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Neurodiversity and Information Sharing

A Handbook for Health and Justice Service Providers

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2025

This handbook was developed by Midlands Partnership University NHS Foundation Trust (MPFT) in collaboration with NHS England. The handbook and information shared within, is the property of MPFT with all rights reserved.

It has been developed to support staff in understanding neurodiversity and making informed decisions around information sharing.

Our goal is to promote inclusive, person-centred care by providing practical guidance that reflects the experience and needs of neurodivergent service users.

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Introduction

This handbook aims to provide those working within the Criminal Justice System (police, probation, prisons, courts, healthcare) some guidance on supporting neurodivergent service users and ensuring effective information sharing with other Health & Justice colleagues.

It is estimated that around 30% of offenders have learning difficulties or learning disabilities, 16-19% have autism and 60-90% of young offenders have a speech or communication difficulty – these all interfere with their ability to cope within the criminal justice system.

Recognising and accommodating neuro-differences enhances service user care, communication and the overall experience when engaging.

This handbook should help increase your:

- Understanding of neurodiversity and associated vulnerabilities;
- Improve interactions with neurodivergent individuals;
- Show the benefits of sharing service user information; and
- Foster an inclusive, person-centred approach.

We have included a page of useful links (page 45) from various charities and organisations to help you understand some of the words you will encounter while reading this handbook.

Reasonable Adjustments

Following the release of the Equality Act 2010, it states that there is a duty to organisations/service providers to make reasonable adjustments to ensure a person with disabilities, or physical or mental health conditions, are not substantially disadvantaged in situations. Reasonable adjustments should be anticipatory and are needs-led, not diagnosis-led.

Process

This is regarding making changes to the way things are organised or done if the way they are currently done could pose as a substantial disadvantage to someone with disabilities, or physical or mental health conditions.

Place

This is regarding the environment and/or physical features which would put someone with disabilities, or physical or mental health conditions at a substantial disadvantage.

Person

This is regarding support for the individual with disabilities, or physical or mental health conditions being put at a substantial disadvantage if aids to support them are not made available.

Examples of the type of adjustments can be found along with the description of the neurodiverse conditions within this handbook.

It is estimated that around 1 in 7 people (15-20% of the population) in the UK have a neurotype (processing style) which diverges from the majority neurotype, these people are referred to as neurodivergent individuals – although with an increase in awareness and late diagnosis this is likely to be higher.

Neurodiversity is a term used to describe cognitive conditions, such as autism, ADHD, dyslexia, dyscalculia and dyspraxia, that are natural variations in the way people think, learn and process information.

Neurodivergence is classed as a disability, although some neurodivergent people do not identify as disabled but need support to live in a neuro-typical society.

The term recognises both the difficulties and unique strengths that people who have these conditions may experience.

Neurodiversity can impact attention, executive function (such as planning tasks), sensory processing, learning, social communication and interaction differences, and mood.

Within the criminal justice system, neurodivergent traits can be misunderstood as defiance, especially in environments that rely on compliance, fast communication, and emotional control. However, these behaviours are often manifestations of disability or stress, not intentional disobedience or disrespect.

Neurodivergence can run through families in various different forms. It is very common for families to have generations of family members who are autistic and/or have ADHD, dyslexia and other forms of neurodivergence. They may not have been formerly identified or diagnosed due to the understanding of it still developing.

Autism, ADHD and dyslexia are the 3 most common co-occurring forms of neurodivergence and can often all be present in one person but not necessarily all identified or formerly diagnosed.

Neurodivergence is very often not obvious, hence being known as 'hidden' disabilities.

What is Neurodiversity?

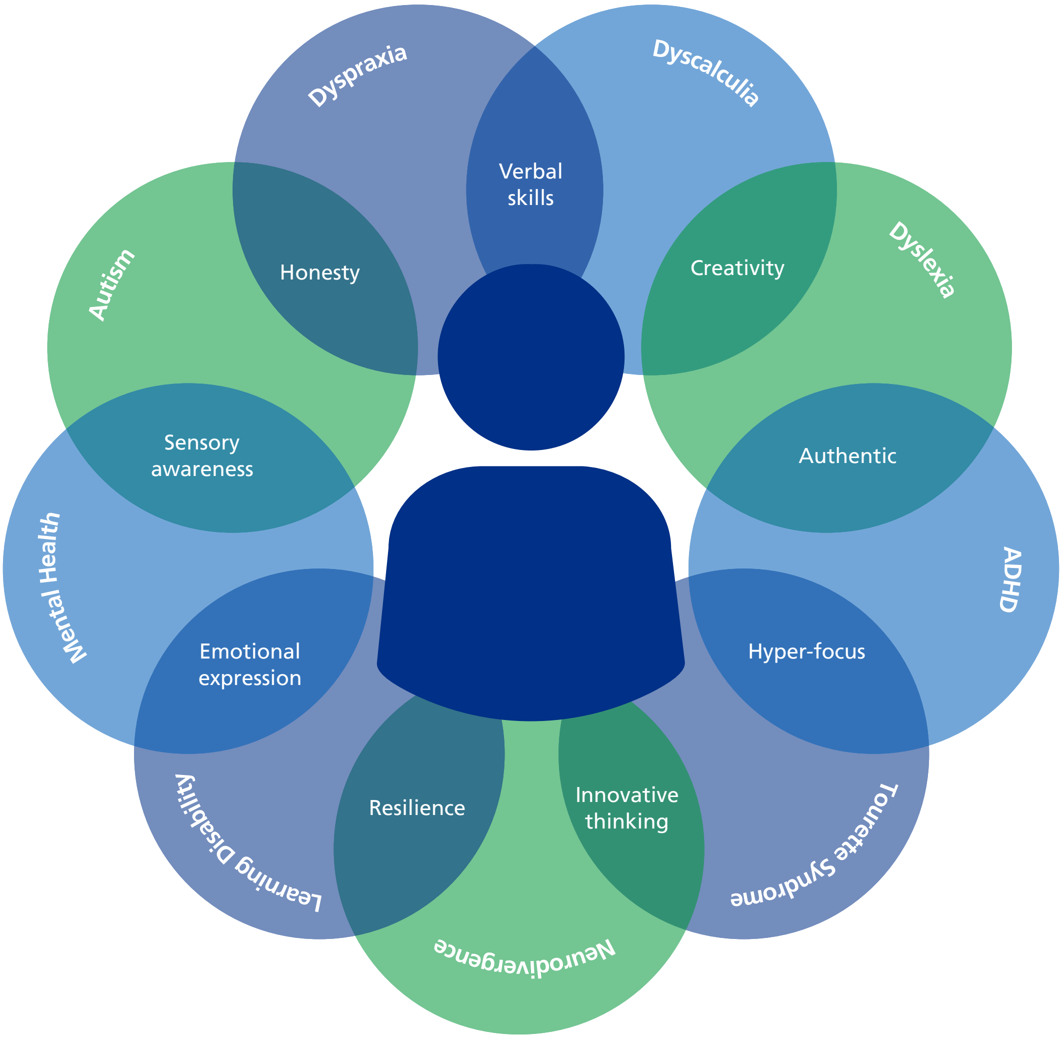
- Neurodiversity (plural) - the term used to describe the natural cognitive variation between all of our brains. The human race is a diverse population of individuals with differing neurotypes.

- Neuro-typical (singular) – describes a person who shares the most ‘typical’ neurotype. This population has a similar experience of the world to each other; they can relate to one another and make up the majority of the global population.

- Neuro-majority - the most common neurotype numbering approx. 80-85% of the global population – individuals are known as neurotypical.

- Neuro-minority – neurodivergent individuals whose neurotype diverges from the neuro-majority – neurotypical people. They are thought to comprise approx. 15-20% of the global population.

- Neurodivergent is the term used to describe people whose brains function differently from the neuro-majority – their neuro-type diverges from the neurotypical population’s.



Sensory Processing

Sensory processing is the way our brains organise and make sense of information received through our senses, including vision, hearing, touch, taste, smell and movement. It involves receiving sensory input, interpreting it, and then responding and interacting with it effectively. This process is essential for everyday activities and understanding the world around us.

Sight

Touch

Taste

Body Awareness

Smell

Hearing

Balance & Movement

Internal Feedback

Some individuals may have difficulty processing sensory information. Challenges can include being overly sensitive to certain stimuli, under-sensitive to others, or having difficulty modulating sensory responses. This can affect daily life, social interactions, and learning.

