Autism and ADHD in Adults
Health Needs Assessment

Devon Public Health
June 2025

Contents

1. Executive Summary

A Health Needs Assessment (HNA) is a recognised approach to systematically review the health needs of a given population and identify priorities for addressing identified unmet needs.

The aim of this HNA was to identify the Social, Emotional and Mental Wellbeing needs of the diagnosed and undiagnosed neurodivergent adult population in Devon with a focus on autism and ADHD. The HNA has focussed on how these needs are met in universal services and services based in communities. This report was led by Devon Public Health with colleagues from Adult Social Care, and in consultation with the local health and care system.

This report contains information of a sensitive and challenging nature that you may find upsetting. This includes discussion of suicide and self-harm.

The following website includes details of support with mental health needs, including if you or someone you know needs urgent help: https://www.devon.gov.uk/adult-social-care/care-and-support/disabilities/mental-health/

A key reason for this work was the increasing evidence and calls for action regarding mental health, suicide and neurodivergence. In addition, local and national intelligence was suggestive of a higher prevalence of neurodivergence in inclusion health groups. Inclusion health groups is a broad term for a range of people including but not limited to those who are homeless, have experience of the criminal justice system, or are dependent on drug or alcohol. The HNA was intended to more fully understand the experiences of neurodivergent people within this cohort that are already experiencing significant challenges.

The HNA was undertaken in the context of substantial increases in referrals for assessment of autism and ADHD, both local and national. The national increase in demand for assessments has been replicated in Devon across autism and ADHD.

Because of this, the intention was to consider services that are inclusive to all (including where there is an absence of diagnosis) and recognise the impact of challenges in assessment and management on the population's experience and needs. However, clinical assessment and diagnosis of autism and/or ADHD and any associated pharmacological and therapeutic treatments (including those for co-occurring mental health needs) were out of scope.

Prevalence of autism and ADHD, and co-existing health and social needs (see section 8)

Although there is some variation in the estimates, approximately 1.1% of the adult (18+) population is estimated to be autistic, and 3-4 % of adults are estimated to have ADHD.

In the available evidence base, there are associations with identified higher levels of co-existing mental and physical needs, and social disadvantages across both autistic adults and people with ADHD. There is an estimated reduced life expectancy for both autistic people and people with ADHD.

Co-occurring physical and mental health conditions are common and there should be greater focus on the holistic needs of a neurodivergent person. Feedback from people with lived experience indicates that mental health needs are frequently (mis)attributed to a person's neurodivergence, or vice versa.

Challenges in the assessment and treatment pathways (see section 9)

Assessment and treatment processes are under significant pressure locally. This is important as the challenges with referrals and assessment directly impacts on mental health and emotional wellbeing, and the lack of opportunity to identify needs at an early stage leads to demand on health and support services over the life course.

It is estimated a significant proportion of autistic adults and people with ADHD are undiagnosed. This supports the need to encourage diagnostic neutral approaches, especially in view of the strong associations with associated ill health, and delays in receiving an assessment and diagnosis for those who choose to seek an assessment.

Higher prevalence in inclusion health groups (see sections 10 and 11)

There is an estimated higher prevalence of autism and ADHD in inclusion health groups including people experiencing homelessness, drug and alcohol use, and the criminal justice system. There are data collection challenges in specific services but there is some evidence from local caseloads to support the wider evidence base.

Neurodivergence may contribute to social exclusion that has been experienced by those in the most marginalised groups, and it can be particularly challenging for people from inclusion health groups when accessing services (for example, sensory challenges experienced in temporary accommodation).

Data collection presents challenges and whether a person is neurodivergent is not consistently collected. Although there is a commitment to using person centred approaches in services supporting people from inclusion health groups, there is a risk that the total level of need is not yet fully understood and responded to appropriately and consistently.

The importance of suicide prevention (see sections 12, 13 and 14)

A critical finding of the HNA is the clear association in the evidence base between autism and ADHD, and suicide. The evidence base suggests there are similar risk factors for suicide in autistic people compared to the wider population, but these may be compounded due to poor levels of feeling of belonging and masking of autistic traits. The reasons behind the apparent additional level of risk needs to be much better understood; however, in the intervening period, there is a compelling case to act where possible, and opportunities to do this within local structures.

The increased risk of suicide is well known and a concern to local people with lived experience, in particular autistic people. There is a desire to be involved in the development of any local interventions.

Local priorities to promote social, emotional and mental wellbeing needs (see sections 15 and 16)

The HNA was heavily influenced and informed by the experiences of local people with lived experience and public and voluntary sector organisations in Devon. Readers should also be aware that people with lived experience were keen to stress that this was not their first time sharing their views. This emphasises the need for action.

This engagement process has enabled a set of local priorities to be identified, and these are included at **Section 16**.

The overriding message was for **greater understanding** from employers, public service providers, and society. There is a strong desire for improved training and awareness in community-based and universal services. There is feedback suggestive of limited understanding of reasonable adjustments and awareness in universal and community services including employers.

Social (and peer) support is in general an important need in these population groups, and the development of networks and groups should be supported.

The wider policy environment is both challenging (including the potentially significant impacts from changes to welfare provision) and may provide additional clarity and good practice (for example, the learning from the national NHS ADHD Taskforce). This includes taking a more holistic approach to a person's needs, consistent application of reasonable adjustments, and comprehensive roll out of training and awareness programmes in community-based services (building on existing practice where appropriate). Within Devon, examples of good practice include adaptations to communication tools and environments, inclusive design of education programmes, and commissioning of specialist training for organisations.

The HNA process and further work

It is recognised that the HNA process risks being perceived as taking a deficit-based approach. In many ways this is unavoidable to better understand the needs of the local population. However, the intention is that this will have a positive effect, by highlighting the challenges that may be faced by these population groups and drawing attention to how these can be addressed to improve wellbeing and support the numerous strengths of the local neurodivergent population.

It is hoped that using these as a guide, together with the implementation of the recommendations will go some way to addressing identified needs for both the undiagnosed and diagnosed populations.

The scope of the HNA was relatively broad and therefore provides an overview of key issues whilst drawing attention to specific health and wellbeing needs. Within each topic area covered by this HNA, it is envisaged a more in-depth exploration of specific issues may be required.

There were limitations regarding the availability of relevant data. The collection of a person's neurodivergence is relatively limited at the community service provider level, and population wide assessment and diagnosis data needs to be better understood. This situation was in part able to be addressed by novel use of the One Devon Dataset. However, the opportunity to draw from this was limited by the timeline of the HNA; additional insights will be possible through future phases of work.

The following recommendations are made:

Recommendation	Potential lead
Strategic and core principles	
1. Throughout future work to support these population groups, a key principle should be co-production of interventions and programmes with autistic persons and persons with ADHD.	All organisations as applicable
2. Development of a strategy for adults in Devon (this should consider both Autism and other neurodivergence), and as part of this process: a) identify opportunities to provide holistic approaches to support between and across agencies; b) integrate the role of people with lived experience into decision making processes associated with the strategy and its implementation.	Within an appropriate system-wide approach
3. The findings of the HNA should inform the refresh of appropriate commissioning strategies, delivery plans and social care Market Position statements, and consider priority groups within this. This should include the Housing Needs Assessment that is being led by Adult Social Care.	Devon County Council Adult Care / Devon Public Health / MHLDN / NHS Devon Integrated Care Board (ICB)
Suicide Prevention	
4. To support Suicide Prevention as a priority within autistic adults and people with ADHD: a) Adopt the findings of the HNA within the local Suicide Prevention Strategy and Action Plan (including alignment with the 'Suicide is Everyone's Business' strand). This should include explicit consideration of awareness raising of the additional risk in autistic adults and adults with ADHD. b) Ensure a focus on neurodivergence within suicide prevention training. This should include: i) organisations most likely to be providing support at the point of crisis (including organisations providing universal support and specific support groups for neurodivergent people)	Suicide Prevention Oversight Group / Devon Public Health

ii) organisations providing support in the community on a universal basis (these groups will include support to neurodivergent adults at multiple life stages and through various means). c) Support and build in opportunities for ongoing learning eg. from the NHS Devon ICB-led Learning from lives and Deaths (LeDeR) process, and Devon Partnership Trust-led Learning Disability and Autism mortality reviews d) Support NHS Devon to ensure local organisations and partnerships are aware that LeDeR process now includes a focus on autistic adults without learning disabilities e) Consider support to social connectivity initiatives through funding programmes with consideration of priority risk groups (for example, through Communities: Local Action on Suicide Prevention - CLASP). This could include support to groups that specifically support neurodivergent people or ensuring initiatives with universal access are accessible and adopt neurodivergent-inclusive approaches. f) Consider how data collection relating to neurodivergence can be improved within the scope of the Real Time Suicide Surveillance (RTSS) and Postvention Support provision g) Continue to review the emerging evidence base (including in relation to safety planning) and ensure the development of suicide prevention tools and interventions is neurodivergent-informed.	
Social and peer support	
5. Support effective access to social support and peer support, including through funding opportunities, during the commissioning of relevant programmes, or other support as appropriate.	Devon County Council / NHS Devon / All relevant funding organisations
Universal and Community Service Provision	
6. Respond to the identified need for training and in particular: neurodivergence awareness; autism, ADHD and Mental Health; reasonable adjustments; examples of adaptations; best practice and availability of support. This should include:	
a) A review of training needs across local community service providers, including services supported or commissioned by Devon County Council for Inclusion Health groups.	Commissioned and partner providers
b) Promotion of training and awareness of the needs of adults with ADHD and autistic adults (including specific reference to the role, obligations and benefits of reasonable adjustments) in all organisations for staff and those they serve.	All relevant organisations
c) Consideration of development of new training provision, using existing courses, programmes and local expertise as a basis,	

and local experience including organisations and people with lived experience.	
7. Promotion of diagnosis-neutral approaches for all people accessing support across local community service providers.	All relevant organisations
8. Emerging opportunities and service developments should be supported to explicitly consider and meet the needs of neurodivergent people (for example but not limited to the Connect to Work Programme).	All relevant organisations as appropriate
Next Phases	
9. As part of future phases of this work, continue to build on the One Devon Dataset (ODD) Use Request, including: a) Understanding of the impact of challenges to accessing assessment, care and treatment, including any variation in shared care and/or prescribing for ADHD; b) And related inequalities.	Devon Public Health
10. As part of future phases of this work: a) consider any emerging and final findings and reports from the national ADHD Taskforce and how these may be applied in Devon b) consider the results of the focussed report into autism and suicide due to be published by National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) in 2025.	All relevant organisations

‘As soon as you turn eighteen you don’t get support for a condition you have for the rest of your life.’

“It feels like you're only allowed to have autism if you are a young person”.

‘I’d really be liking to do more but don’t know how… [I] need a helping hand.’

“When we ask reasonable adjustments, we quite often, and this is in the workplace and in health, quite often treated as difficult people who are asking for too much.”

“I have a supportive employer and am in a leadership position, so being open has enabled me to get support and to signal to actively champion that support to encourage others.”

“I've shared openly that I have ADHD and am awaiting assessment of ASC. I feel it helps people to contextualise some of my behaviours and challenges in a way that is helpful to me and them.”

Contributions from people with lived experience

2. Introduction

A Health Needs Assessment (HNA) is a recognised approach to systematically review the health needs of a given population and identify priorities for resource allocation and addressing identified unmet needs. HNAs enable the opportunity for engagement with relevant populations and stakeholders, and to develop or improve partnerships. The scope and aims of a HNA must be cognisant of the capacity to deliver the HNA, effectively address local public health priorities, and ensure clarity amongst stakeholders on the purpose and expectations of the process.

a) Background

There is increasing evidence and calls for action regarding mental health, suicide and neurodivergence. The National Suicide Prevention Strategy 2023-2028 identifies a number of actions in this space, including: to improve the intelligence picture in relation to suicides in autistic adults and young people through NCISH, and using insights from the Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) programme (DHSC, 2023).

The National Confidential Enquiry into Suicide and Safety in Mental Health (NCSIH) Annual Report 2024 identified an increase in suicides in patients with autism and ADHD over a ten-year period together with higher incidence of self-harm in both groups (NCISH, 2024).

Inclusion health groups is a broad term for a range of different groups including but not limited to people who are homeless, have experience of the criminal justice system, or are dependent on drug or alcohol. However, they very often share a common experience of being socially excluded and marginalised, have poor health care interactions, and have extremely poor health outcomes (NHS England, 2023).

The evidence base suggests there is a higher prevalence of neurodivergence in inclusion health groups compared to the general population (Homeless Link, 2024) (Young et al,, 2018). It is important to more fully understand the experiences of neurodivergent people within this cohort that is already experiencing significant challenges.

The HNA was undertaken in the context of system-wide challenges in relation to assessment and diagnosis and access to subsequent support and treatment where appropriate (for example. waiting lists for assessment, access to ADHD treatment in primary care).

The intention was therefore to consider services that are inclusive to all, including where there is an absence of diagnosis (i.e. encourage diagnosis neutral approaches) and recognise the impact the challenges in assessment and management may have on the population's needs and experience. However, the exploration of treatment options themselves was out of scope.

b) Aim and Objectives

The aim of this HNA was to identify the Social, Emotional and Mental Wellbeing needs of diagnosed and undiagnosed autistic adults and adults with ADHD, including a focus on the inclusion health population. The HNA focussed on how these needs are met in universal services and services based in communities.

This will inform:

- suicide prevention activity
- delivery of the Inclusion Health Framework
- development of future DCC and system-wide strategy to meet needs of the neurodivergent population.

And support and inform colleagues working in health, social care, and community provision.

The objectives were to:

- understand the prevalence of adults with ADHD and Autism in Devon (diagnosed and undiagnosed population)
- understand the social, emotional and mental health and wellbeing needs of this population, including the specific needs of the inclusion health population
- identify best practice in meeting these identified needs and what a good system looks like (including opportunities for prevention and early intervention in respect of emotional and mental health and wellbeing)
- identify current community-based service provision in Devon
- identify gaps which will in turn inform recommendations.

The following groups and topics were out of scope:

- Children and young people (other than where available data supports an understanding of projected need in the adult population);

- Transitions from Children's to Adult services;

- Approaches to specific clinical assessment leading to diagnosis of autism and/or ADHD and associated pharmacological and therapeutic treatments (primary or secondary care) (or in relation to co-occurring mental health need ([for example, treatment of anxiety]).

3. Methods

a) Sources of data

It was recognised from the project outset that data availability may be challenging in this space. This was due to known limitations with the data (e.g. recording of neurodivergence in local service provision – both diagnosed and undiagnosed) following discussions with local authority colleagues, and an anticipated challenge in estimated prevalence and need in undiagnosed populations, and subgroups.

Epidemiological data to support estimates of prevalence and quantitative assessments of types of need was identified through a combination of:

- the national NHS and academic evidence base;
- local data from Adult Social Care, Devon Partnership Trust and ICB;
- individual local service providers.

Estimates of local prevalence have been applied where required.

