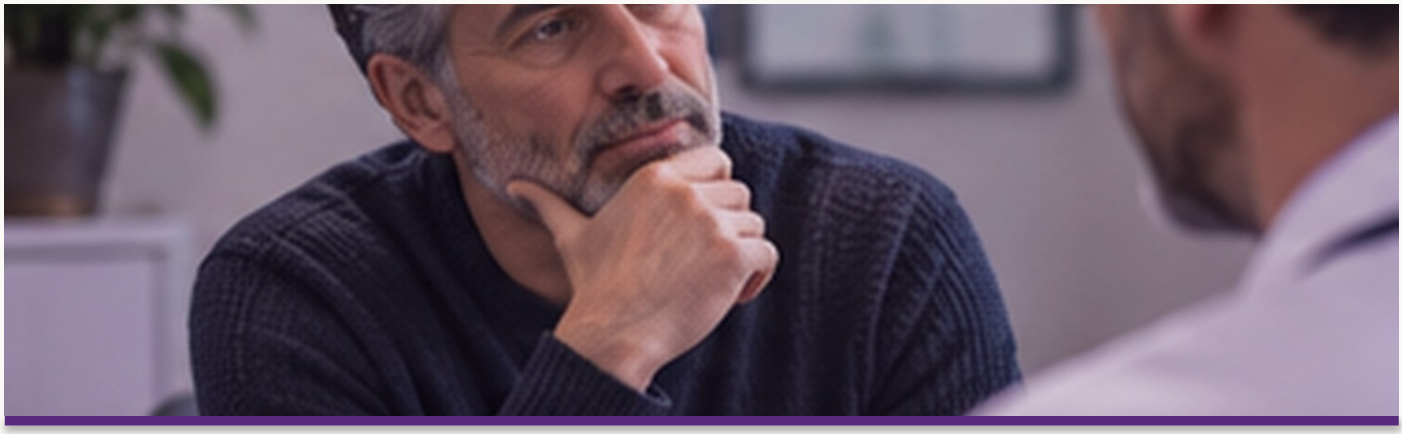
Three cases cannot tell us whether testosterone was responsible. There was no comparison group, and improvements could reflect expectations, other changes in health, or chance. Nor can we tell whether any effect came from testosterone itself, the oestradiol made from it, or indirect changes in sleep and energy. Nevertheless, the report raises a question worth studying: might hormone status influence the day-to-day experience of ADHD in some men?

REFERENCES Rogne & Hassel (2022), doi:10.1186/s13256-022-03651-w; Littman et al. (2021)

CURIOSITY CORNER · CONTINUED

Testosterone and ADHD: what has actually been studied?

Case reports are intriguing; larger genetic studies have not established causation.



CURIOSITY CORNER

The genetic evidence challenges any simple account of testosterone as a cause of ADHD. The 2024 genetic analysis offers an important counterpoint. In 2024, Dinkelbach and colleagues used Mendelian randomisation—a genetic method—to ask whether bioavailable testosterone contributes to the likelihood of ADHD. The sex-specific results did not show a significant link, and an initial signal in the combined sample weakened after adjustment for BMI-related genetic factors. Their conclusion was that there was no robust evidence for a causal contribution to ADHD susceptibility.

That matters, although it does not answer everything. The study asked whether testosterone might influence who develops ADHD, not whether falling hormone levels could change symptoms in someone who already has it. A genetic risk analysis, a blood-test result and an individual's experience over twenty years are not interchangeable.

Trials of testosterone for other reasons also call for restraint. Larger studies in older men with low testosterone have generally not found broad improvements in thinking or memory, although some smaller studies have reported more limited benefits. Those participants were not recruited because of ADHD. The findings neither prove nor rule out an ADHD-specific effect, but they make claims about testosterone as a general cognitive booster difficult to defend.

There is another complication: a low total testosterone reading does not tell the whole story. Levels vary with time of day, illness, weight and SHBG. Measuring oestradiol accurately in men is also technically demanding. If a man feels more focused after treatment for genuine hypogonadism, better sleep or mood could explain part of the change.