What is Autism?

Autism, also known as Autism Spectrum Condition (ASC) or Autism Spectrum Disorder (ASD), is a lifelong developmental disability which affects how people communicate, interact and process the world around them. It is estimated that around 1 in 100 people in the UK are diagnosed with autism, however this number is continually increasing due to the growing understanding and acceptance of autism.

People of all genders, races, ethnicities, and economic backgrounds can be diagnosed with autism and all will have differing support needs and challenges.

Autism has nothing to do with intelligence - only one third of autistic people have a learning disability.

Note: Many autistic people 'mask' their natural autistic differences in order to 'fit in' and be accepted by a predominantly neuro-typical society. This can increase stress and cause autistic people to become impulsive or avoidant in some situations.

Autism is a spectrum condition which can affect people in different ways. You may notice differences in:

Social communication & interaction:

- Social anxiety making social interactions an extremely stressful experience
- Difficult to make and maintain friendships and relationships with others
- Take longer to process verbal information; autistic people are known to have stronger visual perception rather than audio which is why written/drawn information is more helpful
- Literal understanding of language and focus on individual words rather than the general 'gist' of what is being said
- Difficult to 'read between the lines' and decipher underlying messages if they are not communicated clearly and directly
- Unusual eye contact – not to be misinterpreted as evasive or dishonest
- Differences in processing style can make multi-tasking difficult i.e. listening and processing verbal information whilst also looking at someone's face
- Different conversational style; may be more honest and direct and less likely to engage in chit-chat
- Prefer 1-2-1 situations as opposed to groups due to processing differences and managing social expectations
- Differences in their own tone of voice and facial expressions, finding other peoples' difficult to read and translate
- Neuro-typical social conventions and expectations can be confusing and difficult to understand/navigate

Certainty; activities and interests:

- Autistic people tend to prefer structure, routine and order – a strong need for certainty and 'sameness'
- In the absence of this, they may create their own - often rigid routines and rituals that help them feel in control and more able to regulate themselves
- Finding unexpected change difficult - distress at unexpected change can often be misinterpreted as frustration, anger or aggression
- Interests can be all-encompassing and very intense, these are often the person's 'safe zone' and are fundamental to happiness

Sensory processing differences:

- The environment – physical and social – is fundamental to an autistic person's ability to function and engage
- Over (hyper) or under (hypo) sensitivity to various sensory stimuli: touch, taste, sound, smell, sight, balance, internal bodily awareness and sense of body in space
- Sensory differences which can result in difficulties with emotional regulation
- Living with high levels of anxiety and sensory differences can cause meltdowns or shutdowns if the person becomes overwhelmed from the sensory and/or social environment
- Stimming – self-stimulatory actions such as tapping, rocking, pacing, fidgeting etc. to self-soothe and maintain emotional regulation

Reasonable Adjustments

Strategies to help manage situations such as sensory overload:

- Neuro-affirmative language - ‘difference’ rather than ‘disorder’
- Give the person time to recover - keep calm, reduce noise and bright lights - ask if they are OK and give them time to respond. Don’t immediately interpret their lack of response as them not co-operating
- Provision of sensory aids e.g. fidgets or weighted blankets (security clearance permitting)
- Clearly explain the situation and what is happening
- Keep language clear, concise and simple - address the person by name at the start of each sentence, keep sentences short, step by step instructions and allow extra time for responses
- Questions need to be regarding one thing at a time - direct, clear and focused. An autistic person may respond without understanding the implication of what they are saying or may agree with you because they think this is what they are supposed to do
- If they repeat what you say, don’t assume they are being rude, by repeating what has been said, they may be checking they have understood the question
- Offer different ways of communication – ask if it would be helpful to have questions written down/visual as well as spoken
- Be aware that your behaviour or language may be confusing to someone with autism, in the same way that some autistic behaviour may be unexpected to you
- Avoid using sarcasm, figures of speech/metaphors or irony. These may be taken literally, causing misunderstandings
- Don’t interpret avoidance or excessive eye contact as rudeness or a cause for suspicion
- Don’t attempt to stop the person from flapping, rocking, or making other repetitive movements as these can be self-calming strategies. If possible, avoid touching the person

Autism Assessment
Should you require any further advice and guidance regarding autism then please visit the National Autistic Society webpage:

National
Autistic
Society

www.autism.org.uk/advice-and-guidance

Here you will find a range of information, for example:

- Diagnosis – before diagnosis (requesting an assessment), assessment and diagnosis (criteria and tools), after diagnosis (support)
- Support, strategies and interventions – A range of approaches to support autistic people, NICE Guidance, Positive Behaviour Support
- Criminal Justice – www.autism.org.uk/advice-and-guidance/topics/criminal-justice/criminal-justice/professionals

Attention Deficit Hyperactivity Disorder (ADHD) is a lifelong condition that affects people's behaviour. People with ADHD show symptoms such as inattentiveness (unable to keep focus), hyperactivity (excessive movement not fitting with the setting) and impulsiveness (hasty acts that may occur without thought) that interferes with their day- to-day functioning.

Until 2013 autism and ADHD could not be diagnosed together and therefore there are many autistic people who also have ADHD and those who are also autistic but are unaware. Around 70% of autistic people are also thought to have ADHD but don’t have a formal diagnosis. It is therefore important to treat every neurodivergent person as an individual and not overly focus on the label which may not be entirely accurate.

There are three types of ADHD:

- Combined - Both impulsive and hyperactive, trouble paying attention and easily distracted
- Inattentive - Mostly inattentive and easily distracted
- Hyperactive/Impulsive - Impulsive and hyperactive with less trouble paying attention

People with ADHD may struggle with:

- **Organisation and time management**
    - Trouble organising tasks or activities such as missing deadlines, not arriving on time
    - Trouble staying focused and forgets routine tasks such as appointments, calls

- **Following instructions**
    - Trouble staying focused and doesn’t pay close attention to details/makes careless mistakes
    - Struggles to follow instructions or fails to complete work/activities

- **Focusing**
    - Hyper focus – motivated and engaged however become unaware of other things around them
    - Lack of focus – easily distracted - not interested or motivated to engage or complete tasks

- **Coping with stress and anxiety**

- **Feeling restless or impatient**

- **Impulsiveness and risk taking**

- **Depression**

- **Difficulty falling or staying asleep**

Reasonable Adjustments

Strategies to support engagement with someone presenting with Attention Deficit (Hyperactivity) Disorder could benefit from the following:

- Look at minimising distractions where possible – quieter rooms, less digital distractions
- Provision of sensory aids e.g. fidgets (security clearance permitting)
- Clearly explain the situation and what is happening
- Keep language clear, concise and simple – short sentences (as longer/more complicated sentences can be hard to follow), step by step instructions and allow extra time for responses
- Offer different ways of communication – ask if it would be helpful to have questions written down as well as spoken
- Avoid using sarcasm, figures of speech or irony. These may be taken literally, causing misunderstandings
- Don’t attempt to stop the person from flapping, rocking, or making other repetitive movements as these can be self-calming strategies as they may being feeling restless
- They may not appear to be listening, even when spoken to directly. Can appear as if daydreaming - don’t immediately interpret this as them not co-operating, it may be a coping mechanism

What is Dyslexia?

Dyslexia is a common learning difficulty that mainly causes problems with accurate reading, writing and spelling. It is important to note that dyslexia occurs across the range of intellectual abilities and that there are positives to thinking differently. Many dyslexic people show strengths in areas such as reasoning/problem solving and in visual and creative fields.

People can be born with dyslexia, or it can be acquired as a result of traumatic brain injury, stroke or dementia. It is estimated that up to 1 in every 10 people in the UK has some degree of dyslexia.

Dyslexia is about information processing. Dyslexic people may have difficulty processing and remembering information they see and hear, which can affect learning and the acquisition of literacy skills. Dyslexia can also impact on other areas such as organisational skills.