To support the above and address some of the anticipated gaps, a Use Request was developed to explore the role of the One Devon Dataset (ODD). The ODD is a linked dataset combining patient level (pseudonymised) data across health and care providers. The population of the ODD dataset is based on GP registered patient lists; approximately 80% of Practices across the ICB have agreed to submit data therefore it represents a large but not complete sample of the population.

For the purposes of identifying need in the population groups of interest, the ODD provides an opportunity to develop a more granular understanding of patterns of diagnosis, demographic insights, and associations with health and wellbeing needs. The intended use of the ODD would enable:

- greater insight into adults in Devon with an ADHD and/or Autism diagnosis;
- understanding of diagnosis trends over years;
- understanding the socioeconomic and demographic insights;
- calculation of risk ratios for co-or-multi-morbidities;
- understanding of prescriptions of therapies used in the treatment of ADHD, and how patterns have changed.

As a novel source of data this required a process of data identification, and it was only possible to consider a small section of the results in this first version of the HNA. This will however be a valuable resource for future phases of work.

b) Lived experience insight

An important source of data for this HNA was gathered through engagement with local people with lived experience (PWLE). Several activities were undertaken including:

- an online survey distributed through Dimensions for Autism, the Devon; Partnership Trust (DPT) Post Diagnostic Support Group and Experts by Experience, and Devon Carers Peer Support Group for Carers of Autistic People;
- a discussion group commissioned from Dimensions for Autism and Living Options Devon;
- a discussion group hosted by DPT's Together Peer Support Team and the Mental Health Alliance, attended by members of staff and Experts by Experience;
- a discussion group hosted by the Devon Carers Peer Support Group.

c) System stakeholder insight

Stakeholder insight was gathered through:

- an online survey distributed to purposively sampled stakeholders across NHS and community based services, and partnerships including the Suicide Prevention Implementation Group;
- semi-structured interviews with individual stakeholders;
- a stakeholder discussion group with representative of the Devon Housing Options Local Authority network, System Change Action Alliance (SCAA), ICB Clinical Lead for Neurodiversity and commissioning, Devon and Cornwall Police, and Torridge-based TTVS.

A research governance approach was applied using the existing Devon Public Health Research Governance framework. In summary, the following steps were taken:

- Discussion topic guides and survey content was tested prior to distribution with service area leads and people with lived experience to ensure acceptability and appropriateness;

- All participants were provided with the purpose of the research and how it would be used, their rights and confidentiality of responses. Consent to take part was requested in all cases. Participation was voluntary;

- The purpose of the discussion sessions with PWLE were provided 2 weeks in advance to provide as much advance time for consideration to meet the needs of participants;

- Participants in the online survey were provided with details of appropriate emotional and mental health support mechanisms.

d) Policy and evidence base

National and local policy documents and strategies were reviewed on an ongoing basis throughout the HNA process. The academic evidence base was reviewed following a literature review supported by a search process undertaken with the UKHSA Knowledge and Library Service.

e) Resources

The HNA was led a Public Health Registrar and supervised by a Consultant in Public Health. The project was supported by a Steering Group with representation from the Public Health Team including Public Health Intelligence Team, Public Health Clinical Advisor (and representative of Inclusion Health Devon primary care service), and Adult Social Care.

The Public Health Practitioner Apprentice provided specific support with the engagement process.

4. Key concepts and definitions

Unless specifically referenced, within this HNA, where we refer to **neurodivergent people, autistic people, or people with ADHD**, we mean both people with a formal diagnosis and those who do not have a diagnosis.

Mental and emotional wellbeing - relates to being able to (for example) feel good, learn and work well, form positive relationships with others, contribute to the community and manage day-to-day stressors in life. It is closely related to social wellbeing.

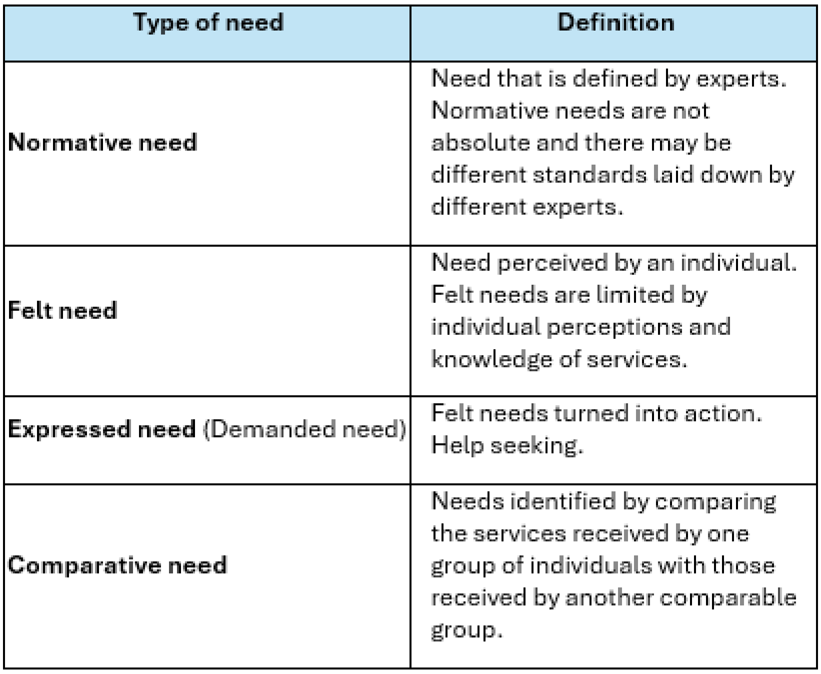
Social wellbeing relates to social capital, trust, and connectedness. It depends on individual mental wellbeing in a group, community or society, the quality of government (local, organisational, national), quality of services and support for those in need, the fair distribution of resources including income, social norms regarding interpersonal relationships in groups and communities, including respect for others, compassion and empathy, and authentic interaction.

Adapted from https://www.fph.org.uk/policy-advocacy/special-interest-groups/public-mental-health-sig/better-mental-health-for-all/concepts-of-mental-and-social-wellbeing/

Universal and community-based services – these are services that are theoretically available to any adult living in Devon and do not require someone to be neurodivergent to access them. These may include for example, education, housing support, the police, primary health care (for example, GP Practice), secondary and community health care, or support with employment. They are usually based in local communities.

Some services may be targeted at supporting types of need or service provision, including services provided by the voluntary and community sector (VCSE). For example, Local Authority Housing Teams may include support dedicated to supporting people experiencing homelessness. These are included in the scope of this HNA, where they are not exclusively developed as specialist services for autistic people or people with ADHD.

Needs – 'Need' does not have a universal definition, but Bradshaw's Taxonomy of Needs is a helpful method of conceptualising this and sets our four types of need:



Type of need	Definition
Normative need	Need that is defined by experts. Normative needs are not absolute and there may be different standards laid down by different experts.
Felt need	Need perceived by an individual. Felt needs are limited by individual perceptions and knowledge of services.
Expressed need (Demanded need)	Felt needs turned into action. Help seeking.
Comparative need	Needs identified by comparing the services received by one group of individuals with those received by another comparable group.

Adapted from https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/concepts-need-sjustice

The ‘quantum’ of need in each of these groups may be very different, and a focus on expressed needs alone will not give a full understanding of need in the community.

This is particularly relevant in the context of this HNA in terms of (for example) the felt need perceived an individual who recognises that may have a neurodivergence, the expressed need of seeking a referral (if someone is able or chooses to), and the normative need as defined by clinicians and public services at the point of assessment.

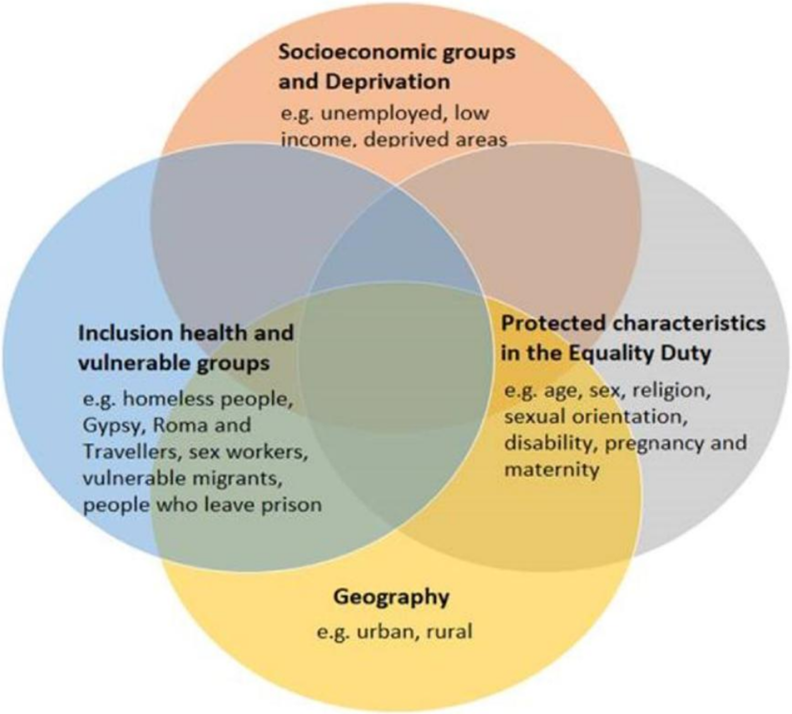
Health inequalities and Intersectionality

Health inequalities are avoidable and unjust differences in health and wellbeing between different sections of society. This may be represented by experiences of lower quality of life, poorer healthcare access or outcomes, or higher mortality (The King's Fund, 2022).

Individuals or communities have many different characteristics that influence their health outcomes. These can be grouped in the following ways: socio-economic status, protected characteristics under the Equality Act (for example age or disability), geography, and vulnerability and social marginalisation (people in the latter are broadly known as people in Inclusion Health groups) (OHID, 2024).

These characteristics can overlap or ‘intersect’, and for some people this creates additional challenges to achieving good health and wellbeing. The following diagram clearly summarises the way in which these different factors can overlap:

Overlapping dimensions of health inequalities



(OHID, 2024)

This is a helpful concept when considering the findings of this HNA given the overlapping factors that have been identified as affecting autistic adults and people with ADHD. Each type of factor may not relate to every person with a neurodivergence in Devon, however, as is described below, there are strong associations with specific characteristics outline above.

This approach enables us to, firstly, recognise and more fully understand the issues facing a community, and then, develop holistic and integrated approaches to more effectively address these issues.

Neurodiversity and related concepts

The model of neurodiversity is based on the concept that all people vary in terms of how they perceive, respond and communicate to the world around them; importantly this includes that all differences should be accepted and respected.

A person may be described as ‘neurodivergent’ when their experience differs more significantly from what may be considered ‘typical’, and a person may have more than one neurodivergence (National Autistic Society, 2025). Therefore, humanity is neurodiverse, an individual person may be neurodivergent.

Various descriptions or types of experience are included under the umbrella of ‘neurodivergence’. These include:

<table>
<tr><td colspan="3">Autism</td><td colspan="3">ADHD</td><td colspan="3">Dyslexia</td><td colspan="3">Dyscalculia</td></tr>
<tr><td colspan="4">Dysgraphia</td><td colspan="4">Obsessive Compulsive Disorder (OCD)</td><td colspan="4">Tic condition (including Tourette Syndrome)</td></tr>
</table>

Acquired brain injury may be included, and in some cases learning disability and mental health conditions.

Learning disabilities in this HNA are generally defined using the NICE criteria of: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. ‘Intellectual disability’ is frequently used as an alternative term in the international and academic literature (NICE, 2025).

A learning disability may be caused by factors including genetics, environmental exposure, illness, accidents and trauma, or neglect. It is distinct from a learning difficulty (for example, dyslexia).

This HNA has a focus on Autism and ADHD.

The medical model and social model of disability are also important concepts. The medical model focusses on how - for medical science - significant differences to a typical human experience represent a disorder; these may then be diagnosed and potentially cured or treated but otherwise represent a deficit if they are not addressed and the person may be seen as ‘disabled’ due to their condition.

Conversely, the social model of disability differentiates between the impairment of a person’s functional abilities, and the disability the person experiences because of the impact of living in a society that presents barriers to that person’s full participation due to lack of accommodation of that impairment. These barriers may be physical or relate to cultural and social norms (Disability Wales Anabledd Cymru, 2023) (National Autistic Society, 2025) (Disability Rights UK, 2025).

The intention is not to be prescriptive about which approach should be used. This HNA recognises that not all people with a neurodivergence may consider themselves as ‘disabled’ or seek or gain a diagnosis (which may be helpful in many circumstances). However, as a general concept, as the intention of the HNA is to identify needs that can be addressed by the removal of barriers in the community, this work is framed by and most closely associated with the social model.

Autism

Autism is a lifelong neurodevelopmental condition characterized by:

- persistent difficulties with social interaction and communication, and;
- rigid and repetitive behaviours, resistance to change, or restricted interests.

The autism spectrum is wide and the presentation and impact of autism ranges from mild to severe. Autism can be expressed and experienced in differing ways between different people and different stages of life. Autistic people may:

- experience differences communicating with and relating to other people, and others to them;
- experience differences in developing and maintaining relationships;
- have strong intense interests which affect their daily lives;
- prefer routine and find adjusting to change challenging;
- have sensory processing differences.

A clinically significant impact on a person's functioning is required to meet the criteria for a diagnosis of autism, such differences must be having a clinically significant impact on a person's functioning (Devon Partnership Trust, 2025).

Autistic people may need significant levels of support to live an independent life, or none at all. Autism is not itself a learning disability or a mental health condition; however, many people with autism do have mental health needs, a learning disability or another condition. These are called co-existing conditions (or 'co-morbidities') and are discussed in more detail at (Devon County Council, 2025) (NHS, 2022).

Aspergers was previously used to describe autistic people with average or above average intelligence and who did not have a learning disability (NHS, 2022). Atypical autism or pervasive developmental disorder not otherwise specific was also used in previous diagnostic manuals (up until the adoption of DSM-V and ICD-11). However, for the purposes of diagnosis, it is now recommended to use autism spectrum disorder (ASD) (nb. a person previously diagnosed as having Aspergers or PDD-NOS may retain their original diagnostic label if they choose) (NICE, 2025).

Therefore, an autistic person may be described as having autism spectrum disorder (ASD), or autism spectrum condition (ASC), particularly in relation to medical model terminology. Where required for use in this HNA, autism spectrum condition is preferred.