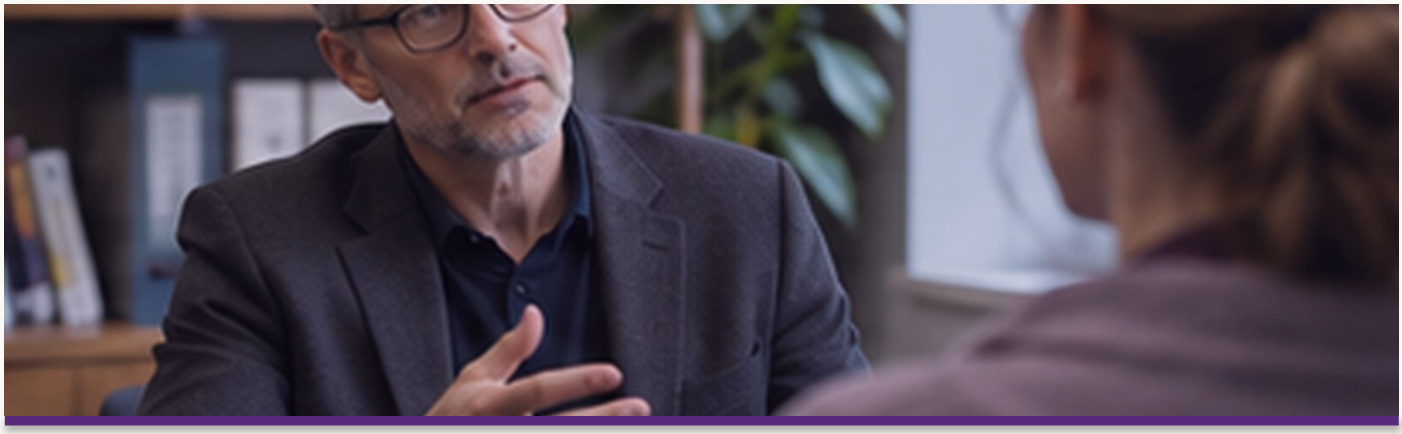
Testosterone is not an established ADHD treatment. Men whose concentration has deteriorated may nevertheless benefit from assessment of sleep, mood, medications and possible endocrine illness.

REFERENCES Dinkelbach et al. (2024), PMID 38536491; Testosterone Trials Cognition (2017)

CURIOSITY CORNER · CONTINUED

How to investigate the hormone hypothesis

Longitudinal studies could separate hormonal effects from sleep, mood and ageing.



CURIOSITY CORNER

Imagine following men with and without ADHD through their forties, fifties and sixties. Rather than taking one testosterone reading, researchers would measure morning testosterone, SHBG, calculated free testosterone and, where reliable testing is available, oestradiol at repeated intervals. They would also track attention, impulsivity, working memory, medication response and—crucially—how well people manage ordinary life.

Sleep quality, sleep apnoea, depression, alcohol, body weight, other illnesses and medication would have to be recorded alongside hormone levels. Otherwise, it would be easy to mistake the effects of poor sleep or declining general health for a direct hormonal effect. The most useful question is whether changes in one man's hormone profile predict changes in his ADHD symptoms over time, once those other explanations have been considered.

Laboratory work could explore whether testosterone acts through androgen receptors, through its conversion into oestradiol, or indirectly via mood and sleep. Researchers could compare men with confirmed hypogonadism, those with low-normal measurements and those with clearly normal levels. They would also need to record whether a person's ADHD medication changed during the study.

If a reliable association emerged, carefully designed clinical trials might follow among men who already meet accepted criteria for testosterone treatment on endocrine grounds. ADHD symptoms could be measured without giving hormones to otherwise healthy men simply to test an attention theory.

A well-designed study might find a hormonal effect in a particular subgroup, or conclude that sleep, metabolic health and mood account for the apparent association. Either result would be useful. Until such research is done, the question remains open.

REFERENCES Rogne & Hassel (2022); Dinkelbach et al. (2024); Wasserstein et al. (2023)

THE CLASSIFIEDS / UK RESEARCH

UK studies seeking participants

ADHD, depression and related conditions: current studies, eligibility criteria and direct research contacts.

OXFORD | RECRUITMENT TO 1 FEB 2027

FAD — Food for ADHD and Depression

Adults 18+ · Formal ADHD diagnosis + current depressive symptoms · Oxford / online

A 16-week comparison of two supported dietary programmes, with group coaching, questionnaires and blood tests. Contact: fad@psych.ox.ac.uk

NIHR: study 60550 ↗

KING'S COLLEGE LONDON | ONLINE SURVEY

PATAS — Positive Attitudes Towards ADHD

Adults 18+ · Diagnosed ADHD · English-speaking · No diagnosed learning disability

A 30-minute survey about experiences of ADHD. £10 e-voucher, plus a possible additional £10 for follow-up. Contact: patas@kcl.ac.uk

King's: survey and sign-up ↗

UNIVERSITY OF BIRMINGHAM | TO APRIL 2027

SNAPPER — ADHD medication and severe mental illness

Adults 18+ · ADHD + history of psychosis or bipolar disorder · UK NHS sites

A trial comparing lisdexamfetamine and atomoxetine in clinically stable adults not recently taking ADHD medication. Contact: S.Marwaha@bham.ac.uk

Birmingham: SNAPPER recruitment ↗

NIHR / SUSSEX PARTNERSHIP | TO 31 JAN 2027

Autism, ADHD and first-episode psychosis

Adults 18+ · Previously experienced first-episode psychosis; currently in remission

Approximately 60 minutes of ADHD questionnaires plus review of clinical records. Sites include London, Worthing and Manchester. Contact: nik.nikolic@spft.nhs.uk

NIHR: study 59321 ↗

Recruitment checked 17 November 2026 · Places and closing dates can change

THE CLASSIFIEDS / PSYCHEDELIC RESEARCH

Psilocybin studies recruiting

Studies in Britain and Canada with eligibility, screening contacts and registry records.