Like autism and ADHD, dyslexia is a lifelong condition that can present challenges on a daily basis. Some of these challenges include:

Reading

- Confuses words that are visually similar such as cat and cot
- Reads slowly and/or re-reads information to understand it
- Omits, repeats or adds extra words
- Displays challenging behaviour when given a task involving reading e.g. following written instructions or reading safety information

Writing/Spelling

- Could spell the same word differently in one document
- Better answering verbally/talking than writing down information
- Poor handwriting and spelling and/or writes very slowly
- Difficulty to express knowledge in writing

Behavioural

- Avoids work that involves reading and/or writing
- Finds it hard to listen and maintain focus
- Finds it hard to concentrate if there are distractions
- Feel sensations of mental overload/switching off
- Has difficulty telling left from right
- Gets confused if given several instructions at once
- Often forgets important information, conversations or dates
- Regularly late
- Find some tasks really easy but unexpectedly challenged by others
- Poor self-esteem, especially if dyslexic difficulties have not been identified in earlier life

Reasonable Adjustments

Strategies to support engagement with someone with dyslexia could be:

- Look at minimising distractions where possible – quieter rooms, reduce verbal distractions, less digital distractions
- Clearly explain the situation and what is happening – avoid overwhelming with information, break up information into small chunks
- Keep language clear, concise and simple – allow extra time for thinking/processing what is being said and responding
- Offer different ways of communication – ask if it would be helpful to have information read to them or/and visuals alongside written information to help with understanding
- When communicating via documents/emails, to ensure ease of reading, use font size 12+, use bullet points and ensure text is spaced out well
- Take regular breaks – supports engagement, productivity and concentration

What is Dyscalculia?

Dyscalculia is a lifelong learning difficulty that affects the ability to use and acquire mathematical skills – it is a specific and persistent difficulty in understanding numbers which can lead to a diverse range of difficulties with mathematics.

Around 6% of people in the UK have dyscalculia.

An estimated 25% of people have maths learning difficulties which can be caused either by other neurodiverse conditions such as dyslexia or external issues such as a traumatic learning experience related to maths or school absence etc. 60% of individuals with dyslexia will have difficulties with maths. Dyscalculia is at the severe end of the maths learning difficulties.

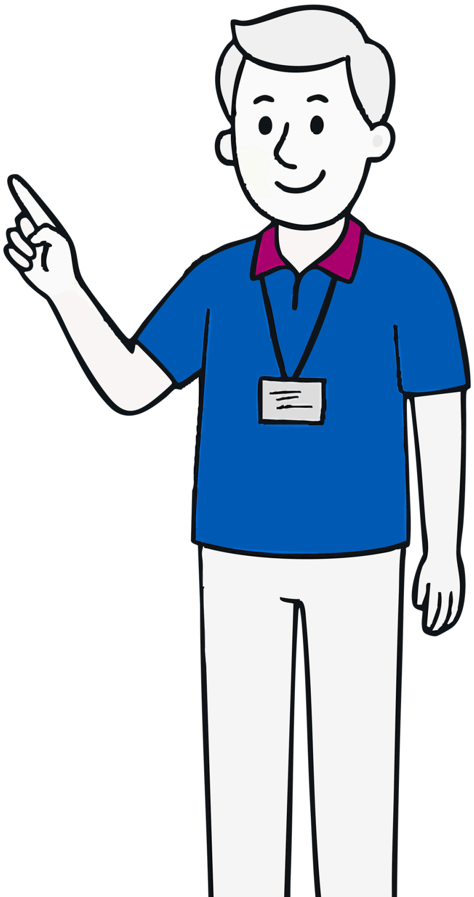
People with dyscalculia may struggle with:

- Giving or following directions
- Mental arithmetic skills
- Trouble handling money and keep track of finances
- Remembering 'basic' facts
- Poor memory for number related facts e.g. dates, phone numbers
- Time keeping – frequently late, difficulty telling the time, runs out of time doing tasks
- Extreme difficulties spotting patterns in numbers and making generalisations
- High levels of maths anxiety

Reasonable Adjustments

Strategies to support engagement:

- Clearly explain the situation and what is happening
- Keep language clear, concise and simple – allow extra time for responses
- Questions need to be regarding one thing at a time - direct, clear and focused, check their understanding at regular intervals



What is Dyspraxia?

Dyspraxia is a common disorder that affects movement and co-ordination (also known as Developmental Coordination Disorder). It does not impact intelligence and can affect people of all intellectual abilities.

Dyspraxia can also affect fine motor skills, such as writing or using small objects.

It is thought dyspraxia affects up to 6% of the UK population.

People with dyspraxia may also have autism, dyslexia, ADHD, dyscalculia, depression and/or anxiety.

They may struggle with:

- Co-ordination, balance and movement
- Learning new skills and remembering information
- Daily living skills, such as dressing or preparing meals
- Ability to write, type, draw and grasp small objects
- Time management, planning and personal organisation skills

Reasonable Adjustments

Strategies to support engagement:

- Clearly explain the situation and what is happening – avoid overwhelming with information
- Keep language clear, concise and simple – allow extra time for processing what is being said and responding
- Take regular breaks – supports engagement, productivity and concentration.
- Offer different ways of communication – ask if it would be helpful to have questions written down as well as spoken

What is Dysgraphia?

Dysgraphia is a developmental learning disorder that affects fine motor skills like writing, buttoning a shirt, or tying a shoelace, as well as the mental processes associated with writing, like picking a topic, organizing ideas, and making a coherent point.

Writing-related challenges early in life are frequently missed or chalked up to sloppiness. This means that a child with dysgraphia could easily reach adulthood without receiving a diagnosis. Since so many adults with dysgraphia remain undiagnosed, it's difficult to estimate just how many are living with the condition. In children, the rate is often estimated between 4% and 20% — and since dysgraphia can't be outgrown, just as many adults are living with this learning disorder.

It is thought that dysgraphia affects men more often than women. Although this condition can occur alone, this can go hand-in-hand with other learning disabilities such as dyslexia or specific language impairment (SLI), or a related condition like ADHD.

Those with dysgraphia may struggle with:

- Illegible handwriting, often to the point that you can't read what is written
- Makes spelling errors
- Struggles with cutting food, doing puzzles, or manipulating small objects by hand
- Uses a pen grip that is "strange" or "awkward" – can experience hand cramps or pain when writing
- Slow to understand the rules of games or follow sequential directions
- Trouble reading maps; prefers to give or get directions orally, instead of in writing
- Difficulty drawing, tracing, or painting
- Avoids writing whenever possible; may also dislike texting
- When using spell-check on a computer, difficulty picking out the correct word from a list of similar words
- Trouble filling in routine forms by hand, particularly if they require fitting words into set boxes
- Mixes lowercase and uppercase letters, or print and cursive letters, seemingly randomly
- Often leaves out individual letters or the ends of words, particularly when writing quickly
- In some cases, may have trouble with typing
- Often uses grammatically incorrect sentences when writing

What is Developmental Language Disorder?

Developmental Language Disorder (DLD), previously known as Specific Language Impairment (SLI), means the individual has significant, ongoing difficulties understanding and/or using language (spoken or signed). There is no obvious reason for these difficulties, for example, there is no hearing problem, physical disability or known condition (e.g. autism) that explains them.

The prevalence of Developmental Language Disorder is estimated at 6–15% but is more common with other co-occurring neurodevelopmental disorders.

People with DLD/SLI may struggle with:

- Finding the words they want to say
- Substitution of related words when talking, even if they don't mean the same things e.g. saying 'table' instead of 'chair'
- Switches sounds within words without noticing
- Forgets words or says them out of order
- Doesn't understand jokes; takes everything very literally
- Finds it difficult to focus on what someone is saying, particularly if there is background noise
- Finds it difficult to answer questions about what was just said or answer direct questions
- Finds it difficult to keep up with conversations
- Unable to follow multi-step verbal instructions
- Acts impulsively and doesn't seem to think through the consequences of their actions

Although it is different for everyone, below are some comments made from people with DLD/SLI:

> Like when you are half asleep and you can hear what someone says, but your brain feels too sleepy to do anything with the stuff you heard and then it leaves your head.

> You have ideas and know what you want to do and how, but you can't seem to explain yourself. You get muddled. Or you think that you've explained it and the other person is muddled. It's hard to get ideas to make sense to both of you.

> Getting people's names right is a nightmare – especially ones with similar sounds like Sarah and Sharon.

> I always have to write myself a note to help me remember.

> For me, I get my thoughts mixed up if I have two thoughts in my head. I once said that I'd put the butter in the car because I was answering a question 'where's the butter?' but thinking about the car.

> Well, I just couldn't say what I wanted and then I got bullied – so I just used my fists – it was easier.