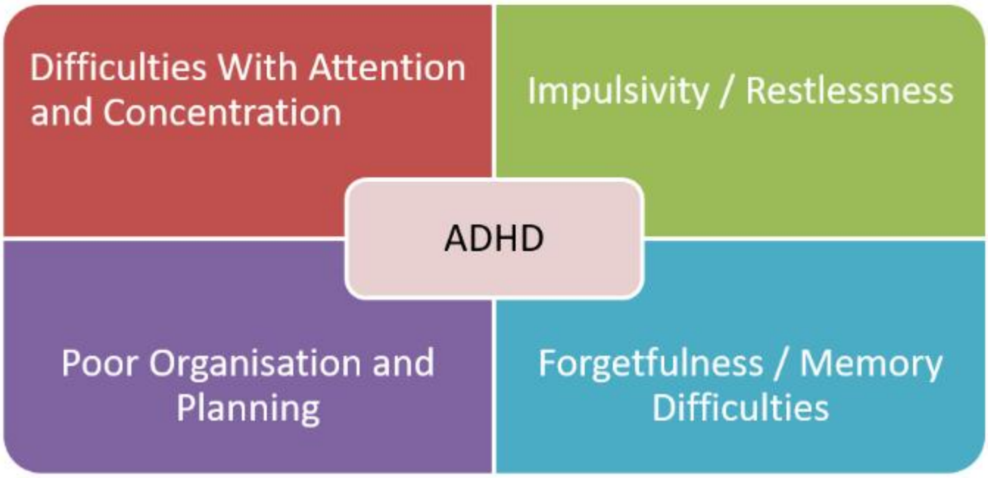
Autistic adults may present at any age however it is considered more common at times of stress and life events and may become apparent because of challenges in relationships or workplaces, for example (BMJ, 2023).

The cause of autism is not fully understood. A combination of genetic and non-genetic factors play a role. Genetic factors are estimated to pay a significant role with estimates of heritability ranging from 40-90% (meaning 40-90% of the variability in the population may be due to genetic differences). Environmental associations include but are not limited to maternal health factors, but additional research is needed. Autism is not caused by different parenting approaches or emotional deprivation (BMJ, 2023) (NICE, 2025).

Attention Deficit Hyperactivity Disorder (ADHD)

People with ADHD show a persistent pattern of inattention and/or hyperactivity–impulsivity that interferes with day-to-day functioning and/or development' (NICE, 2025).

The range of symptoms can be summarised as follows:



(Devon Partnership Trust, 2025)

ADHD (should be suspected) if 'there are at least six (five in adults) inattention symptoms and/or at least six (five in adults) hyperactivity-impulsivity symptoms that have:

- started before 12 years of age;
- occurred in two or more settings such as at home and school;
- been present for at least 6 months;
- clearly interfered with, or reduced the quality of social, academic or occupational functioning;
- not occurred exclusively during the course of a psychotic disorder and are not better explained by another disorder such as oppositional defiant disorder or conduct disorder.'

As with autism, causation of ADHD is subject to further research. It is considered likely to comprise of genetic and environmental factors leading to altered brain structure and neurochemistry. Estimates based on childhood twin studies place ADHD at 70-80% heritability. Environmental factors with the strongest role in the available evidence include low birth weight, and there is a strong association with childhood adversity. Overall, causality is difficult to establish due to the complex interplay of potential factors (BMJ, 2024) (NICE, 2025).

5. National and local policy context

National policy and legislation

Relevant national policy and legislation is included at Appendix 1. Of note are the following:

- the Equality Act protects all persons in England, Scotland and Wales from discrimination (which may be direct or indirect or take the form of harassment or victimisation). Under the Act, a disability is defined as 'a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities'. Not all persons with a neurodivergence consider themselves from having a disability but it contains important protections for those who do;
- the Autism Act 2009 requires Government to publish an adult autism strategy and make associated guidance for the NHS and local authorities.

The policy context is more developed with respect to autism compared to ADHD. An initial review was undertaken by NHS England in 2023 to more fully understand ADHD service provision in the NHS. This was to more fully understand challenges in capacity, medication versus therapeutics, variation in NHS service provision, and lack of data. The findings of this initial review found that there was a need for greater joined up approaches across health, care, education and the justice system. A major issue was the lack of good quality data on ADHD, and there was a need to better understand pathways and service models that had rapidly developed. Cohorts at risk of inequalities of access, experience, and outcomes included: victims and perpetrators of crime, those facing broader socio-economic deprivation, and marginalised groups (NHS England, 2024).

As a next step, the Government launched an ADHD Taskforce in 2024. The intention was this would work alongside NHS England to develop a national data improvement plan, better understand the commissioning landscape, and capture innovative examples of NHS provision. The taskforce plans to engage with a range of sectors including patients, primary and secondary care, local authorities, schools, and educational providers[1]. This approach may change following Government announcement to abolish NHS England and re-allocate and merge its functions.

---

[1] https://www.england.nhs.uk/2024/03/nhs-to-launch-cross-sector-adhd-taskforce-to-boost-care-for-patients-in-england/

Local policy

ICBs and partner trusts are required to publish a Joint Forward Plan (JFP). The most recent JFP for Devon was refreshed in April 2024. This sets out how the local health and care system will meet the population's needs and take forward the objectives of the Integrated Care Strategy. Relevant elements of the JFP are included below:

Aspirations under the Learning Disability and Autism strand:

'Our vision is that autistic people get the support and opportunities they need to lead full and happy lives. As partners, we will work to improve services, reduce waiting lists, support the removal of barriers for autistic people of all ages and their families/carers, through improving training and awareness, such as Oliver McGowan, provision of meaningful support, assessment and diagnosis, early identification and reducing the reliance on inpatient care through community services'

'The empowerment of people and families to work with us as partners in making sure people get the best care and support possible. We want to find more ways to bring this to life in the work of the innovations we support. Reaching out to those communities, that are difficult to engage due to rurality and culture, hearing more balanced views and increasing opportunities to co-produce.'

'A reduction in health inequalities and improvement in health outcomes for people with a learning disability and autistic people delivered through actions and learning.'

'Opportunities to increase the number of our adult working age community into meaningful employment.'

'Collaborative working, with system ownership, shared outcomes and examples of good practice and innovation, led by expertise and clinical knowledge and experience.'

'Housing and Accommodation: A new model of delivery for people with learning disabilities and autism, including those with the most complex needs. Housing-based needs share five common principles of providing the best living environment; a clear common pathway for delivery; ensuring better life outcomes and making best use of financial resources to create sustainable housing and services over the long-term.'

'Golden thread of reasonable adjustments to access all services across Devon.'

The related objectives include (but are not limited to):

- Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times by March 2028;

- Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in the guidance.

As can be seen the system's priorities include a focus not only on clinical care but how support is provided in the wider community, including the opportunities to work more closely with communities. This is helpful in providing the wider strategic context for this HNA and alinement with its aims and objectives.

NHS Devon has developed a revised Neurodiversity Strategy for Children and Young People 2025-30. The strategic initiatives include enhanced 'ordinarily available provision' including support into family hubs and early help and promotion of inclusive environments and communities, and needs led support. The latter point will include help available to all, without or without a diagnosis. Ordinarily available provision refers to 'inclusive provision and practice that all Devon schools, early years, and post 16 settings should be able to provide for all children and young people, including those with SEND, from within their own resources' [2].

There is currently no specific adult-focussed Autism Strategy or Neurodivergence Strategy held specifically by Devon County Council or the ICS. The previous joint strategy, Living Well with Autism Strategy for Devon, Torbay and Plymouth covered the period 2015–2020 with details for each area under local Action Plans. The main priorities of the plan were: diagnosis, information and training, and person-centred support.

The local Autism Involvement Group is a forum to discuss the implementation of the local Autism Strategy. During the period of the HNA, the AIG was under review and was not currently meeting.

Relevant sections of the Devon Suicide Prevention Strategy and Action Plan 2024-27 are included at section 14. This HNA will contribute to the implementation of this action plan. During the period of the HNA it was agreed that the Suicide Prevention Action Plan would henceforth be Devon-wide and so include joint priorities with Plymouth and Torbay areas.

During the production of the HNA, Torbay Council was simultaneously in the process of developing an Autism Strategy. This followed the development of a Learning Disability Strategy on behalf of the LD Partnership Board. The Torbay Autism Partnership Board and Autism Ambassadors requested the development of a specific autism strategy, following the end of the previous Devon-wide version.

This will focus on Adults but dovetail with transitions and relevant SEND/neurodiversity strategies. The Strategy-in-development will follow the same priorities for the National Strategy for Autistic Children, Young people and Adults, but respond to local needs and aspirations. A key area of interest for the Ambassadors is health inequalities for people with autism.

Cornwall Council has recently refreshed its JSNA Autism Focus Paper which made recommendations for development of a local strategy with supporting actions including community and organisational awareness, data collection, and the role of trauma informed support (with appropriate adjustments) (Cornwall Council, 2024).

---

[2] https://www.devon.gov.uk/support-schools-settings/ordinarily-available-inclusive-provision/

6. Assessment Processes

It is important to note that many autistic people or people with ADHD do not receive a diagnosis. This may be due to a range of reasons including poor access to assessment. Alternatively, it may be because they or their friends and family do not recognise them as possibly neurodivergent. People who recognise themselves as being autistic or having ADHD may choose not to seek a diagnosis as they have access informal support or perceive that a formal diagnosis may be associated with stigma and discrimination. They are often referred to as 'self-identifying'. There may also be a temporary period of adjustment prior to seeking a formal diagnosis (National Autistic Society, 2025).

This HNA will not be making recommendations specifically on the assessment process, or the care and treatment that a person may receive because of their diagnosis of autism or ADHD, or co-existing mental health needs. However, the process of referral, understanding when and why a diagnosis may be important, associated delays, and the support in and around assessment are very important to a person's wellbeing. Therefore, the process for assessments is described below.

Autism Assessment and Diagnosis

Guidance was issued by NHS England in 2023 to inform the development of autism assessment services and recognising the rapid increase in demand.

As noted above, not all individuals who self-identify as autistic may seek a diagnosis, however the guidance outlined when a diagnosis may be considered beneficial and is summarised here:

- An autism diagnosis is important in healthcare as it allows clinicians to recommend safe and effective interventions tailored to the individual's needs. These evidence-based interventions can be aimed at autistic individuals or their parents to improve communication, behaviour, or well-being outcomes;

- An autism diagnosis helps ensure reasonable adjustments in physical and mental health services. It is important for treatment for co-occurring conditions, as some mental health interventions may be less effective or need adaptations, such as CBT for anxiety or depression;

- Clarity about autism diagnosis can be validating for many people in their day-to-day lives;

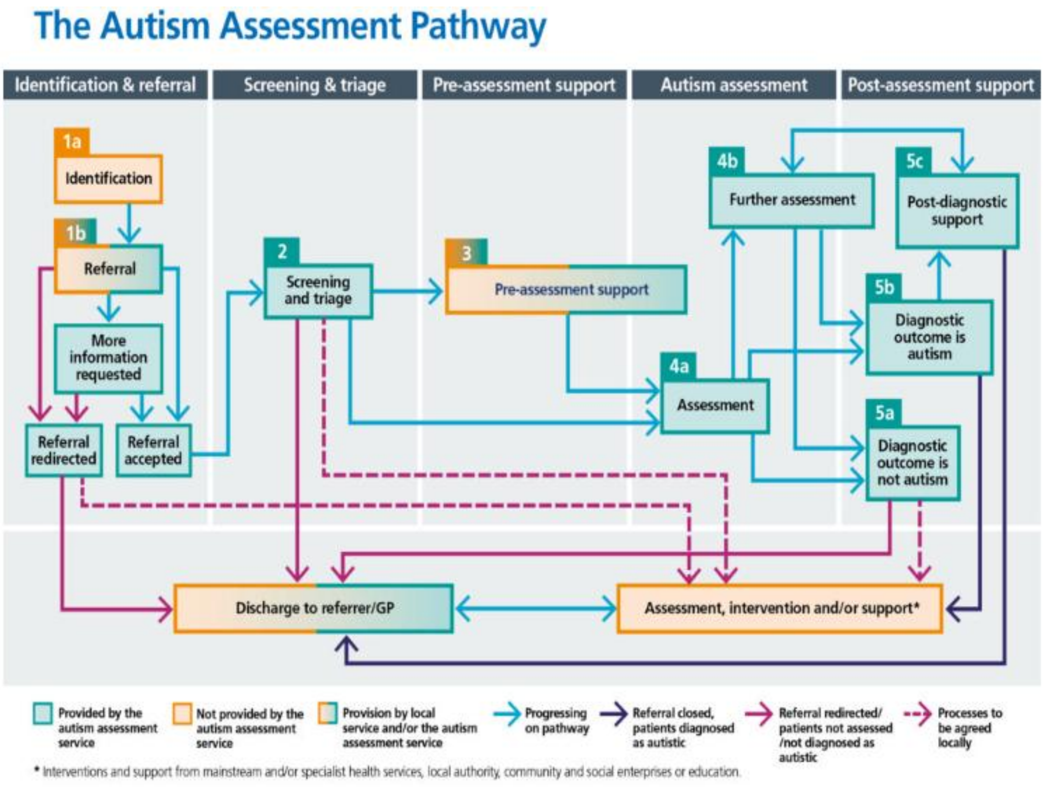
- It can help facilitate access to some forms of statutory protection beyond the healthcare context. This may be associated with a person's protected characteristic under the Equality Act 2010 or seeking reasonable adjustments in the workplace. Autistic adults are also entitled to a care assessment under the Care Act 2014;

- When a person is undiagnosed, their access to health and support may be withheld, and lead to poor health and social outcomes across the lifecourse, including abuse. It is important to note that autistic people (and especially people without an intellectual disability) represent a significant proportion of the mental health inpatient population in England;

- Delayed or unequal access to assessment may result in missed opportunities for support from education, social care and the VCSE. This may increase the long term costs to health and care services.

This identified some key elements for local systems to consider when planning local pathways:

- Autism assessment demand capacity modelling needs to continuously plan for changing demand;
- plan capacity by recognising that autism assessment is time consuming;
- planning capacity for post-assessment support improves autistic people's mental health and may reduce the amount of mental health support required;
- Autism assessment pathways must respect a person's right to choose about interventions;
- assessment services must be delivered by specialist multidisciplinary teams.



(NHS England, 2023)

For clinicians, the recommended approach for adults with possible autism and do not have a learning disability is to screen using AQ-10 tool. A score above 6 or clinical judgement should then lead to an offer of referral to autism team or psychiatrist for comprehensive assessment.

For individuals with a moderate or severe learning disability, an initial assessment is made as to whether two or more relevant behaviours are present.

At the point of referral, the person should be offered 'verbal and written' information on autism (including the diagnostic process, available services and next steps) (NICE, 2025)

If a diagnosis is provided, NICE outlines the care that should be offered to the person:

- Receive follow up appointment in secondary care to discuss initial concerns and implications. A decision should be made whether to initiate routine review in primary care going forward. Specialist care should be identified where appropriate;
- Ensure the person has access to psychosocial support. This may include social learning, problem solving to avoid victimisation, and supported employment programmes;
- Treatment or referral for any co-existing mental health conditions;
- Management of behaviour that challenges (where present);
- Provision of verbal and written information including local support groups.

Families and carers should be offered an assessment of their own needs. This should include personal support and support in their caring role. This may include information, advice or training. A Carer Assessment may be provided by the Local Authority (NICE, 2025).