LONDON / KING'S COLLEGE LONDON / RECRUITING

SLEEPY — can psilocybin be studied during sleep?

Healthy volunteers aged 18–65 · Previous psilocybin experience · No current psychotropic medicine

Researchers are testing whether administering psilocybin around sleep can improve blinding in clinical trials. Recruitment: Nov 2026–May 2028. Online prescreening available.

Contact: sleepy@kcl.ac.uk

Study and pre-screening ↗

UNITED KINGDOM / PHASE III / RECRUITING

CYB003 — investigational psilocin analogue in depression

Adults with major depressive disorder · Sites in London and Reading · NCT06793397

A double-blind trial of two CYB003 doses against placebo as an add-on treatment. The registry lists recruiting UK centres; site-specific eligibility and availability may differ.

London contact: vjardim@clerkenwellhealth.com

ClinicalTrials.gov record ↗

CANADA / SUNNYBROOK / RECRUITING

Psilocybin, brain imaging and depression

People with depression · MRI-based phase II study · NCT06072898

A randomised study comparing brain activity after psilocybin and placebo, alongside supportive psychotherapy. Target enrolment: 50 participants.

Sponsor: Sunnybrook Health Sciences Centre, Toronto

Study eligibility & locations ↗

Status on source pages checked 17 November 2026 · Eligibility is determined by the study team

THE CLASSIFIEDS / CANNABINOID RESEARCH

CBD, anxiety and psychosis: current studies

The three studies investigate different questions. Check each listing for eligibility and recruitment status.

SOUTH LONDON & MAUDSLEY / INVITING APPLICATIONS

SYT-510 — endocannabinoid signalling in anxiety

Camberwell, London · Adults 18–55 with GAD · Unmedicated for anxiety

A nine-week experimental medicine study, including MRI, EEG, overnight visits and a study drug intended to affect endocannabinoid signalling. £1,100 on completion; travel expenses reimbursed.

Apply using the NHS study page screening form

Study details and form ↗

UNIVERSITY OF MINNESOTA / RECRUITING

Does regular CBD use change stress responses?

Minneapolis, USA · Adults 21–70 · NCT07069478

Researchers compare regular CBD users and non-users during laboratory stress tasks, measuring mood, cortisol and cardiovascular responses. CBD is not administered by the study.

Contact: umdbml@d.umn.edu

ClinicalTrials.gov record ↗

UNIVERSITY OF OXFORD / NOT YET RECRUITING

STEP-ASSIST — CBD added to clozapine

UK sites planned in Oxford, London and Cambridge · Ages 16–50 · NCT07326124

A phase III trial of cannabidiol versus placebo alongside clozapine in treatment-resistant psychosis. The registry currently says NOT YET RECRUITING; monitor for site opening.

Future enquiries: steptrials@phc.ox.ac.uk

Registry status & criteria ↗

Research listings checked 17 November 2026 · “Not yet recruiting” is labelled explicitly

THE CLASSIFIEDS / EVENTS

The 2027 conference diary

Major psychiatry, ADHD, autism and neuroscience meetings, with confirmed dates and venues.

25–26 JAN

ECNP Roadmap: Precision Psychiatry

Amsterdam, Netherlands + online

Biomarkers, trial design and moving precision psychiatry into practice.

ecnp.eu / Roadmap ↗

21–22 MAR

ECNP New Frontiers: AI in Mental Health

Nice, France + online

What AI can realistically offer diagnostics, treatments and care.

ecnp.eu / New Frontiers ↗

18–21 MAY

INSAR Annual Meeting 2027

CTICC, Cape Town, South Africa

The international annual meeting for autism research.

autism-insar.org / 2027 ↗

3–6 JUN

11th World Congress on ADHD

Cape Town, South Africa

Scientific and clinical developments across the ADHD lifespan.

adhd-congress.org ↗

14–17 JUN

RCPsych International Congress

SEC Glasgow, Scotland, UK

Psychiatry's largest UK professional congress.

rcpsych.ac.uk / Congress ↗

25–28 SEP

40th ECNP Congress

CCIB, Barcelona, Spain

Psychopharmacology, translational neuroscience and new treatments.

ecnp.eu / Congress 2027 ↗

Organisers' published dates and venues checked 17 November 2026

THE CLASSIFIEDS / PROFESSIONAL DEVELOPMENT

Professional training and CPD in 2027

Adult ADHD training and specialist neuroscience meetings, with published dates, formats and fees.