Reasonable Adjustments

Strategies to support engagement could be:

- Get the person's attention by sitting at their level (or get eye contact), saying their name and getting them to look
- Offer regular breaks to give the person the best opportunity to remain engaged
- Keep language clear, concise and simple – allow extra time for processing what is being said and responding
- Where possible, try to say things in the order that they will happen, or describe events in chronological order. For example, instead of "before being released from prison, you will need to complete XYZ" you can say "you will need to complete XYZ before being released from prison".
- Check the person has understood what you have said. Do not ask "have you understood?" as the person may just agree to avoid embarrassment. Instead, you could ask them to repeat back to you in their own words
- If a sentence comes out in a muddle and there are grammatical errors, don't say they are wrong. Say it back for the person to hear with the errors corrected. This is called recasting. For example, if the person says "I went to see the Peer Support Worker tomorrow", you could reply with "okay, you're going to see your Peer Support Worker tomorrow"
- It can be hard for people with DLD to remember words therefore try to offer choices, for example if the person is struggling to answer "who did you meet with?" you could offer "was it your RECONNECT Practitioner, or your Probation Lead?"

What is Tourette Syndrome?

Tourette syndrome is a genetically determined neurological condition, the key features of which are tics, involuntary and uncontrollable sounds (vocal/phonic) and movements (motor). Tourette Syndrome is a complex condition and a large number of people with the condition will also experience co-occurring features and conditions.

Over 300,000 children and adults are living with Tourette Syndrome in the UK.

Motor and vocal tics are defined as sudden, rapid, uncontrollable, and recurrent/repetitive movements or vocalisations that can happen in any part of the body. In order to be diagnosed as Tourette syndrome, both motor and vocal tics must have been present for at least one year, although they may not manifest concurrently or consistently. Up to 85% of people with Tourette Syndrome will also experience co-occurring conditions and features which might include attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), anger/rages and anxiety. When a person presents with tics and co-occurring symptoms this is clinically referred to as ‘mixed neurodevelopment symptoms’.

Tourette Syndrome is often misunderstood as a condition which makes people swear or say socially inappropriate things. Although it is true that ‘coprolalia’ – the clinical term for involuntary swearing – is a symptom of Tourette Syndrome , it only affects a minority of people. 80-85% of people with Tourette Syndrome do not have coprolalia.

Tics can be divided into Simple and Complex categories. Below is an example of common motor and vocal tics:

	MOTOR TICS	VOCAL TICS
SIMPLE	• Eye blinking/jerking/rolling • Tongue movement – sticking out • Head twitches/jerks • Facial grimacing • Shoulder shrugging • Limb and head jerking • Abdominal tensing	• Whistling • Throat clearing • Sniffing • Coughing • Tongue clicking • Grunting • Animal sounds
COMPLEX	• Jumping, hopping, squatting • Twirling • Touching objects and other people • Obscene movements or gestures (copropraxia) • Repeating other peoples' gestures (echopraxia)	• Uttering words or phrases out of context • Saying socially unacceptable words (coprolalia) • Repeating a sound, word or phrase (echolalia)

Reasonable Adjustments

- Where possible, ignore the tics
- Be aware that if the individual is tic-ing they are unlikely to be able to listen to and understand what you are saying
- Offer regular breaks to give the person the best opportunity to remain engaged
- Keep language clear, concise and simple – allow extra time for processing what is being said and responding

What is a Learning Disability?

A learning disability is a reduced intellectual ability combined with difficulty with everyday activities. It affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently (impaired social functioning). A learning disability will have started before adulthood and have a lasting effect on development.

There is approximately 2.16%* of the population (1.5 million people) in the UK that are believed to have a learning disability however only around a quarter of adults with learning disabilities are identified on GP learning disability registers or known to specialist learning disability services.

A Learning Disability can be mild, moderate (MLD), severe or profound. It can be difficult to identify a mild learning disability as the individual will often mix well with others and will be able to cope with most everyday tasks. Whereas people with a severe learning disability or profound and multiple learning disability (PMLD), will need significant care and support with areas such as mobility, personal care and communication.

A Learning Disability can be caused due to difficulties before or during birth when the brain is still developing, or after birth due to early childhood illnesses, accidents or seizures.

mencap

For further information, help or guidance, you can find support at https://www.mencap.org.uk

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*The figures on this page have been calculated using learning disability prevalence rates from Public Health England (2016) and population data from the Office for National Statistics (2024).

People with a Learning Disability may struggle with:

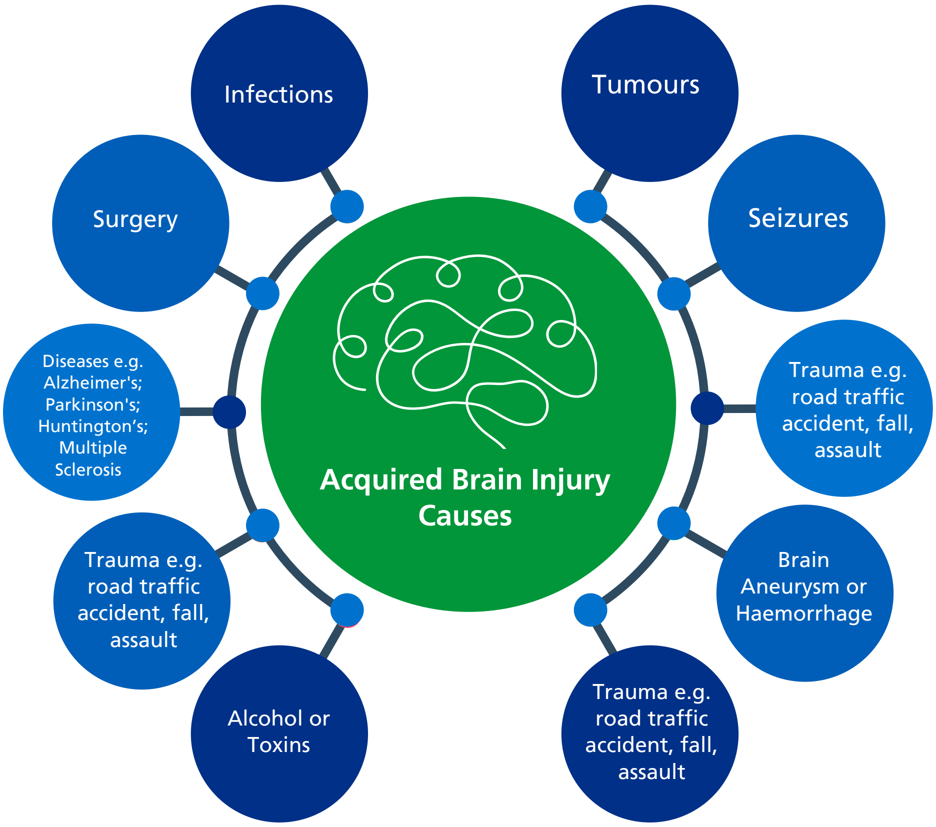
- Not talking about their history chronologically
- Confusion about times of appointments
- Difficulties in understanding and following instructions
- Difficulties in processing information quickly
- Poor planning and sequencing
- Repetition of phrases in conversation without expanding on content
- Not able to cope with more than one task at a time
- Difficulties in understanding information
- Problems with maths, reading or writing
- Learning new skills at a slower pace
- Problems with communication, such as speaking slowly or having a small vocabulary or mixing up or consistently mispronouncing or misusing words

Reasonable Adjustments

Strategies to support engagement:

- Give information using minimal words and short sentences
- Use pictures and objects of reference when appropriate
- Give the individual time to process information
- Help with appointments
- Help managing issues of consent in line with the Mental Capacity Act
- Clearly explain the situation and what is happening – avoid overwhelming with information
- Keep language clear, concise and simple – allow extra time for thinking/processing what is being said and responding
- Offer different ways of communication – ask if it would be helpful to have information read to them or/and visuals alongside written information to help with understanding
- Check the person has understood what you have said. Do not ask “have you understood?” as the person may just agree to avoid embarrassment. Instead, you could ask them to repeat back to you in their own words

What is an Acquired Brain Injury?



Acquired brain injury (ABI) covers all situations in which brain injury has occurred since birth and includes Traumatic Brain Injury (TBI) which is an injury to the brain caused by a trauma to the head (head injury).

Each year, around 350,000 people are admitted to hospital in the UK with an acquired brain injury, with an estimated 1.3 million people living with a disability as a result.