ADHD Assessment and Diagnosis

Where possible ADHD is identified in an adult, and moderate or severe psychological, social, educational or occupational impairment is associated with symptoms, the person should be referred as follows:

- 'Refer people without a prior diagnosis of childhood ADHD for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD.
- Refer people who have previously been treated for ADHD as children or young people to general adult psychiatric services for assessment.'   (NICE, 2025)

The diagnosis process should be based on relevant information through screening questionnaires/rating scales and clinical history. Rating scale results may be combined with the results of patient interview and assessment, secondary sources, and additional testing (including psychological and medical). BMJ Best Practice highlights that assessment of occurring mental health conditions should be an 'essential facet' of ADHD assessment; it recommends that: 'ADHD as a primary condition is most clearly diagnosed when mood or anxiety disorders are not active. Treat obvious psychiatric disorders as normal and assess the effects of that treatment on cognition (attention, concentration, memory) carefully' (BMJ, 2024).

Management and Treatment of ADHD

A key difference to the management of ADHD compared to autism is the availability of pharmacological therapy as a treatment for ADHD (recognising that autism is not a condition to be 'treated').

The management of a person with confirmed ADHD should be co-ordinated by specialists. Key points include:

- advice to eat a healthy diet and take regular exercise;
- ask families and carers how the ADHD affects them and consider any needs for support following assessment or self-help;
- provision of written information and local support groups;
- medication is offered to adults if they continue to experience impairments after environmental changes have been made. The first line treatments are lisdexamfetamine or methylphenidate;
- supportive psychological intervention and or CBT should be considered if after medication, significant impairment continues to be experienced.

Drug treatment may be supported through primary care (see below) (NICE, 2025).

Devon Pathways

For both Autism and ADHD, in Devon, patients referred to Devon Partnership Trust would be placed on a waiting list for assessment by the Devon Adult Autism and ADHD (DAANA) service.

This provides diagnostic assessments, some post-diagnostic support, and pharmacological and psychological interventions for adults with ADHD.

Within DAANA, patients will be provided with several appointments. Information is gathered from the person including where possible information on their childhood, and possibly other people who know them well. Video appointments are offered, with in-person appointments offered as an adjustment.

The autism pathway is outline in more detail here: https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/autism

The ADHD pathway is outlined in more detail here: https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/adhd

The post diagnostic monthly support group element had been reviewed and was due to close in March 2025 to enable the service to focus on its assessment function and provision of time-limited support. The support group had over 200 persons on its membership, with some members of the group having attended for several years.

During the period of the HNA, a project was underway to identify the availability of community based support.

In addition to DAANA, DPT host the Devon Adult Autism Intervention Team (DAAIT) that has been commissioned to work across the whole of Devon. This is not a care co-ordination or crisis provision; this relatively small team works with an individual's existing health, social care and support networks to:

- prevent unnecessary hospital admission;
- reduce length of stay;
- prevent placement/accommodation breakdown (including in the family home);
- work to better understand where autism is impacting on the person's stability, and barriers to interventions/treatment options, where autism is the key or contributing factor to individuals needs/concerns.

The provision is time-limited and does not provide services which can be provided by mainstream services, with reasonable adjustments.

Right to Choose

The Right To Choose (RtC) pathway enables patients to seek assessment from a wider range of NHS-funded providers. A patient may request a Right to Choose referral in the following circumstances:

- they have an elective referral for a first outpatient appointment;
- they are referred by a GP;
- the referral is clinically appropriate;
- the provider has an NHS-commissioned contract (ICB or NHS England) for the required services.

Right to Choose Services commissioned and available to Devon ICB-registered patients are outlined at Appendix 3.

An individual may also choose to pay for a self-funded assessment in private health care.

Shared Care

Shared Care Protocols enable whereby responsibility for ongoing management and prescribing in a patient's care plan is held jointly by the specialist team and the person's GP. The specialist team initiates treatment and titration of medication, which is then continued and monitored in primary care.

This includes treatment for a range of conditions but includes ADHD and is recommended in NICE guidelines (where locally agreed arrangements are in place) (NICE, 2025).

The guidelines for Devon can be found here: https://onedevon.org.uk/our-work/services-and-support/medicines-and-treatments/clinical-guidance-for-prescribers/

Responsibility for patient management remains fully with the commissioned specialist service until a Shared Care request is accepted. GPs should be satisfied that they are able to safely manage the patient and may refuse a request.

NHS Devon does not support shared care plans between privately funded and NHS-funded clinicians: https://onedevon.org.uk/our-work/services-and-support/medicines-and-treatments/mixed-funding-private-and-nhs-shared-care-requests/

7. Prevalence of autism and ADHD and associated health outcomes

National prevalence of autism / ADHD

Autism

The estimated prevalence of autism spectrum disorder in adults is c 1.1% (NICE, 2024).

Data on autism diagnoses of all registered patients (including children) in 2024 was placed slightly higher as follows:

Autism prevalence calculated as a proportion of registered patients with an autism diagnosis (March 2024)

Region	Number of people with an autism diagnosis	Number of people registered at a GP Practice	Autism Prevalence
England	828,138	62,907,729	1.32%

Coverage of open and active Practices included in the data was 98% (NHS Digital, 2024).

Taken together with the higher estimated prevalence in children of 1-2% (NICE, 2024) this is taken to mean autism is under-recognised and underdiagnosed in adults.

A 2023 study of primary care data estimated high levels of under-diagnosis, particularly in older age groups (estimated at between 150k-500k undiagnosed in the 20-49 age group, and between 250k-600k in those aged 50+). This means only 3.5-7.9% of autistic people aged 50+ have a diagnosis (ie. 9 out of 10 do not have a diagnosis).

In this study, of those who did receive a diagnosis, overall, the most socio-economically deprived areas were associated with higher rates of diagnosis (in 2018, people in the most deprived localities were approximately twice as likely to be diagnosed compared to those in the least; this gap had developed the study period). This may be due to multiple reasons; over/under diagnosis in the most/least deprived communities respectively, but also reverse causality given the social challenges that can be experienced by autistic people and contribute to experiences of deprivation (explored more below) (O'Nions et al., 2023).

This is an area for further investigation and for Devon the use of ODD data will be particularly helpful when available (deprivation is an identified variable within the ODD extract).

In the evidence base there is a consistently higher proportion of men diagnosed with autism compared to women (the ratio is in a range of 3:1 to 5:1). It is suggested this may not be a true reflection of the profile and may be due to women being able to better mask autistic traits, and under-reporting of these traits leads to under-diagnosis (NICE, 2024). This may also result from diagnostic tools being less accurate in identifying autism in females (BMJ, 2025).

ADHD

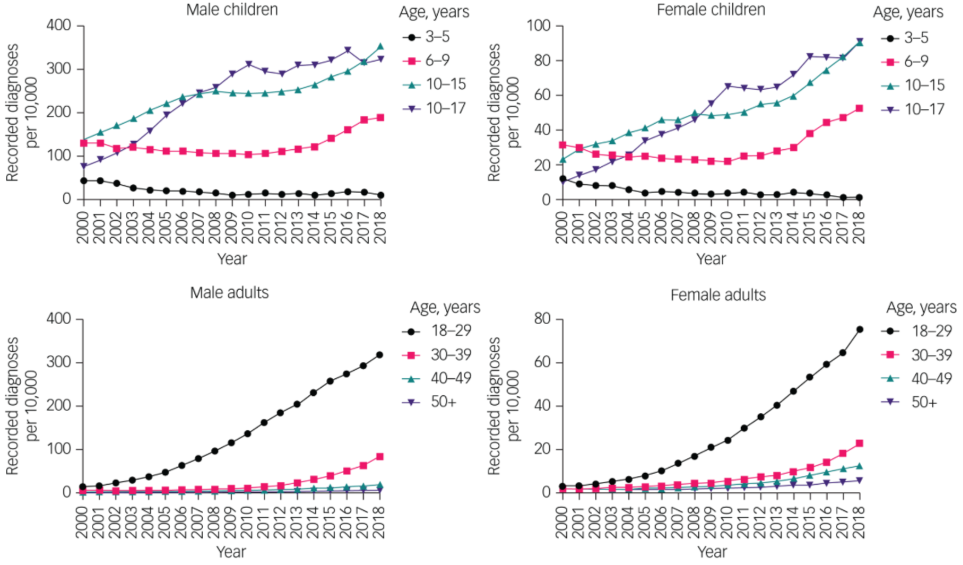
The prevalence of adults with ADHD in the United Kingdom (UK) is estimated at 3-4%, with a male to female ratio of 3:1 (NICE, 2024). There is a higher prevalence in children with global prevalence at 5% (NICE, 2024). Of those diagnosed with ADHD as children, by the age of 25 years, only 15% retain the full ADHD diagnosis. A larger proportion (65%) fulfil the DSM criteria for ADHD in ‘partial remission’ (BMJ, 2024).

The difference between sexes in children is considered as possibly due to different presentations; boys more likely to be presenting with disruptive behaviour that prompts referral, whereas girls more commonly have the inattentive subtype, for example (NICE, 2025).

National-level data available to NHS England on ADHD referrals, assessments and diagnoses is considered too variable in terms of completeness to provide reliable estimates.

In UK Primary Care data, between 2000 and 2018, the incidence and diagnostic prevalence of ADHD had increased across all adult age groups, including a 20-fold increase in diagnoses in men aged between 18-29.

Time trends of ADHD recorded diagnoses in children and adults for period 2000-2018 (by gender and age group)



(Source (McKechnie et al., 2023)

There are recognised nationwide challenges to respond to the demand for assessment and diagnosis of both autism and ADHD and the data on this is included at section 9. The precise reasons need to be better understood, but increased referrals may relate to increased societal awareness, and diagnoses due to unmet needs being recognised and/or higher identification in childhood, for example (Nuffield Trust, 2024).

Neurodivergence and learning disabilities

The estimates for the proportion of people with autism who have a learning disability vary substantially. Estimates of autistic children with an intellectual disability vary between 40-80% (BMJ, 2023).

In adults, a Scottish Census-based study estimated 29% of autistic adults over the age of 25 had intellectual disabilities (Rydzewska et al., 2018).

In the context of wider perceptions of underdiagnosis, it is suggested 55% of autistic people with a learning disability are undiagnosed in England, with potentially significant impacts on their care and support needs (for example, unrecognised reasons driving behaviour that challenges) (O'Nions et al., 2023).

In terms of people who are registered with a learning disability, experimental statistics for England are available. Data relating to neurodivergence and registered GP patients with learning disabilities has been published covering the period up until March 2024 (NHS Digital, 2024):

Learning disability and autism Prevalence

Percentage of patients **who have a learning disability** who also have an autism diagnosis has increased from 21.4% in 2017-18, 32.4% in 2022-23, and 33.3% in 2023-24.

Percentage of patients **without a learning disability** who have an autism diagnosis has increased from 0.5% in 2017-18, to 1% in 2022-23, and 1.2% in 2023-24.

Learning disability and ADHD prevalence

Percentage of patients **who have a learning disability** and an ADHD diagnosis has increased each year from 5.5% in 2017-18 to 8.6% in 2022-23 and 9.0% in 2023-24.

Percentage of female patients who have a learning disability and an ADHD diagnosis is 5.3% for 2023-24 and is lower than for male patients (11.4%).

Percentage of patients **without a learning disability** who have a diagnosis of ADHD has increased from 0.5% in 2017-18 to 1.0% in 2022-23 and 1.2% in 2023-24.

The highest rates of ADHD were in those who are autistic:
- in those who are autistic but with no learning disability, 19.8% had an ADHD diagnosis in 2023-24.
- 17.1% of those who are autistic and had a learning disability also had a diagnosis of ADHD.

(NHS Digital, 2024)

The main challenge to this set of experimental data is coverage; this dataset included c. 50% of patients registered in England. The trend is for increased ascertainment of autism in patients with and without learning disabilities. This pattern can also be seen for ADHD. ADHD is highest in autistic people.

Life expectancy

A 2025 matched cohort study estimated life expectancy for adults **diagnosed with ADHD** in United Kingdom Primary Care data (using all-cause mortality data from 2000-19). Compared to the general population, the estimated reduction in life expectancy for adults with diagnosed ADHD relative to the general population was 6.78 years (95% CI: 4.50, 9.11) for males, and 8.64 years (95% CI: 6.55, 10.91) for females. The estimated reduction in life expectancy is suggested to be due to modifiable risk factors, unmet support needs and co-occurring conditions (O’Nions et al., 2025).

A matched cohort study on people with an **autism diagnosis** between 1989 and 2019, found the estimated reduction in life expectancy for people diagnosed with autism but not an intellectual disability was: 6.14 years for men (95% CI: 2.84,9.07); 6.45 years (95% CI: 1.37, 11.58 years) for women. The estimated reduction in life expectancy for people diagnosed with autism and an intellectual disability was 7.28 years (95% CI: 3.78,10.27) for men and 14.59 years (95% CI: 9.45,19.02 years) for women. This gender difference in people with a learning disability may be explained by the disproportionate underdiagnosis of autism in women with learning disabilities; alternatively, women with learning disabilities may experience higher adversity or poorer care. This needs to be better understood.

Although there is uncertainty in the estimates given the wide intervals, the estimated reductions in life expectancy for autistic adults are less than the 16 year reduction quoted extensively elsewhere. The study proposes that due to the recognised levels of undiagnosed people (and the possible association between diagnosis and higher levels of support needs), the true reduction in life expectancy for all autistic people compared to the non-autistic population may be lower (nb. it should also be recognised that some undiagnosed autistic people may have reduced life expectancy due to co-occurring conditions or other challenging circumstances). Overall, as a minimum, the study indicates there is a group of autistic people experiencing premature mortality that may be addressed through support and inclusive policies (O'Nions et al., 2024)

Both studies recognise they may not be generalisable to the whole population of adults with autism and ADHD due to the estimated numbers undiagnosed, and that those with a diagnosis may have been more likely to receive one due to contact with services for co-occurring needs.

Co-existing (or co-occurring) conditions

There are strong associations with a range of co-existing conditions:

Autism

At least one associated mental health condition or neurodivergence occurs in approximately 70% of autistic people. These include:

- Anxiety and depression.
- Learning (intellectual) disability.
- Obsessive-compulsive disorder (OCD).
- ADHD
- Tourette’s syndrome/tic disorder.
- Dysexecutive syndrome.
- Developmental coordination disorder.
- Catatonia.
- Eating disorders.
- Gender identity disorder.
- Personality disorder.
- Psychosis.
- Sleeping difficulties.

Other coexisting conditions associated with autism:

- Sensory problems occur in about 90% of autistic adults without a learning disability.
- Gastrointestinal problems occur in c. 50% of adults with autism and a learning disability (including inflammatory bowel disease, coeliac disease, chronic diarrhoea, and constipation).
- Epilepsy —increased incidence of epilepsy (20–30%) in people with autism.

(NICE, 2025)

ADHD

c.75% of adults with ADHD will have at least one other mental health disorder (BMJ, 2024)

Mental health or neurodevelopmental comorbidities include:

- oppositional defiant disorder (ODD),
- conduct disorder,
- and possibly mood disorders, such as depression and mania.
- Dyslexia, dyscalculia, and dyspraxia are over-represented.