18 JAN ONLINE · 25 JAN LONDON · 11 FEB BRISTOL · 18 MAR MANCHESTER

UKAAN — Adult ADHD Diagnosis & Assessment

£400 · Online or in person · CPD certificate

Structured assessment, DSM-5/ICD-11, collateral history, impairment and differential diagnosis.

ukaan.org / Diagnosis 2027 ↗

26 JAN LONDON · 12 FEB BRISTOL · 25–26 FEB ONLINE · 19 MAR MANCHESTER

UKAAN — Pharmacological Treatment of Adult ADHD

£400 · Online or in person · CPD certificate

Initiation, optimisation and monitoring of stimulant and non-stimulant treatments.

ukaan.org / Medication 2027 ↗

8 FEBRUARY 2027 · 09:30–16:45 · ONLINE

UKAAN — Psychosocial Support & Skills

£325 · One-day online workshop · CPD certificate

CBT-based strategies, planning, emotional regulation and practical support beyond medication.

ukaan.org / Psychosocial skills ↗

18–21 MARCH 2027 · NICE, FRANCE

ECNP Early Career Workshop

In person · For early-career clinical and neuroscience researchers

Research methods, scientific exchange and career development in applied neuroscience.

ecnp.eu / Early career ↗

21–22 MARCH 2027 · NICE + ONLINE

ECNP New Frontiers — AI in Mental Health

Hybrid professional meeting · Virtual registration details online

Clinical AI tools, digital phenotyping, biomarkers, validation and patient safety.

ecnp.eu / New Frontiers ↗

UKAAN prices verified 17 November 2026 · Availability can change

THE CLASSIFIEDS / SAVE THESE DATES

Registration dates and research deadlines

Key dates for studies, courses and meetings listed in this issue. Refer to the organiser for updates.

11 JAN 2027

ECNP 2026 Congress recordings: access closes

Registered delegates can view the recorded 2026 congress sessions until 12:00 CET on 11 January.

ECNP recordings information ↗

18 JAN 2027

UKAAN diagnostic training — online course

Published course date; £400. Other online and in-person options follow in January–March.

Course dates and booking ↗

26 JAN 2027

ECNP Precision Psychiatry virtual registration

Organiser lists 26 January as the virtual-registration deadline; check time-zone details on the live page.

ECNP deadline calendar ↗

31 JAN 2027

Autism/ADHD + first-episode psychosis study

The NIHR record lists this as the planned recruitment close. NHS study contacts are on the listing.

NIHR study 59321 ↗

1 FEB 2027

Oxford FAD: ADHD and depression diet study

Planned recruitment close. Formal ADHD diagnosis and depressive symptoms required.

NIHR study 60550 ↗

17 MAR 2027

ECNP New Frontiers virtual registration

Published cut-off for virtual participation in the Nice meeting on AI in mental health.

ECNP deadline calendar ↗

30 APR 2027

SNAPPER: medication trial recruitment

The NIHR record lists April 2027 as the recruitment close for the ADHD/psychosis/bipolar trial.

SNAPPER official study ↗

Dates published as of 17 November 2026; availability may change

THE CLASSIFIEDS

Independent Listings

Clinics, charities, networks and specialist resources

CLINICAL CARE

Augmentive

ADHD and autism assessments, psychiatric treatment and talking therapies.

augmentive.io

SPECIALIST ASSESSMENTS

Diverse Diagnostics

ADHD and autism assessments for children and adults.

diversediagnostics.co.uk

INDEPENDENT MEDIA

ADHD TV

Video programmes and conversations exploring ADHD and neurodiversity.

adhdtv.com

THERAPY & COACHING

Headstuff ADHD Therapy

ADHD counselling, coaching, training and specialist support.

headstuffadhdtherapy.co.uk

PROFESSIONAL NETWORK

UKAAN

Clinical education, research and adult ADHD professional training.

ukaan.org

CHARITY

ADHD UK

Information, advocacy and support for people living with ADHD.

adhduk.co.uk

RESEARCH & POLICY

Drug Science

Evidence-led information on drugs, cannabis and psychedelic research; founded by Professor David Nutt.

drugscience.org.uk

PUBLISHER

Neurohaven

Free mental-health information, tools and independent educational media.

neurohaven.co.uk

Information supplied for readers; please consult each organisation for current services.