Reasonable Adjustments

- Where possible, in advance, reach out to those supporting the person to gain a better understanding of how their functioning is affected by the brain injury
- Use this information to make reasonable adjustments. They will likely vary from person to person as brain injury affects people in different ways
- There may need to be specialist assessment to help the person and those supporting them to understand difficulties and what might help
- Keep language clear, concise and simple – allow extra time for processing what is being asked and responding. Their brain injury may result in slower verbal or physical responses to avoid misinterpreting them as evasive or uncooperative behaviour
- Take regular breaks – supports engagement, productivity and concentration

What is an Acquired Brain Injury?

Effects of brain injury that may have an impact on a person's journey through the criminal justice system are typically grouped in three major categories: physical, cognitive/thinking, and emotional/behavioural differences.

Some physical changes may include:

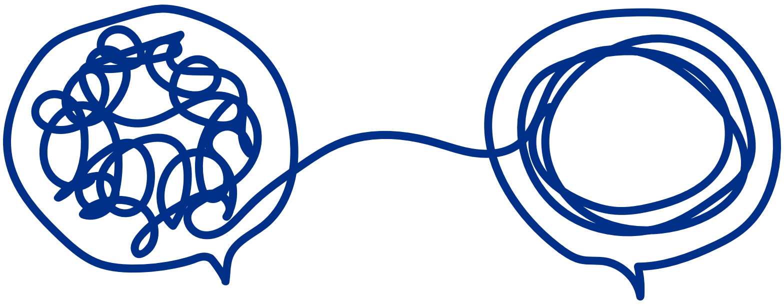
- Fatigue – can impact every aspect of their day-to-day functioning/life however may come across as ‘lazy’ or ‘disinterested’
- Muscle coordination problems
- Full or partial paralysis
- Changes in senses: hearing, sight, smell, touch, taste.
- Dizziness and/or headaches
- Epilepsy – may result in seizures and require medication

Some cognitive/thinking changes may include:

- Difficulty communicating – difficult to understand others and own needs/views
- Memory problems including reduced ability to process and retain information or instructions – difficult to follow routines and remember rules
- Poor judgment/vulnerable/may be led astray and exploited
- Difficulty learning new things

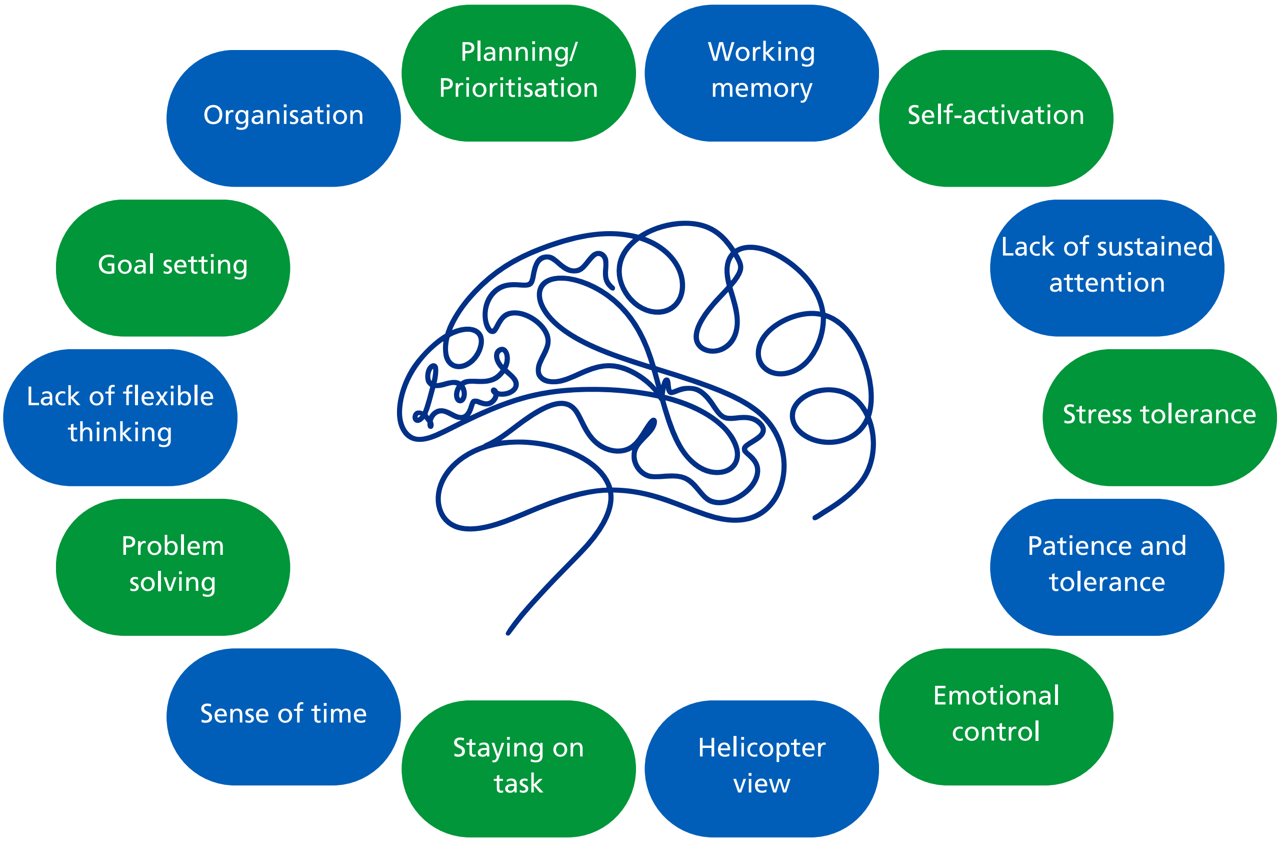
Some emotional/behavioural changes may include:

- Anxiety and depression
- Increased risk of self-harm and suicide
- Irritability/frustration/anger – may result in outbursts
- Difficulty with social skills
- Inability to recognize changes in themselves
- Impulsivity and lack of self-control - may lead to displays of inappropriate behaviour and confrontation



What are Executive Functions?

Executive functions are a set of cognitive processes or thinking skills that allow us to manage every aspect of our lives, stay safe and get things done. These include basic cognitive processes, and associated challenges if compromised, as shown below:



- Organisation
- Planning/ Prioritisation
- Working memory
- Self-activation
- Lack of sustained attention
- Stress tolerance
- Patience and tolerance
- Emotional control
- Helicopter view
- Staying on task
- Sense of time
- Problem solving
- Lack of flexible thinking
- Goal setting

Challenges can be experienced in day-to-day planning, organisation, and regulating emotions, particularly in a world typically created for neurotypical brains. If these challenges are significant and consistent, the individual may then experience dysregulation and distress. These challenges are sometimes described as ‘executive dysfunction’.

Some research suggests that up to 80% of those with autism suffer from executive function disorder, leading to difficulties managing time, completing tasks, and making what might be thought of as simple tasks – like cleaning your room – very complicated or seemingly impossible.

What are Executive Functions?

People may have challenges in relation to the following areas of executive functioning:

Initiation/Self-activation/Time awareness

- Procrastination - getting past thinking about the task to doing the task
- Poor time management - not being able to foresee how long a task will take
- Challenges sustaining focus

Working memory

- Challenges with short term memory - remembering what has just been said
- Thinking you need to do something but not remembering what it is
- Slower gaining information and losing focus easily

Emotional and impulse control

- Getting frustrated for forgetting to do things, as can be seen as lazy or incompetent
- Finding it hard to shut off a busy brain which can affect sleep patterns
- Being impulsive and not considering the context
- Difficulty adjusting and graduating your pace or changing gear - this can lead to an all or nothing mindset

Hindsight and foresight

- Harder learning from past experiences and then repeating the same actions again and again
- Difficulties with predicting future challenges

Reasonable Adjustments

Strategies to support engagement:

- Processing of instructions may be difficult therefore breaking instructions down, for example in to bullet points, with clear timeframes
- Use pictures and objects of reference when appropriate
- Clearly explain the situation and what is happening – avoid overwhelming with information
- Offer different ways of communication – ask if it would be helpful to have information read to them or/and visuals alongside written information to help with understanding and alleviate stress
- Keep language clear, concise and simple – allow extra time for thinking/processing what is being said and responding

What is Developmental Trauma?

The effects of childhood trauma can lead to neurological and developmental differences that overlap with or mimic neurodivergent traits. These impacts are sometimes referred to as developmental trauma or complex trauma, and they can shape how a child thinks, behaves, learns, and relates to others.