(NICE, 2025)

In addition, for adults, associations have been identified with:

- Addiction (including internet and gambling addictions)
- Sleep problems and challenges with healthy weight
- Accidents and injuries (but with a peak in adolescence and young adulthood)

(French et al., 2024)

(https://doi.org/10.3389/fpsyt.2024.1343314)

There are identified associations with suicide and self-harm and this is included in more detail below at section 12.

The latest available Adult Psychiatric Morbidity Survey for England (APMS, 2023-24) noted that adults with a common mental health condition (CMHC – defined as: Depression, Generalised anxiety disorder, Panic disorder, Phobias, OCD, and CMHC not otherwise specified[3]) were five times more likely to screen positive for ADHD (38.5%) than those without a CMHC (7.2%) (NHS Digital, 2025).

The proportion of adults screening positive was higher in working age adults not in employment (29.6% screened positive in the unemployed group, 26.1% in the economically inactive group, 14.1% in the employed group). In adults with problem debt, 28.1% of adults with problem debt screened positive versus 12.7% in those with no problem debt.

A positive screen in the APMS means a score of 4 or more on the ASRS screening tool (this does not represent diagnosis but indicates a person has sufficient symptoms to lead to further assessment).

As these data are cross sectional it is also not possible to conclude the extent to which symptoms of ADHD directly or indirectly contribute to the CMHCs identified and the role of other factors; however given the evidence in this HNA, some impact is plausible.

A systematic review of the risks associated with *undiagnosed* ADHD and/or autism identified three main themes (nb. the results mainly focussed on ADHD, and were based on studies that screened populations that had not received a diagnosis):

- Health: this encompassed lower quality of life and higher rates of mental health needs in terms of depression, suicide attempts, anxiety, and receipt of mental health care. Physical health impacts included sleep related problems;

- Offending behaviour: high rates of undiagnosed ADHD were found in adult male prison populations. This study also included high rates amongst patients on substance use programmes in this category;

- Day to day impact: this category included fewer years in education, challenges at work, and social and relationship difficulties (French et al, 2023).

---

[3] CMHCs were assessed using the Clinical Interview Schedule - Revised (CIS-R) which assesses types of CMHC symptom. Scores of 12 or more are taken to indicate a CMHC. An algorithm is used to generate ICD-10 diagnoses using survey participant answers.

In respect of substance use and addiction, the international consensus statement on ADHD, noted that people with ADHD were three times more likely to be nicotine dependent, and 50% more likely to develop have drug or alcohol use disorders (also increased likelihood of nicotine use) (Faraone et al., 2021).

A range of studies from smaller samples focussing on undiagnosed ADHD in similar populations estimate prevalence at 20% (people in a residential alcohol treatment programme) and 43% (people in a residential substance misuse programme) (French et al., 2023).

It is recognised this association may either be due to self-medication and/or the impact of ADHD leading to social marginalisation in turn leading to drug and alcohol use.

There is some evidence that treatment for ADHD can reduce the risks of substance use but the complex interaction with substance use needs to be more fully understood (French et al., 2024).

The International Consensus Statement highlights a range of outcomes that may be mitigated by effective treatment (for example poor mental health, unintentional injury, and educational outcomes in children). A more recent review identified stimulants and atomoxetine as effective in reducing core symptoms in the short term but there was no evidence of an effect on wider outcomes (eg. quality of life) and longer term outcomes needed to be better understood (Ostinelli et al., 2025).

This HNA focusses on need in adults, but it is clear that social and educational impacts experienced within childhood can have significant effects over the life course. For children with ADHD, this includes performing worse relative to their peers regarding academic attainment, absences and exclusions from school, risky behaviours and behaviours that challenges including links to youth offending. This means that young people entering adulthood with neurodivergence may have a range of challenges that can be detrimental to their employment, learning, and other social outcome (Faraone et al., 2021) (French et al., 2024).

A challenge with diagnosis of ADHD is the characteristic features that may be seen in mental health conditions for example attention levels and distractibility that can be seen in depression, anxiety and bipolar disorder. This can increase the risk that ADHD is not identified resulting in social and wellbeing impairment across the life course (NHS Digital, 2016).

Experiences of local organisations and people with lived experience

This HNA was enriched by substantial input from people with lived experience. A key theme emerging in discussion was the view that the needs of people who are autistic and/or have ADHD need to be considered holistically incorporating physical, mental health, and social needs.

This was supported by clinicians responding to the HNA, reporting a gap in terms of supporting the physical health of people as it relates to neurodivergence.

Some examples of how this can impact on a person's whole body and health were shared in discussion groups and summarised here:

- Autistic individuals may have a high or low pain thresholds, which is not always understood by emergency responders, resulting in underestimations of their presenting condition;

- Emergency services personnel often do not recognise the severity of conditions due to communication barriers, leading to delays in receiving appropriate care;

- Mental health services often lack staff trained in autism, leading to inappropriate or ineffective treatments;

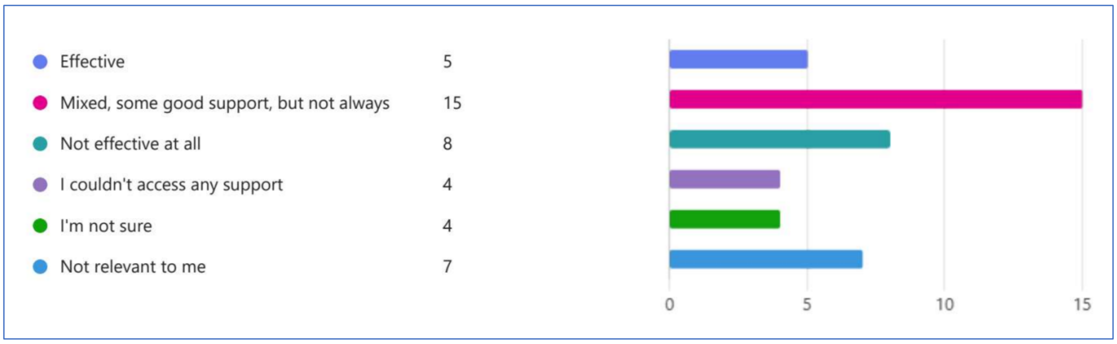
- There is a significant gap in services addressing the intersection of autism, ADHD, and substance misuse.

And

- Autism should be seen as a whole-body experience as it affects eating behaviour (for example, ARFID), motor skills and mental health, and these shouldn't be approached from the perspective of a neurotypical presentation.

Experiences of addressing physical health needs (and accessing primary care) were variable in the online survey.

PWLE Survey Response: If you have experienced physical health problems, how effective were healthcare professionals at supporting you to manage these or get better?



"It's important to remember that a person with Autism is very likely to have comorbid/other health conditions that impact upon the Autism [...] *These are ALL hidden disabilities, you can't see them to look at any of us and that is how we are seen and treated. Invisible to what else is going on, complex human beings* [living] *in so many systems that don't work in the way we need them to."*

[Member of Devon Carer Peer Support Group]

Some respondents to the survey noted that they had been diagnosed with mental health conditions before being diagnosed with autism or ADHD, and the diagnosis of neurodivergence had led to much greater understanding of their needs and an appropriate reduction in mental health support.

Observations – Prevalence and Health Outcomes

a) National estimates of prevalence in the adult population stand at 1.1% (autism) and 3-4% (ADHD).

b) In the available evidence base both groups are associated with clearly identified higher levels of mental, physical and social impacts across both autistic adults and people with ADHD groups. There is an estimated reduced life expectancy for both autistic people and people with ADHD.

c) Co-occurring conditions are common. Consistent feedback indicates that needs are misclassified as mental health needs, or mental health needs are dismissed due to neurodivergence.

d) There should be greater focus on the holistic needs of a neurodivergent person given the strong correlation with mental health but also physical health needs. This was a common theme from PWLE.

e) It is estimated that a significant proportion of autistic adults and people with ADHD are undiagnosed, with additional differences in sub groups (women are estimated to be less likely to be identified). There are particular challenges with NHS data relating to ADHD. This supports the need to encourage diagnostic neutral approaches, especially in view of the strong associations with associated ill health.

8. Estimated local prevalence (diagnosed and undiagnosed) of autism / ADHD

The Devon Adult (18+) population as of 2023 was estimated at 686,095 persons.

Autism

Local estimated prevalence can be identified using several methods. The following data are projections from the Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI) provided by Adult Social Care. Within PANSI and POPPI, the information about ASD is based on Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007 which was published by the Health and Social Care Information Centre in September 2009.

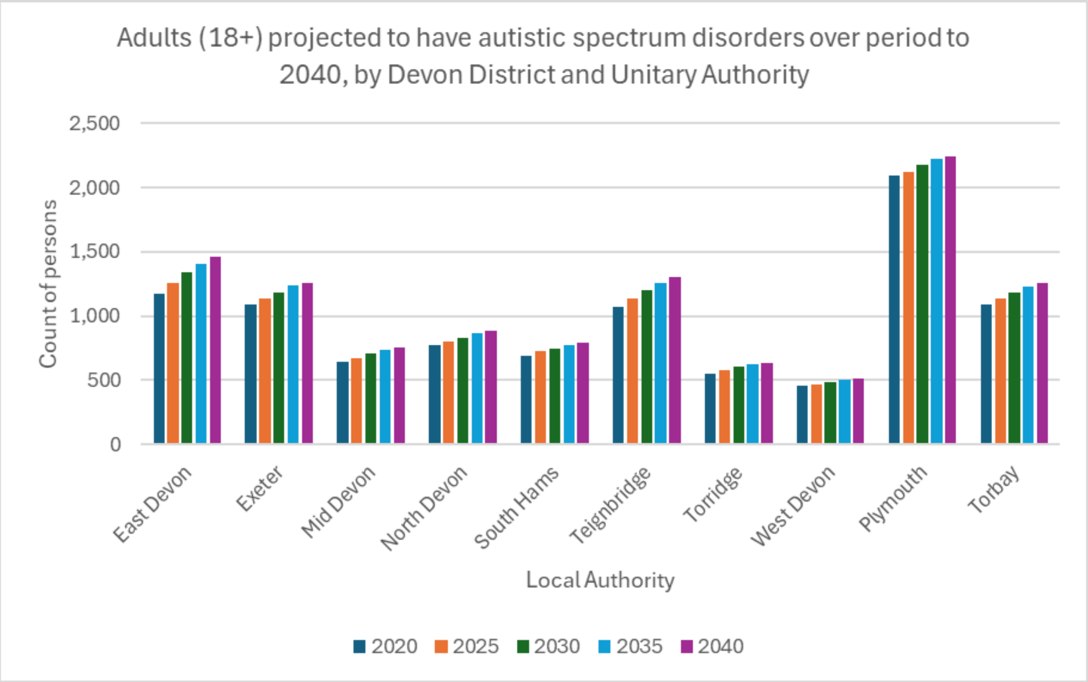
Please note as the following estimates for autism are based the 2007 APMS data, these indicated overall England prevalence for autism at 1%. The more recent APMS 2014 gives the prevalence slightly lower at 0.8% (NHS Digital, 2016). An updated position on ADHD was available following the publication of APMS 2023-24, but the chapter on autism was not yet available at the time this HNA was finalised. Once PANSI and POPPI data is updated this may see a significant change.

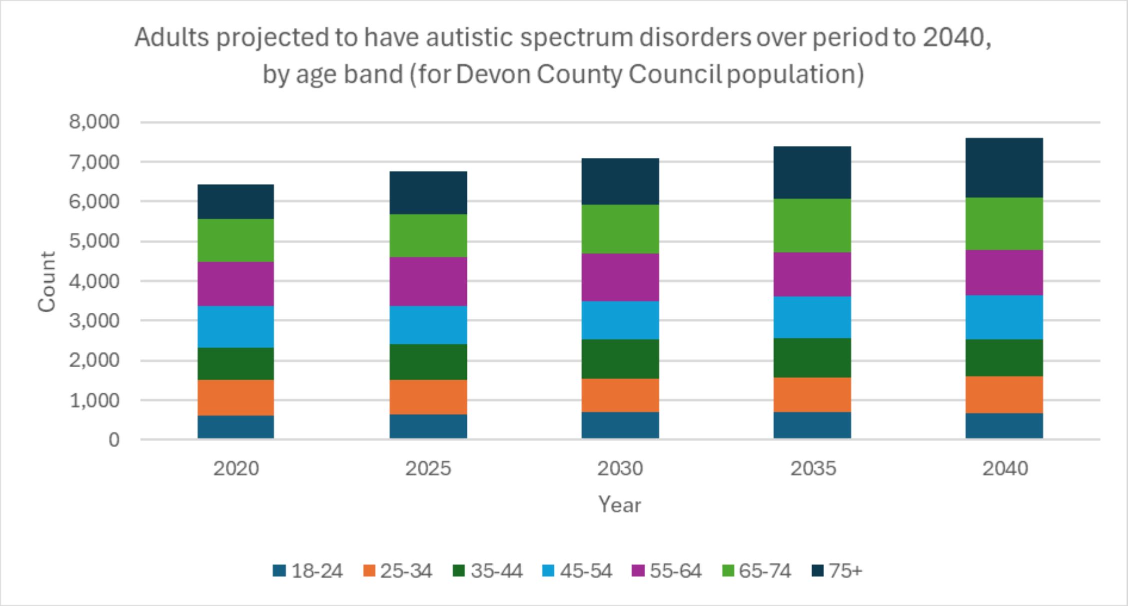
The total number of autistic adults (18+) for Devon estimated over the projected period to 2040 is as follows:

Local Authority	2020	2025	2030	2035	2040
Devon County Council	6,441	6,768	7,107	7,386	7,588

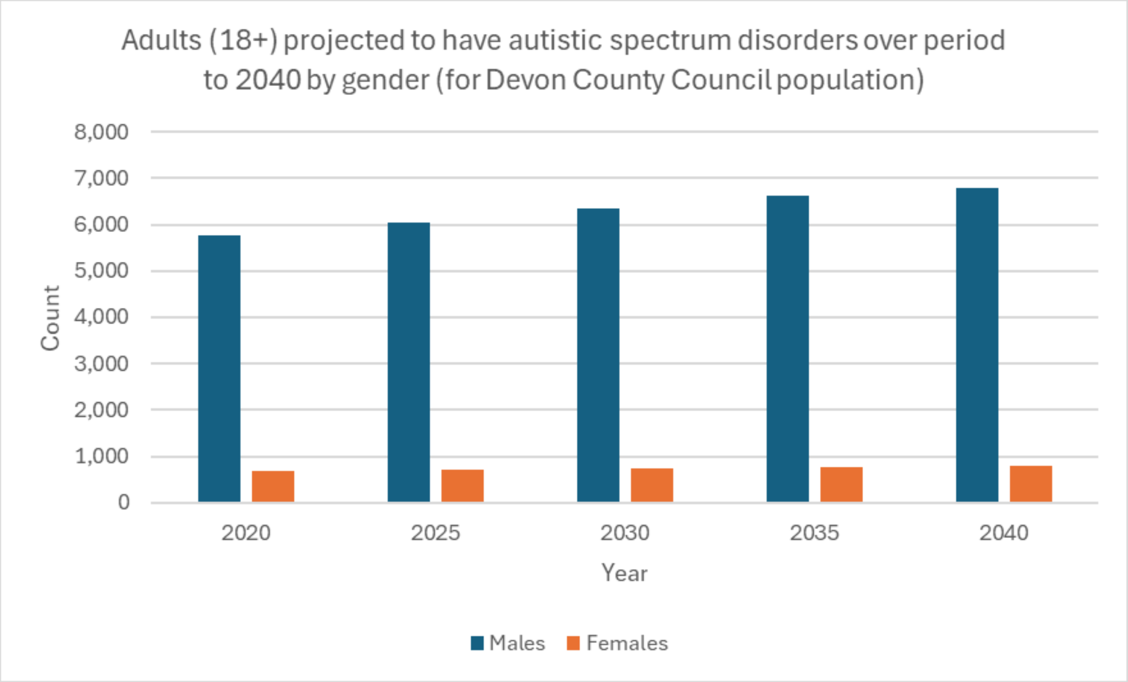
This is in the context of a projected overall increase in population over the same period (the total Devon 18+ population will increase by 23% over the same period) (ONS, 2025).

This dataset enables projections by local district, age group, and gender.





In 2024, 19.6% of autistic adults are projected to be in the 75+ age band; this would be an increase of 6% (0.06) between 2020 and 2040 (95% CI: 0.05, 0.07). This is in the context of an ageing population.



As noted, the PANSI and POPPI source data is from 2007. The APMS 2023-24 chapter on autism was not yet available, however the 2014 APMS data provide some additional and more timely context. Applying the 2014 APMS estimates for the population as a whole (which were combined with 2007 for a larger sample) to the 2023 Devon population would indicate the following breakdown by age group (with 95% confidence intervals applied) and in the context of an overall estimated prevalence in adults in private households in England of 0.8% (95% CI: 0.5% to 1.3%). Please note a two phase screening process was used with the ADOS tool, and this data does not represent clinical diagnosis:

		16-34	35-54	55-74	75+	All
	Devon Male Population	86,386	93,327	109,791	49,223	338,727
Devon (Count)	**Men with Autism**	**2,246**	**187**	**2,196**	**345**	**5,081**
	CI lower limit	950	93	988	98	2,710
	CI upper limit	5,270	653	4,941	1,624	8,807
APMS (%)	**Men**	2.6	0.2	2	0.7	1.5
	CI lower limit	1.1	0.1	0.9	0.2	0.8
	CI upper limit	6.1	0.7	4.5	3.3	2.6
	Devon Female Population	84,336	99,571	119,413	61,584	364,904
Devon (count)	**Women with Autism**	**506**	**0**	**-**	**-**	**730**
	CI lower limit	169	0	-	-	365
	CI upper limit	1,602	299	-	-	2,189
APMS (%)	**Women**	0.6	0	-	-	0.2
	CI lower limit	0.2	0	-	-	0.1
	CI upper limit	1.9	0.3	-	-	0.6
	Devon Population - Total	170,722	192,898	229,204	110,807	703,631
Devon (Count)	**Total Persons with Autism**	**2,732**	**193**	**2,292**	**443**	**5,629**
	CI lower limit	1,366	0	917	111	3,518
	CI upper limit	5,634	772	4,813	1,884	9,147
APMS %	**All adults**	1.6	0.1	1	0.4	0.8
	CI lower limit	0.8	0	0.4	0.1	0.5
	CI upper limit	3.3	0.4	2.1	1.7	1.3

(Source: APMS 2014)

These data are cross-sectional (rather than a cohort over time), and as can be seen due to autism being a low prevalence condition, the findings should be interpreted with caution with uneven variation across the age bands, and the estimated count data for women is limited. The total number of estimated autistic women is similar to the PANSI and POPPI projections for 2025 (n=~716) but substantially less than the estimated numbers for Devon using the NICE estimate as can be seen below (even whilst including a lower age range of 16 and over).

Using the NICE national prevalence data, and male to female ratios ranging from 3:1 to 5:1, a crude estimate for all autistic adults (18+) Devon in 2023 would be:

NICE National Prevalence Estimate	**Total Autistic Persons**	**Males**	**Females**
1.1%	7547	5660 to 5031	1886 to 1257

There is some variation in the implications for Devon of the estimated total number of autistic adults. In each case however the number of males is higher than females in line with the overall epidemiology.

When available, the One Devon Dataset will provide a local sample of autism diagnoses and additional context that can help us better understand these data.

ADHD

The PANSI and POPPI estimates do not include a breakdown by ADHD.

Using the national (NICE) estimated prevalence rates for the adult population, a crude estimate based on the Devon adult (18+) population can be applied as follows:

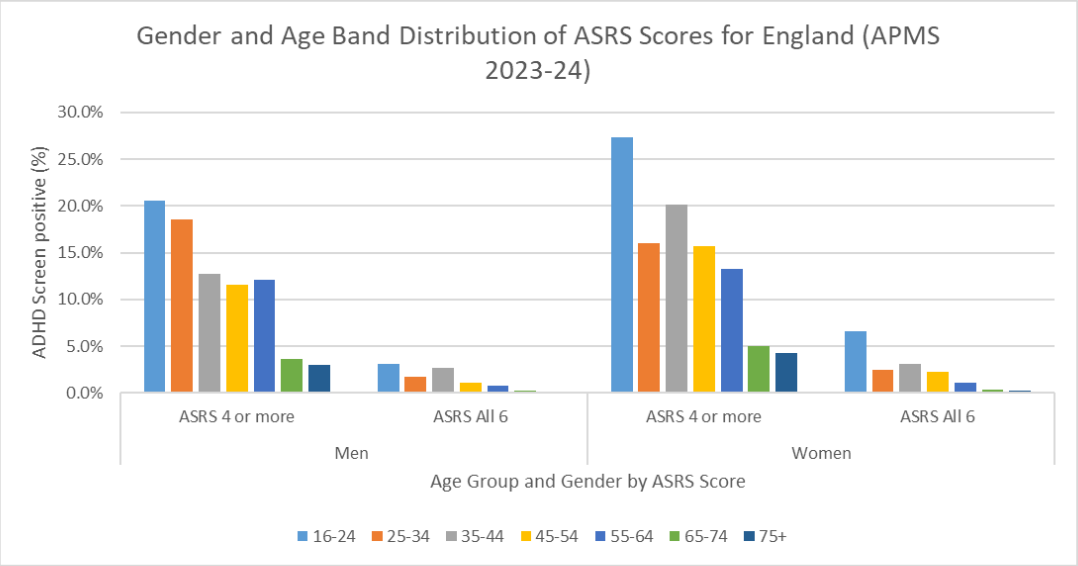
	Total Persons with ADHD	**Males**	**Females**
3%	20,582	15,436	5,145
4%	27,443	20,582	6,860

The APMS 2023-24 study used a screening tool to understand possible ADHD in the population but did not use a specific diagnostic tool (NHS Digital, 2025).

The six-item ASRS was used which is a shortened version of the 18-item Symptom scale, that measures the frequency of recent symptoms and consistent with the DSM-IV and DSM-5-TR criteria (nb. with regard to the DSM and ICD diagnostic criteria, the DSM-5 diagnostic classification includes a broader definition and so may over-identify individuals that primarily have other mental health needs, conversely ICD-10 used a more restrictive criteria that would only detect the most severe cases. The ICD-11 criteria updated the diagnostic guidelines for ADHD and is more aligned with DSM-5. Irrespective of these changes, the ASRS methodology used by the APMS has been unchanged from 2007 onwards) (NHS Digital, 2025).

The sample indicates a group that have a greater chance of meeting the criteria. A score of 4 is recommended as an indication for clinical assessment, but the higher the score the greater the likelihood that ADHD is present (hence the reporting of persons scoring all 6 criteria). The actual ADHD rate is likely to be lower than the rate screening positive for ADHD. Some participants may lack a significant impairment or other important characteristic of ADHD.

An important finding is to note the national increase in the proportion of adults screening positive for ADHD across recent surveys as follows: 8.2% in 2007, 9.7% in 2014, to 13.9% in 2023/4. The age and gender distribution can be seen in the following chart:



(NHS Digital, 2025)

In the national APMS sample, 27.1% of adults screening positive thought they had ADHD, and 9.6% had been diagnosed (9.4% of men screening positive, and 8.3% of women screening positive). The higher proportion of total women screening positive (14.9% compared to 12.4% in men) compared to the evidence base on diagnosis represent could suggest additional evidence of under-diagnosis (or mental health conditions with similar presentations). However, there are recognised limitations with the screening tool in general population samples, and as can be seen there is a low positive predictive value (Chamberlain et al., 2021).

Age-band estimates (%) are available in the APMS dataset and have been applied to the Devon population as follows:

		16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**All**
Men	**ASRS 4 or more (%)**	20.6	18.6	12.7	11.6	12.1	3.6	3	12.4
	ASRS All 6 (%)	3.1	1.7	2.7	1.1	0.8	0.3	0.1	1.5
	Devon Total Pop	43,464	42,922	45,018	48,309	58,871	50,920	49,223	338,727
	Devon Count 4 +	8,954	7,983	5,717	5,604	7,123	1,833	1,477	42,002
	Devon Count all 6	1,347	730	1,215	531	471	153	49	5,081
Women	**ASRS 4 or more (%)**	27.3	16	20.1	15.7	13.3	5	4.3	14.9
	ASRS All 6 (%)	6.6	2.5	3.1	2.3	1.1	0.4	0.2	2.3
	Devon Total Pop	40,569	43,767	47,804	51,767	63,777	55,636	61,584	364,904
	Devon Count 4 +	11,075	7,003	9,609	8,127	8,482	2,782	2,648	54,371
	Devon Count all 6	2,678	1,094	1,482	1,191	702	223	123	8,393

(Source: (NHS Digital, 2025))

The count of persons scoring all 6 may provide a more accurate guide to the distribution across the age groups compared to the. For Devon this would remain an under representation when considered against the estimated prevalence of 3-4% used by NICE.

The use of the One Devon Dataset is intended to provide a more nuanced view of the patterns of diagnosis as they relate to factors such as socio-economic status (recognising this will need careful consideration in relation to where a diagnosis has been received as this may reflect the ability to pay for private assessment). In the interim, the review of national primary care data by McKechnie et al, found that ADHD diagnosis rates were highest in the most deprived areas for children and adults (this was approximately two- to three-fold higher in the most deprived quintile versus the least deprived quintile). Similar patterns were seen for first prescriptions of ADHD medication.

It should be noted that the relationship between deprivation and ADHD is complex; lower socio-economic status may contribute to exposure to hypothetical risk factors such as adversity, potential reporting and labelling biases, or may represent reverse causality due to the associations with challenges that adults experience with employment for example (McKechnie et al., 2023).

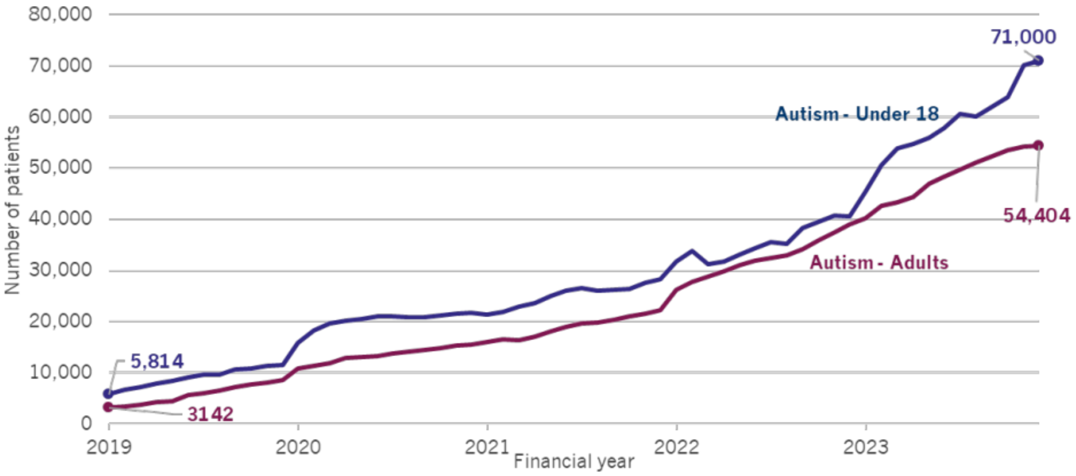
9. Assessments and Waiting Times

National assessment and waiting times context

Challenges in the management of referrals for assessment for ADHD and autism in recent years have been well described. This applies to both adults and children.

The Independent Investigation of the NHS in England (2024) noted the rate of increase in adults waiting more than 13 weeks for an assessment for autism had been at 77% per year since 2019 (Darzi, 2024).