While trauma itself is not widely accepted as a neurotype, it can lead to enduring neurobiological adaptations that shape a child's development in ways that intersect with neurodiversity. A trauma-informed, inclusive approach helps ensure these children are not unfairly or wrongly considered as a problem but supported with compassion and insight.

Understanding Childhood Trauma in a Neurodiverse Context

Childhood trauma refers to experiences that overwhelm a child’s ability to cope, such as:

- Abuse (physical, emotional, sexual)
- Neglect
- Domestic violence
- Parental substance abuse or mental illness
- Loss of a caregiver or chronic instability

How Trauma Affects Brain Development

Repeated or chronic trauma can alter brain development, particularly in areas responsible for:

- Emotional regulation
- Memory and learning
- Executive functioning (attention, planning, impulse control)
- Social connection and trust

These neurological changes may resemble or co-occur with conditions like ADHD, autism, or learning disorders which can lead to misdiagnosis or overlooked trauma.

Neurodiversity and Trauma: Key Connections

- Overlap of Traits: Children with trauma histories may be hypervigilant, emotionally reactive, or socially withdrawn - traits that can look like neurodevelopmental conditions
- Double Impact: Neurodivergent children are also more vulnerable to experiencing trauma (e.g. bullying, exclusion, misunderstanding)
- Complex Presentations: A child may be both neurodivergent and traumatised, requiring integrated, trauma-informed and neurodiversity-affirming support

Reasonable Adjustments

Some common neurodivergent symptoms may appear like defiance, but are actually signs of distress, misunderstanding, or communication challenges. Below are reasonable adjustments and ways to support those affected by childhood trauma:

- If someone is avoiding eye contact, this may not be them being disrespectful or evasive – some people with neurodivergent conditions find eye contact overwhelming or distracting
- Focus on safety, trust and choice – avoid discipline; use relational and restorative approaches
- Non-compliance or refusing to cooperate by not responding to questions quickly could be a sign of a processing difficulty, ADHD or autism, which can cause delayed processing or overwhelm the individual
- Focus on understanding behaviours as a possible way of communication, not defiance
- Sensory overloads, anxiety or an inability to regulate emotions under stress can sometimes come across as agitated, aggressive or even dangerous
- Some people, in an attempt to self-regulate, deescalate or avoid a shutdown do have a habit of walking away or refusing to answer which can be misinterpreted as disrespect or defiance
- Don’t attempt to stop the person from fidgeting. flapping, rocking, or making other repetitive movements as these can be self-calming strategies. If possible, avoid touching the person. It may appear that they are not taking the situation seriously however this may be how they focus, calm nerves or manage hyperactivity
- Is specialised support available? Collaborate with therapists trained in trauma. Refer to liaison and diversion CYP service
- By the individual repeating questions or phases, it could appear like they are mocking or challenging authority, however this could be their form of communication, self-regulation or to ensure they have understood what has been asked - check for understanding before assuming resistance
- Slow down communication; use plain, clear language. Avoid using sarcasm, figures of speech, metaphors or irony. These may be taken literally and misinterpreted as them being difficult causing misunderstandings
- Allow support persons or intermediaries during interviews and court appearances

Information Sharing

Effective and appropriate information sharing is essential for delivering safe, coordinated, and person-centred care.

This section outlines key principles and legal frameworks that guide the sharing of personal information within healthcare settings. It covers topics such as consent, direct care, data protection, and responsibilities when handling information about service users.

The aim is to support staff in making informed decisions that balance the rights of the service user with the need to provide high-quality care.

When working with service users who have specific health care needs, it may be necessary to share their personal information with other organisations, for example to:

- Investigate complaints or potential legal claims
- Protect children and adults at risk
- Assess need
- For the purposes of service delivery and treatment

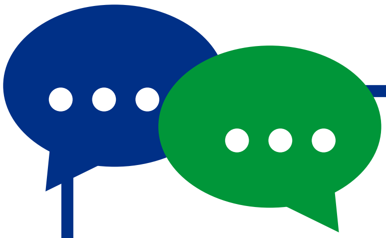
Factors to consider: When deciding whether to enter an arrangement to share personal data (either as a provider, a recipient or both) you should consider what is the sharing meant to achieve? There should be a clear objective or set of objectives.

Sharing and Risk Assessment

Any organisation/individual deciding whether to share information or not should first consider key questions:

- What is the purpose of the information sharing — is there a clear objective that can best be achieved by sharing the information?
- What is the risk to individuals (both the subject of the information or any third parties) of sharing the information and is this risk proportionate to the benefits to the individual that will be achieved? This includes considering if there is a risk to individuals if the information is not shared
- How will the information be shared?
- What is the minimum data required to achieve the purpose?

1. Remember that the Data Protection Act and UKGDPR is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.



2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared.

3. Seek advice if you are in any doubt, without disclosing the identity of the person if possible.

4. There may be instances where there is an overriding interest or need to share patient information such as a safeguarding concern or a risk to life, you should use your professional judgment to consider what you need to share and how you will do so. All decisions should be documented. If you have concerns or need support, you should liaise with your manager or your organisation's Information Governance team.

Information Sharing Checklist

Key points to consider:

- What is the sharing meant to achieve?
- Have you assessed the potential benefits and risks to individuals and/or society of sharing or not sharing? Is it fair to share data in this way? Consider any relevant functions or powers of your organisation
- The nature of the information you have been asked to share
- Whether there are any legal requirements that need to be met when sharing the data - such as a duty of confidence, or any prohibitions
- Whether there is a legal obligation or other legal requirement about sharing information – such as a statutory requirement, a court order, common law, or safeguarding

☑ **Is the sharing necessary and proportionate to the issue you are addressing?**

- What is the minimum data you can share to achieve the aim?
- Could the objective be achieved without sharing personal data, or by sharing less personal data?
- What safeguards can you put in place to minimise the risks or potential adverse effects of the sharing?

☑ **What information will you share?**

- Is any of it special category data or criminal offence data?
- What Safeguards are in place for this type of data?
- What data items are necessary?

☑ **How should you share the information?**

- You must share information securely
- You must ensure you are giving the information to the right recipient. Who in each organisation can access the shared data?
- Ensure it is restricted to authorised personnel in each organisation
- What organisation(s) will be involved? You all need to be clear about your respective roles

☑ **How should I record the information?**

- Record any decisions to share
- Document what you shared, why, with who, and how you shared it
- Keep your records accurate and up to date
- Use the repositories/storage areas/systems recommended by your organisation

Fear of Information Sharing

Often staff are worried about not understanding the rules when it comes to data sharing, so they simply don’t share for fear of getting it wrong. Fears come from a place of concern, with niggling questions such as do I need consent? Can I share this information? Am I doing it properly?

To get over these fears, individual staff need to understand the rules around information sharing and have clear data sharing agreements and processes in place. But ultimately it comes down to building confidence in partnerships at an organisational level, with teams and frontline staff across health and care settings that need to work together as a team.

Information Governance (IG) is all about how to manage and share information safely and securely. Information should be shared to support individual care. However, you should ensure that you restrict your disclosure to the information that is necessary for the purpose, and to those with a ‘need to know’.

Make sure that the person you are sharing information with has a legitimate and appropriate reason to be involved in the care of the patient or service user.

MYTH ✗ Data protection law stops all organisations and businesses from sharing personal data.

FACT ✓ Data protection law enables organisations and businesses to share personal data securely, fairly and proportionately.

MYTH ✗ Personal data can’t be shared in emergency situations.

FACT ✓ You can share data in an emergency, and you should do whatever is necessary and proportionate to save someone’s life. Data protection does not stop that.

Examples of an emergency situation are the risk of serious harm to human life, a public health crisis, or the protection of national security. Organisations should be confident that relevant personal information can be shared lawfully if it is to protect someone from serious physical, emotional or mental harm. For instance, safeguarding.

MYTH ✗ Consent is always needed to share people’s data with another organisation.

FACT ✓ Not always. You can usually share without consent if you have a good reason to do so, for example in ‘direct care’. And often it is inappropriate to rely on consent, but another legal basis.

Data protection law provides other lawful bases that may be more appropriate than consent - if in doubt, seek advice from your Information Governance Lead.

Fear of Information Sharing

It is vitally important that health and social care professionals understand that they have a duty to share confidential information in the best interests of an individual in their care – when they are providing ‘direct care’. Confidential information should be shared within the direct care team if that is expected to result in better or safer care. Most people who use health and social care services assume social workers, doctors, nurses and other professionals will share confidential information among the care team.