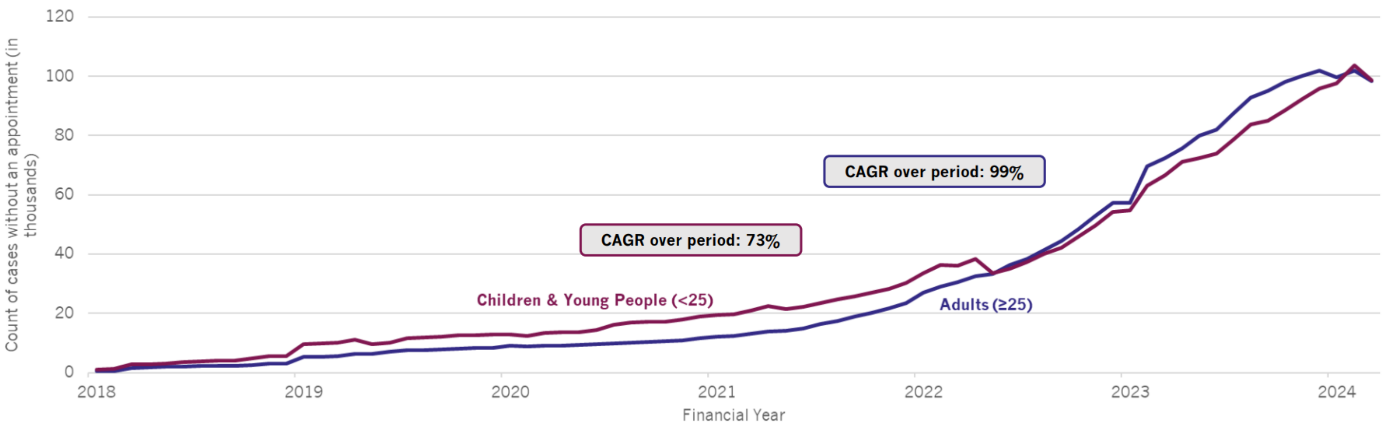
Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, in England (April 2019 to March 2024)



(Darzi, Independent Investigation of the National Health Service in England:Technical Annex, 2024)

The following data is considered to be predominantly driven by ADHD referrals and does include community mental health services so is likely an underestimate:

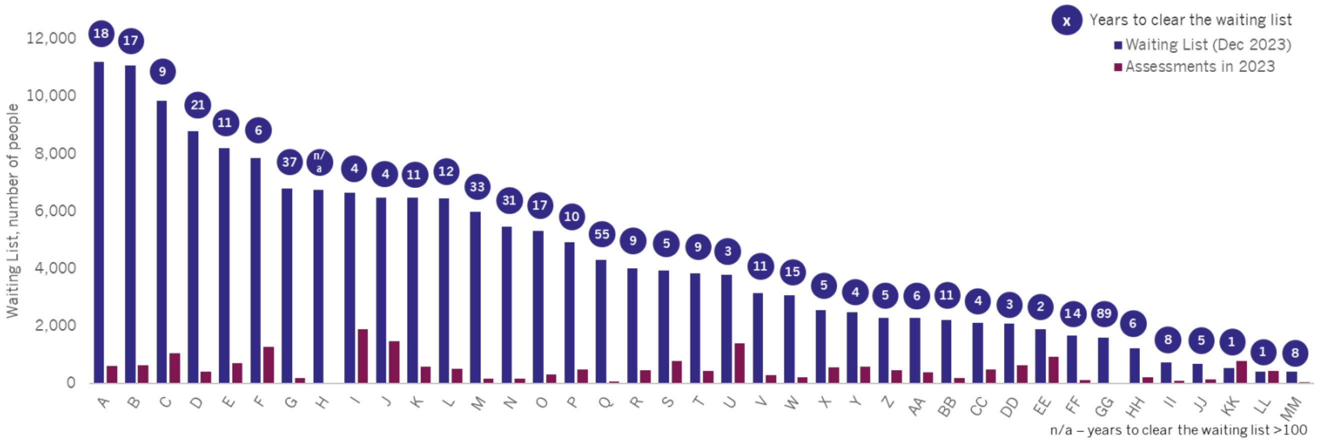
Reported (known) case load without appointment over time, for neurodevelopmental conditions (excluding Autism), for England



(Darzi, Independent Investigation of the National Health Service in England:Technical Annex, 2024)

A sample of individual providers report significant implied adult ADHD wait list clearance times (nb. it is not possible to identify a Devon-based provider as these have been anonymised):

Implied clearance time for adult ADHD assessments based on activity and wait list size (based on 44 providers, in England, Wales and Scotland)



Nb. this represents a subset of providers who responded to a BBC FoI request and may include inconsistent reporting methodologies.

(Darzi, Independent Investigation of the National Health Service in England:Technical Annex, 2024)

The challenges relating to ADHD assessments has led to the creation of the national taskforce described above. It should also be noted that the reported wait times are in the context of rising demand for NHS mental health, learning disability and neurodevelopmental services as a whole.

Local provider diagnoses and waiting times

For both autism and ADHD, in the local NHS-led assessment route, there is a significant mismatch between referrals and assessment capacity, leading to increasing numbers on the waiting list over time.

At the time of publication, DPT's situation is summarised below (please note this will include patients living in Torbay):

Number of people currently on the waiting list for an ADHD diagnostic assessment: 4590 as of July 2025 (change from 4,135 reported in January 2025)

For new referrals, most of the people currently being seen were referred in June 2020. This is not a reflection of the timeframe that a person referred now would be seen by due to a range of clinical and operational factors.

Number of people on the waiting list who already have a diagnosis of ADHD and are awaiting assessment for treatment: 1018 as of July 2025 (change from 884 in January 2025)

For people who have already been diagnosed elsewhere but are not in treatment and who are waiting for a review to consider treatment options, most of the people DPT were seeing (as of July 2025) were referred March 2021.

This is not a reflection of timeframe that a person referred now would be seen by due to a range of clinical and operational factors.

Please note it is not possible to say whether this group includes people who have received a Right to Choose assessment prior to the change to the RtC Pathway in April 2024, whereby RtC providers were accredited to provide treatment by the ICB.

Number of people on the waiting list who are Transitioning from Children's Service to Adult Services: 117 as of July 2025 (change from 104 in January 2025)

This is for people who were previously under the care of Children's Services and are now approaching adult age, for their ongoing care to be transferred to the Adult ADHD Service. Most of the people DPT are currently offering appointments to were referred in October 2024 (as of July 2025).

Number of referrals received in the past quarter across all ADHD pathways: 499 in Q1 2025-26 (change from 660 in Q3 2024-25, and 609 in Q4 in 2024-25).

Number of people currently on the waiting list for an Autism diagnostic assessment: 2967 as of July 2025

Most people now having a routine assessment from the team were initially referred in January 2019. This is not a reflection of timeframe that a person referred now would be seen by due to a range of clinical and operational factors.

(https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/waiting-times
Accessed 2.4.25 and 30.7.25)

For referrals managed by DPT, it should be noted that, due to the structure of the team, the number of cases assessed is directly linked to the capacity available to subsequently manage cases (i.e. a higher caseload of managed cases reduces the capacity of DPT to undertake assessments).

As can clearly be seen, the increase in activity and limited capacity to respond is having a substantial impact on wait times for NHS-provider managed referrals in Devon.

To understand this position in greater granularity for Devon-registered patients, data was requested from DPT. This included referrals, assessments, and diagnoses for autism and ADHD (with a breakdown by age, gender, ethnicity for each category). Count data was requested for the period 2020-25.

A comprehensive breakdown was kindly provided (and a high level overview was also provided by the ICB for Devon and Torbay patients managed by DPT), however there were substantial limitations with data including the impact of the introduction of a new patient record system and therefore unfortunately it has not been included in this HNA.

Should the limitations be addressed in future, validated data that was available to the same level of demographic detail would be able to inform:

- understanding assessment and diagnosis patterns as they relate to gender and ethnicity;
- actions driven by an improved understanding of diagnoses compared to these variables and by age, and specifically the number of people receiving diagnoses in adulthood, and in progressively older age bands, and support needs.

As noted, the Right to Choose routes provide alternative pathways for assessment. Right to Choose providers do not routinely report referral and assessment data to the ICB therefore the overall picture specifically for Devon relating to referrals and assessments is limited.

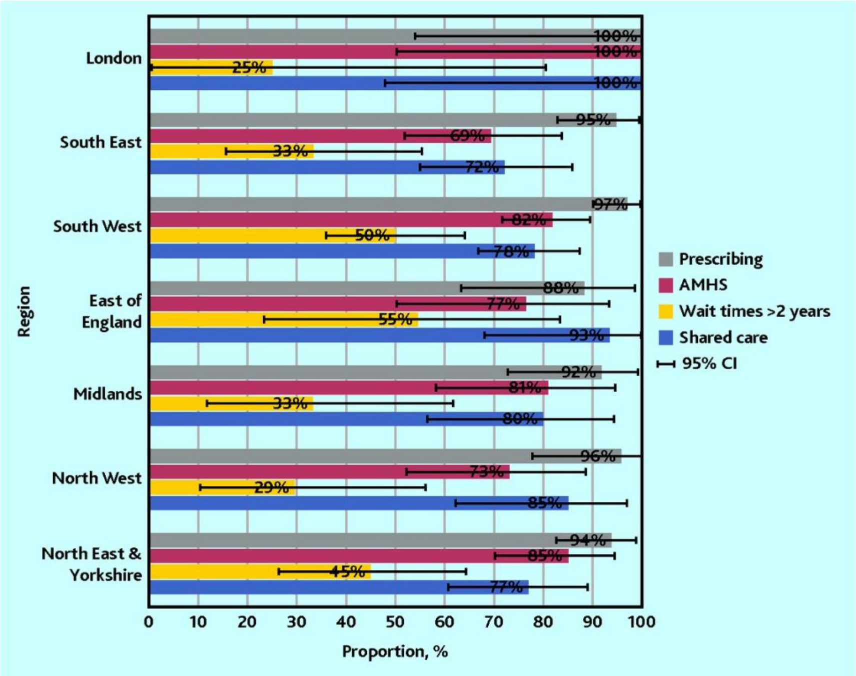
Access to treatment local services (ADHD)

Concerns have been raised regarding the consistency of shared care arrangements across the country.

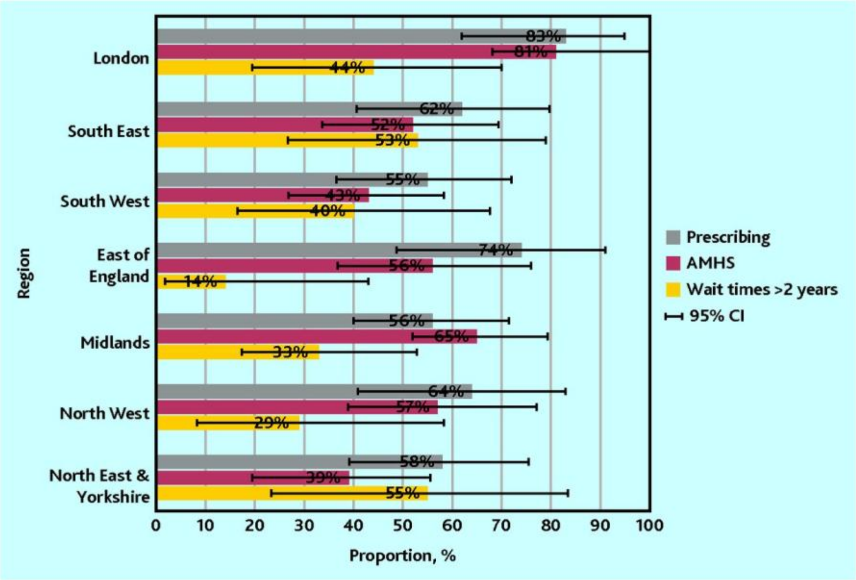
A nationwide survey identified variations in ADHD treatment, including challenges in transition from children and young people services to adult services, and variation in the provision of Shared Care particularly at the crucial period of transition (NIHR, 2024).

The following describe the elements of support that were available (prescribing of medication, adult mental health services [AMHS] available for patients with ADHD, waiting list length, and shared care agreements in place).

Proportions of health professionals (n = 331) reporting elements of support for primary care prescribing of adult ADHD medication by NHS region



Proportions of patients and supporters with lived experience of ADHD (n = 409) reporting 'elements of support' for primary care prescribing of adult ADHD medication by NHS region



(Price et al., 2024)

(The survey did not collect detailed demographic information and may reflect participation from people with lived experience who were particularly motivated to respond.)

During the period of GP Collective Action, this has impacted upon the number of Practices agreeing to Shared Care. As of April 2025, DPT reported that generally unless informed otherwise there is an assumption that in Devon and Torbay Practices are signed up to shared care arrangements. However, '*more recently there have been GP* *surgeries declining to accept a shared care agreement for ADHD medications and there are currently 6 surgeries declining these shared care agreements for ADHD across Devon'* (FoI Request to DPT).

Stakeholder feedback (including from NHS respondents) has highlighted that there are challenges with shared care in the local system. Of note is the impact on delayed or interrupted access to care for people who may be temporarily in the area or move between GP Practices, including those at university with a potentially significant impact on their studies and quality of life. This may also apply to other people who experience multiple moves between homes and care providers, including within inclusion health groups. One of the identified benefits of the Inclusion Health Devon ADHD pathway is the shared approach to management with DAANA.

Stakeholder reflections on assessment and treatment pathways

- The challenges with referrals and assessments are well recognised in the system, including in partners in housing, education, and social care.
- Assessment services are available regardless of mental health needs, and there is choice of diagnostic routes through Right to Choose.
- Diagnosis and treatment and support in DAANA (when able to be accessed) is seen as robust. Patient feedback and outcomes also indicate this.
- Within NHS care, there is an ethos of encouraging the management of comorbid mental health needs in mainstream care, and avoidance of inpatient settings where possible.
- Lack of support whilst on waitlist (other areas of country have arranged regular contacts, for example).
- The limited opportunity to identify needs at early stage, leads to demand on services (including welfare, mental health, criminal justice system) due to the accumulation of unsupported needs over the life course.
- The long waiting lists for assessments and then treatment (the latter particularly relevant for ADHD) leave patients in a huge gap between services during that time.
- The gap represented by this delay of support can lead to people experiencing a loss of motivation and confidence, and being accustomed to the 'disabled' role.
- The overlap of Autism and ADHD means separate referrals to DAANA for assessment of each is inefficient.
- Disconnect between the number of people with diagnoses, and the support available post-diagnosis. People with more significant needs are at risk of not having these met.
- Challenges with ADHD shared care or prescribing and monitoring provision puts an extreme strain on specialist services and leaves many without effective treatments.
- Comorbid mental health difficulties such as emotional dysregulation, impulsivity, self-harm and distress are common but often have their routes within neurodivergence. This leads to avoidable escalation and inappropriate labelling (eg. Complex Emotional Needs).

Within secondary care:

- When complex mental health needs and neurodivergence co-exist there are limitations on mainstream service's ability to appropriately adjust available psychological treatments (for example, an adjustment may mean 1:1 rather than group psychological interventions)
- Non-specialist services in DPT are not always understanding of the needs of neurodivergence.
- *[conversely]* a lack of awareness in mental health care is not necessarily the issue - as opposed to a lack of resources or availability of the reasonable adjustments that are recognised as being required.
- Additional time and resource for consultant led care in DPT, and training on nuances of ADHD for consultants would be beneficial.

In summary the main gaps were stated to be commissioned support prior to assessment, timely diagnosis, consistent availability of shared care arrangements, and support services that consistently do not include thresholds or exclusions that can be hard to manage for people with ADHD (for example, opt in and missed appointment policies).

Many of the points raised related to the operation of secondary care, however, as can be seen the role of assessment, support pre- and post- diagnosis, and follow on support is a crucial consideration for promotion of mental health and social wellbeing.

Impact of late diagnosis

People with lived experience have shared their experiences of late diagnosis and called for better understanding of the impact. Late diagnosis was said to be important for an individual but may also represent a real missed opportunity for them with significant impacts. For example, a late diagnosis can lead to a deep personal crisis and may strongly associate with trauma that has been previously experienced, or introduce a new trauma (for example, how a parent may reflect back on their role once their child is diagnosed). Support for partners was a key point brought up as partners may go through a process of understanding the impact of their neurodivergence on their relationship. They may want to restore these relationships.

Post diagnosis support

A qualitative study in the UK found that an 'autism diagnosis and accessing support promoted rather than diminished independence and choice, suggesting a need for support should not be considered a poor outcome for autistic people and an accurate diagnosis at any age can be helpful'. It is recognised that this is not universal however and negative responses to disclosure can impact on wellbeing (Featherstone et al., 2023).

The period following a diagnosis is recognised as one that may incorporate self-understanding and acceptance. It can also lead to significant life adjustments and emotional processing and a mental health impact. Support in this period is recommended (although evidence of efficacy is limited).