Sometimes individuals are put at risk when confidential information is not shared. For example, a vulnerable adult being looked after by a care worker who does not know what medication was prescribed when they were discharged from hospital. Tragically, lives have been put at risk when information has not been shared and this has been identified as the root cause of failure in many serious case reviews.

Sharing information is important as part of early intervention and preventative services.

There is an increasing emphasis on integrated working across services with the aim of delivering more effective intervention at an earlier stage. Early intervention aims to prevent problems escalating and increase the chances of achieving positive outcomes.

There are two main types of information shared within and outside of a Trust:

1 **Systematic**

Routine data sharing for an established purpose - this should be managed by an information sharing agreement.

2 **Exceptional**

One-off decisions to share data for any of a range of purposes. Caldicott principles apply and, in some instances, approval may be required from the Caldicott Guardian.

Dame Fiona Caldicott's Information Governance Review: information to share or not to share introduced the seventh Caldicott principle:

> The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients and service users within the framework set out by the Caldicott Principles.
>
> These Principles should be supported by the policies of their organisation, regulators and professional bodies. Practitioners must balance patient confidentiality with the need to share information to provide the best care for service users.

Appropriate information sharing is an essential part of the provision of safe and effective care. Service users may be put at risk if those who provide their care do not have access to relevant, accurate and up-to-date information about them.

In line with the Caldicott Principles, only relevant information about a service user should be shared between professionals in support of their care.

What is Direct Care?

> A clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals. It includes supporting individuals' ability to function and improve their participation in life and society. It includes the assurance of safe and high-quality care and treatment through local audit, the management of untoward or adverse incidents, person satisfaction including measurement of outcomes undertaken by one or more registered and regulated health or social care professionals and their team with whom the individual has a legitimate relationship for their care.

It does not include research, teaching, financial audit, service management activities or risk stratification.

The Direct Care Team

Sharing for direct care can take place across departmental and organisational boundaries. For example, the direct care team may include physiotherapists, nurses, midwives, occupational therapists and others on regulated professional registers. For direct care of an individual, registered and regulated social workers must also be considered part of the care team and covered by implied consent when the social worker has a legitimate relationship to the individual concerned.

Related Legislation:

Health and Social Care Act 2012 as amended by the Health and Social Care (Safety and Quality) Act 2015* Section 251B (Duty to Share); Common Law of Duty of Confidentiality (CLDC) (Section 251B and implied consent under CLDC will together provide the lawful basis to share in most cases of direct care.)

*Please visit the following website:
http://www.legislation.gov.uk/ukpga/2015/28/pdfs/ukpga_20150028_en.pdf

Consent

UK Data Protection Legislation requires the collection and processing of personal data to be fair, lawful and transparent.

When NHS staff provide health care for service users, they do not need the service users' consent to share their medical information with other health or social care providers for the purpose of direct care. For example, when the patient agrees to a referral to a specialist team in Secondary Care.

In the event of service user data being used for something other than direct care (e.g. video recordings of consultations to support a clinician's professional development) you must obtain the patient's explicit consent as the recording is most likely to be shared with course tutors, peer groups, etc. Please ensure that you seek guidance from the IG Team before sharing recordings with an external organisation so that the Trust can ensure that it is done lawfully and securely.

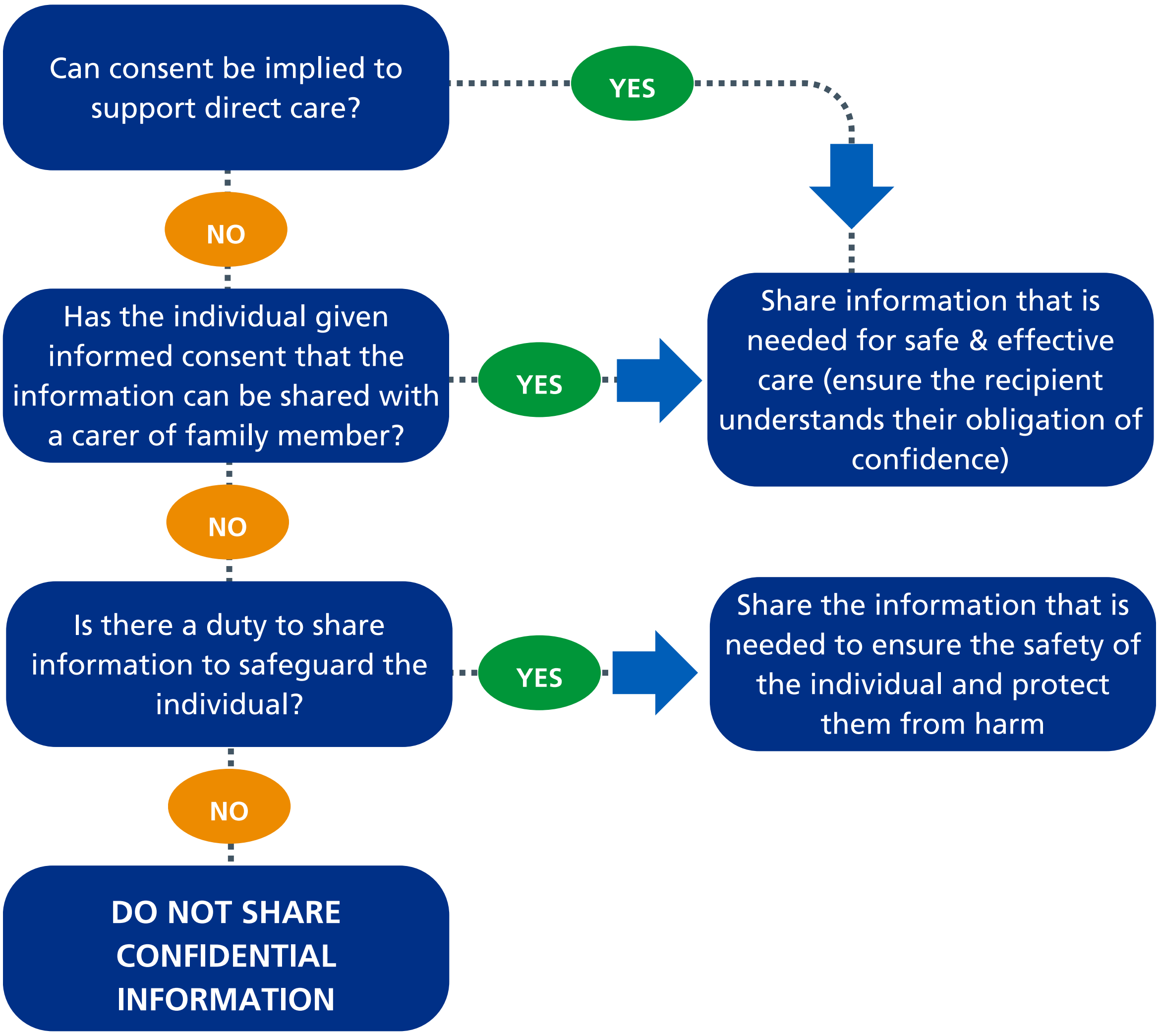
There are two types of consent, Implied Consent and Explicit Consent - these are detailed below.

If confidential patient information is accessed and used for direct care then consent is implied without the patient having to be formally consulted. This is because it is reasonable to expect that relevant confidential patient information will be shared with other health and/or social care providers on a need-to-know basis.

If a patient doesn't want information about them being shared to support their own treatment they need to inform you. This may result in you having to inform the patient that it won't be possible to refer them for further care with another provider and you will need to explain why.

Explicit Consent

If confidential patient information is required for purposes beyond their own care, for example a research project, then it will be necessary for staff to obtain their explicit consent. This is a very clear and specific statement of consent.



Can consent be implied to support direct care?

Has the individual given informed consent that the information can be shared with a carer of family member?

Is there a duty to share information to safeguard the individual?

DO NOT SHARE CONFIDENTIAL INFORMATION

Share information that is needed for safe & effective care (ensure the recipient understands their obligation of confidence)

Share the information that is needed to ensure the safety of the individual and protect them from harm

Transparency

Your organisation is legally obliged to be transparent about how information is used and shared. It should make information readily available to patients and service users explaining how their information will be used, and their right to object. This is provided in an organisation's Privacy Notice.

If you are concerned or unsure about information sharing, your organisation’s Caldicott Guardian, Data Protection Officer, Information Governance Team or senior staff can support you.

Video – Joint Statement on Information Sharing for Direct Care

The National Data Guardian, Information Commissioner and the Chief Medical Officer for England have published a joint statement and video on sharing information for direct care.

Capacity

All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

As capacity can sometimes change over time, it should be assessed at the time that consent is required. This will usually be done by an appropriately trained and experienced healthcare professional who's either:

- Recommending the treatment or investigation
- Involved in carrying it out

If the healthcare professional feels you do not currently have the capacity to give consent and you have not made an advance decision or formally appointed anyone to make decisions for you, they'll need to carefully consider what's in your best interests before making a decision.

Important elements to take account of include:

- Considering whether it's safe to wait until the person can give consent if it's likely they could regain capacity at a later stage
- Involving the person in the decision as much as possible
- Trying to identify any issues the person would take into account if they were making the decision themselves, including religious or moral beliefs – these would be based on views the person expressed previously, as well as any insight close relatives or friends can offer

Some people with certain health conditions may have periods when they're capable and periods when they're incapable.

Consent - Children and Young People

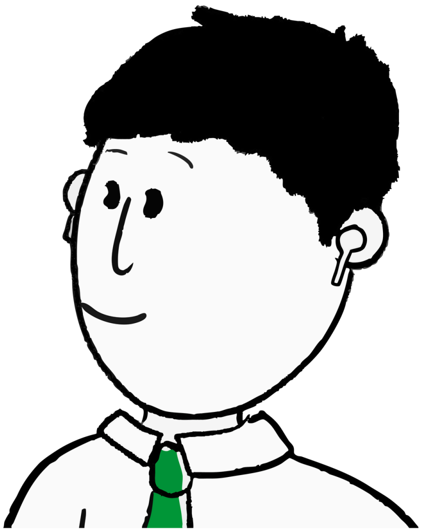
When working with children and young people, professionals often face decisions about whether to and how to share personal information. Under data protection legislation, the rights over personal data rest with the individual the data concerns. In the case of children over the age of 13, this means the child holds these rights - not automatically the person with parental responsibility.

As the children grow older and begin to develop a mature understanding of their own health, welfare, and privacy, they also gain the right to make decisions about how their information is shared. Typically, once a child reaches the age of 13, they are considered likely to have sufficient maturity and are fully competent to make their own choices regarding consent. At this point, they should be directly informed of their rights and the options they have regarding their personal information.

It is important to remember that consent is only one legal basis for sharing personal information. There are five other lawful bases available, and professionals should always select the one that best reflects the actual purpose for processing the data. If another lawful basis applies - such as a legal obligation or vital interest - then explicit consent may not be necessary.

Those with parental responsibility play a vital role in supporting their child's care. In most cases, they should be provided with relevant information in order to help them do this effectively. However, the degree to which information is shared with them should depend on the child's age, maturity, and the nature of the situation. Sometimes offering general information, rather than full disclosure, can be a helpful compromise.

Professionals should always check clinical or case records to see if there has been a conversation with the child about confidentiality and the circumstances in which information might be shared to ensure transparency as this is key at all times. Where appropriate, records should also show whether the child's parent, carer or responsible adult has been involved in this discussion. The level of detail provided in these conversations will vary, depending on the complexity of the issue and the age of the child.



There are times when a competent child may refuse to consent to information being shared. In these cases, if the professional believes that sharing the information is essential for the child's welfare, they must ensure this falls under their duty to share and record their decision. Decisions to override a competent child's wishes should never be made lightly. In such cases, consultation with the Caldicott Guardian (the person responsible for protecting patient information within the organisation) is strongly advised before any action is taken.

Safeguarding

When safeguarding is a concern, if a professional believes that a child may be at risk of harm, it may be necessary to share their information, even if neither the child nor those with parental responsibility have given consent. Safeguarding the child's safety and well-being takes precedence. It is not necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child. This means that fears about sharing information must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children.

Ultimately, professionals must use their judgement, guided by legal frameworks and ethical principles, to make decisions in the best interests of the child. By understanding when to seek consent, when it's not required, and how to communicate appropriately with both children and their families, we can ensure that children's rights are respected while still acting to protect them when needed most.

UK Data Protection Legislation

On 25th May 2018 the Data Protection Act 2018, in line with European Union (EU) law, the UK enforced the General Data Protection Regulation (GDPR) 2016.

Although the UK is no longer part of the EU, GDPR remains in force and it is now known as UKGDPR and it's incorporated into the DPA2018.

Organisations that collect personal information are accountable for how it is used and they must adhere to a set of 'data protection principles' that ensure that information is:

1 **Used fairly, lawfully and transparently**
The data subject should be informed why their information is being collected (e.g. to support their health care).

2 **Used for specified, explicit purposes**
Information cannot be collected for one purpose and then used for another (e.g. to support a referral but you then use the data subject's email address to advise them of something completely unrelated such as a Service User Group Meeting).

3 **Used in a way that is adequate, relevant and limited to only what is necessary**
You should use the minimum amount of data possible in order to support the activity you are undertaking.

4 **Accurate and, where necessary, kept up to date**
Ensure you record facts, never second guess dates and always record data as soon as possible after it has been obtained.

5 **Kept for no longer than is necessary**
All records (medical, HR, reports, minutes of meetings, etc.) have minimum retention periods. Refer to your organisation's retention policy.

6 **Handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage**
Unauthorised access to personal information is classified as an information security breach which will result in an investigation and could lead to disciplinary action being taken against the employee(s) involved.

Privacy Template Documentation

Data Protection Impact Assessment (DPIA)

Where high risk processing of personal data may impact the rights or freedoms of a living person - a DPIA should be conducted.

Data Sharing / Information Sharing Agreements (DSA/ISA)

Good practice documents outlining the purpose(s) and responsibilities of processing between two or more controllers.

Data Processing Agreement (DPA)

Document between controller and processor outlining how and what information is being processed.

Remember!

Just because you can access personal information doesn’t mean you should if it’s not required for you to do your job.

When sharing personal confidential information:

Transparency is important
- Make it known upon direct contact with patients as well as in notices and information provided to them

Communication is key
- Explain in clear language and keep them informed

What is the risk if you don’t share?
- If there is a serious health or care risk, you have a duty to share. Record your decision

Speak up
- Use your network for help

UK data protection legislation also requires organisations to provide greater security (e.g. restricted access/disclosure) for more sensitive information, for example:

Race, ethnic background, political opinions, religious beliefs, trade union membership, genetics, biometrics (e.g. facial recognition), health, sex life or orientation (e.g. data subjects identifying as heterosexual, bisexual, homosexual, transsexual). There are also safeguards for personal data relating to criminal convictions and offences.

- Consider what “needs” to be shared and be prepared to justify that
- Record your decision making
- Ensure plain English (and accessible alternatives) notices/information etc. is available and provided upon contact where possible (esp. where information is taken directly)

To find out more about the DPA 2018 and UKGDPR please visit the Information Commissioner’s Office (ICO) website https://ico.org.uk.

Useful Links

Useful Websites

Acquired Brain Injury: https://www.headway.org.uk/

ADHD: https://www.adhdfoundation.org.uk/

British Institute of Learning Disabilities: https://www.bild.org.uk/

British Dyslexia Association: https://www.bdadyslexia.org.uk/dyslexia/neurodiversity-and-co-occurring-differences

General information around neurodiversity: https://geniuswithin.org/what-is-neurodiversity/

Intermediary information: https://theintermediarycooperative.co.uk/

Mate crime: https://dimensions-uk.org/dimensions-campaigns/i-am-a-teacher/mate-crime-warning-signs/

NAS guidance for professionals working in the CJS: https://www.autism.org.uk/advice-and-guidance/topics/criminal-justice-and-police

Useful Content

Children and Young People - By reframing behaviours not as "defiance" but as potential signs of neurological difference or distress, the justice system can move closer to being equitable and humane. National Autism Association video – Can you make it to the end? https://www.youtube.com/watch?v=aPknwW8mPAM

Double empathy video: https://www.youtube.com/watch?v=qpXwYD9bGyU

Importance of autistic identity: https://www.autism.org.uk/advice-and-guidance/professional-practice

Monotropism video: https://www.youtube.com/watch?v=qUFDAevkd3E

The Punch (podcast) – Jacob Dunne: https://www.bbc.co.uk/sounds/series/m000l0jr

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