Post diagnostic support may include low level support for help with daily living, psycho-education to understand autism and the assist with self-management, and peer support groups with possibly autistic led approaches. The evidence base suggests the provision of such support in the UK mainly consists of an emphasis on the provision of information and signposting (Norris et al., 2024).

A study using a Delphi process (utilising the views of autistic adults, relatives and clinicians) identified what optimal adult post-diagnosis support may look like. The proposed standards include secondary care, but they are included here to give an overview of the totality of the type of support that members of the community and clinicians feel would be of benefit:

	Round 1 (n = 27)	% agreement
1	All adults who receive an autism diagnosis should be offered an additional follow-up meeting 2–4 months after the feedback meeting to discuss implications of diagnosis, coping strategies and future planning.	71
2	Services across primary, secondary and specialist care should have access to a clear pathway of how people can access a local autism post-diagnostic support service	85
3	Round 1 Statement - Dedicated post-diagnostic autism services should be commissioned/resourced separately to (but closely coordinated with) the autism diagnostic assessment service Round 2 Statement - Diagnostic teams should be commissioned and resourced to provide (in partnership with other agencies) post-diagnostic support	35 (After Round 1) 86 (after Round 2, n=29)
4	Core members of post-diagnostic autism services should include people with expertise in autism, from multiple agencies/specialists	85
5	Post-diagnostic autism support should be available in both 1-1 and/or group settings depending on the needs of the autistic adult	89
6	A diagnosis of autism should not limit access to community and/or inpatient mental health services.	96
7	Autistic adults should be able to access (community and specialist) mental health and physical health services that can provide the reasonable adjustments to meet their needs	96
8	Dedicated autism post-diagnostic services should include occupational therapy	85
9	Dedicated autism post-diagnostic services should include speech and language therapy	85
10	Autism post-diagnostic services should provide opportunity to access step on/off support to protect mental health and maintain well-being moving forward from diagnosis	85
11	All areas should have an autism champion to facilitate implementation of statutory guidance as part of the local strategic partnership network	74

Agreement threshold ⩾ 67%.

(Wigham et al, 2022)

The online survey of people with lived experience asked respondents to consider the support available prior to and following diagnosis (of those who had received one) within Devon. The overall balance was of an additional desire for support prior to diagnosis, and of the support that was provided, an increased proportion was focussed on mental health and support before diagnosis. Further feedback was also gathered through discussion groups.

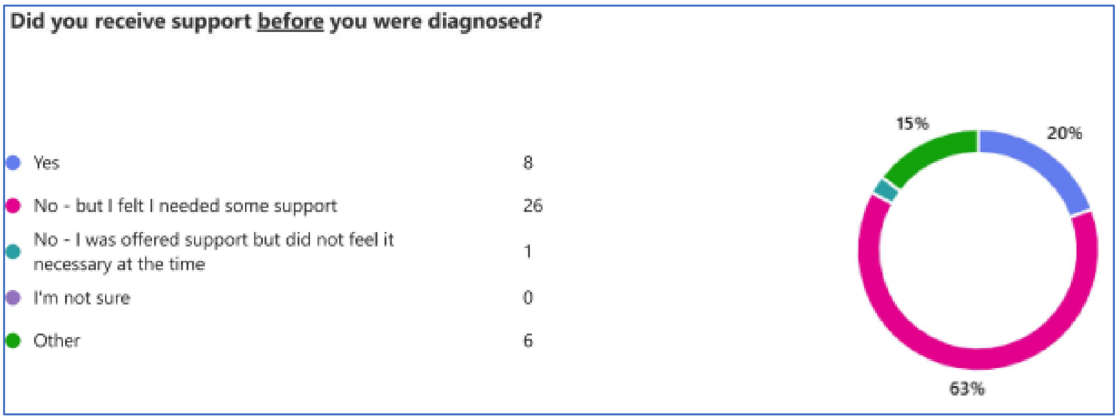
For autism, when comparing the proposed standards (above) to the local Devon situation, it would appear challenging to apply these within existing resources. In addition to the feedback on pre- and post- diagnosis support (below), there is concern that mental health services (i.e.. not those specific support services through DAANA) do not fully meet the needs of autistic adults through reasonable adjustments (stakeholder feedback in previous section refers), and that mental health services needed an improved understanding of neurodivergence.

People of lived experience fed back variable experiences of post-diagnostic support. Furthermore, it was recognised that the DAANA post-diagnosis support offer was changing with reduced access to the group support element. There was a desire for some form of 'hub' support that could provide this longer term touchpoint. There was also concern from the community about leadership in the context of the local strategic partnerships.

However, the DAAIT service is available to provide specialist time limited input across the health and care system and is a local strength.

The survey responses are summarised as follows:

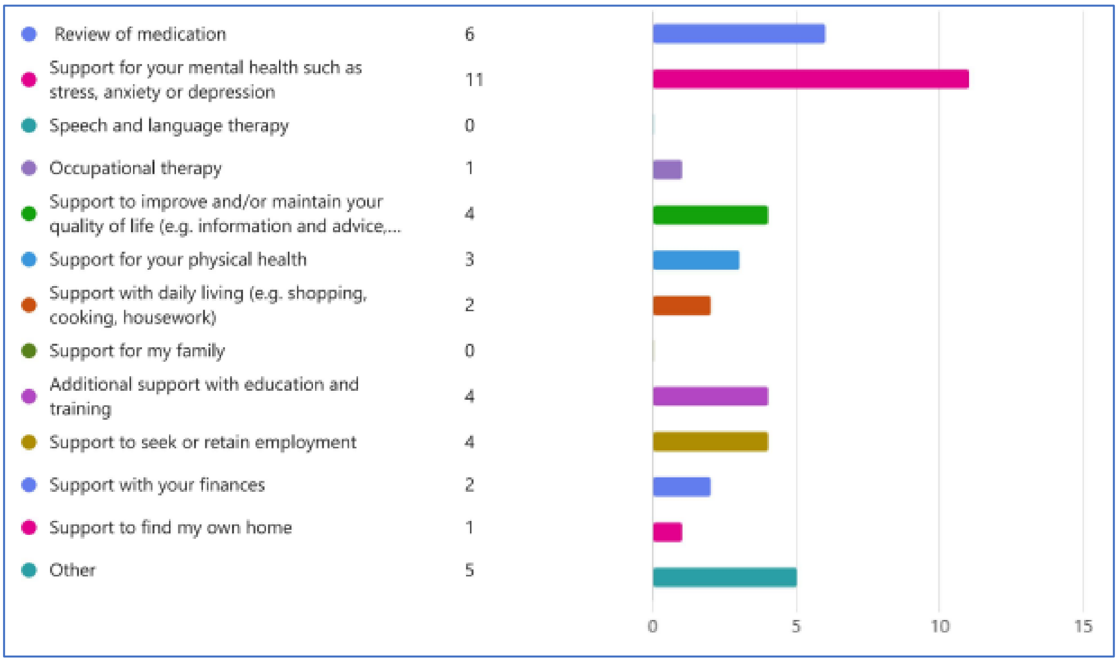
PWLE Survey Response: Did you receive support before you were diagnosed?



Did you receive support before you were diagnosed?

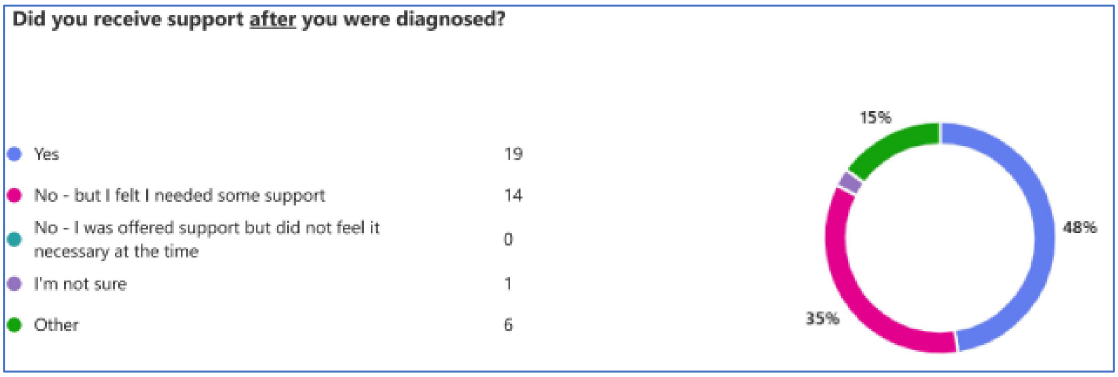
● Yes	8
● No - but I felt I needed some support	26
● No - I was offered support but did not feel it necessary at the time	1
● I'm not sure	0
● Other	6

If yes, please select what type of support was provided?

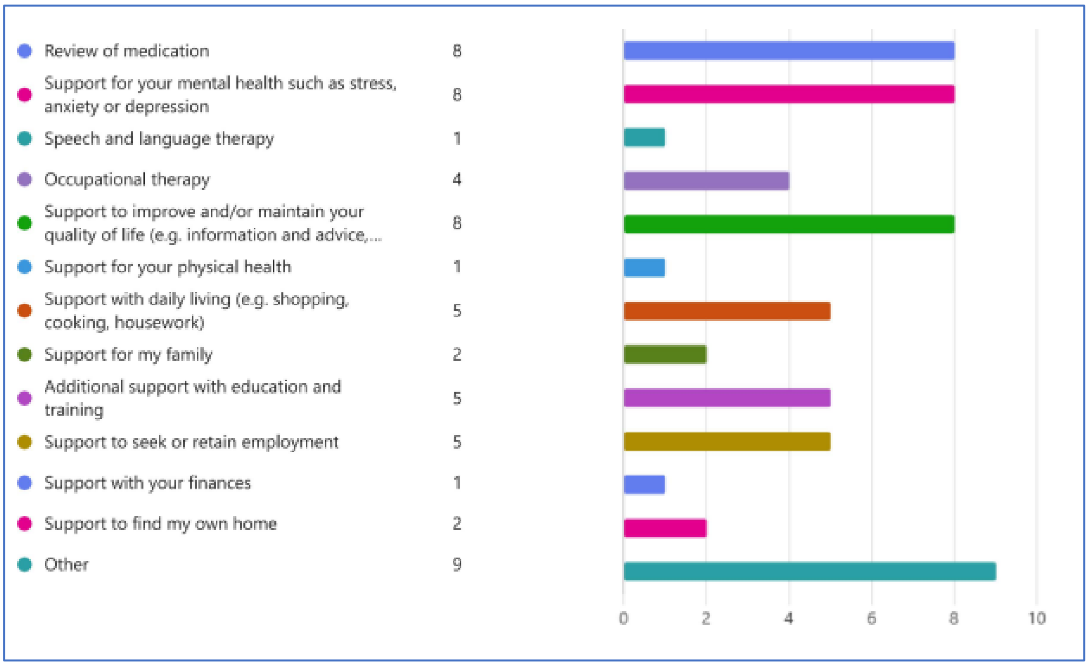


(Please note this question may have been interpreted as the type of support that was not provided but desired.)

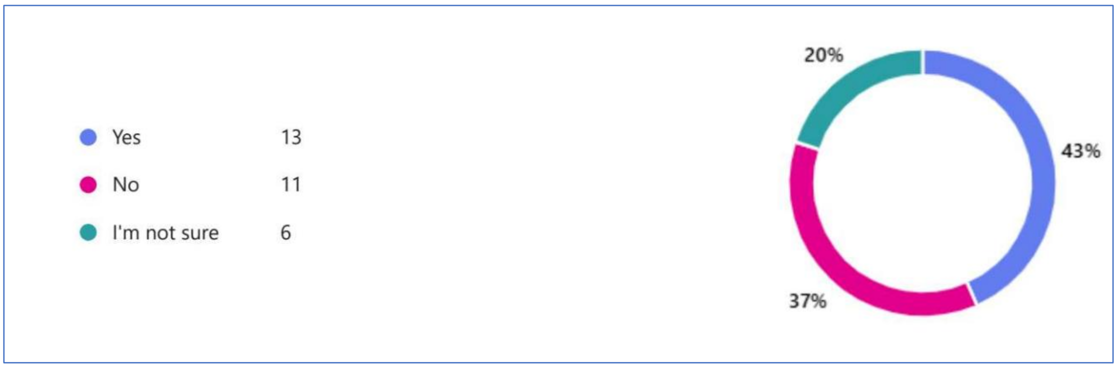
PWLE Survey Response: Did you receive support after you were diagnosed?



If yes, please select what type of support was provided?



PWLE Survey Response: If you were provided with support after your diagnosis, did this make a difference to your mental and emotional wellbeing [definition provided]?



Where support was indicated as being particularly helpful, this included meeting with other neurodivergent people, DAANA support and online groups, medication, counselling, and support with independent living.

Observations on Assessment and Treatment

a) Assessment and treatment processes are under significant pressure locally. The national increase in demand for assessments has been replicated in Devon across autism and ADHD.

b) For those who can access these, NHS-led assessments are felt to be robust by the system.

c) There is a more limited understanding of Right to Choose activity.

d) This HNA has not focussed on assessment/treatment however:
   - the impact of unrecognised autism and ADHD is directly impacting on mental health and emotional wellbeing, and potential consequential impacts across life-course;
   - the lack of opportunity to identify needs at early stage leads to demand on health and support services over the life course;
   - assessment is important for many, and treatment for ADHD can lead to improved outcomes (although not universal)
   - pre-diagnostic support is identified as limited;
   - there are reported challenges with people on the community waiting list for assessment for ADHD and who then enter prison, with some reported to be losing a place on waiting list due to NHS services not having a correct follow up address [also see section 10];
   - although the majority of GP Practices are understood to undertake shared care in principle, and local ICB policies are in place, there are perceptions of challenges with shared care and medication for ADHD, which can lead to treatment delays and interruptions.

e) Within Devon, the DPT DAANA post-diagnostic support offer is changing with greater emphasis on community provision (e.g. the support group is closing). This represents a challenge to local people with lived experience given the long standing nature of this provision and the need to develop alternatives (which were being scoped by DPT during the HNA).

f) People with lived experience indicate additional need for pre- and post-diagnosis support. Experiences of support that has occurred are variable and it was more common post-diagnosis compared to pre-assessment.

g) There is a gap in provision for a cohort of autistic individuals with a range of complex needs but who do not fit service criteria; these are often perceived to have trauma but not a diagnosed mental health condition that would meet eligibility for secondary care provision and are at risk to themselves or sometimes to others. This may increase the importance of encouraging effective support in the community (but does not mean this commissioning gap is not a priority elsewhere) (feedback from Adult Care also relates – see section 15).

10. Prevalence in Inclusion Health Groups

Estimating local prevalence in inclusion health groups

There are acknowledged challenges with identifying autism and ADHD within some service caseloads, and service caseloads do not necessarily represent the totality of local need, especially in inclusion health groups that have well established challenges with access and experience of health and support services. Where data has been made available it is included here, but the HNA recognises further research is required in this area.

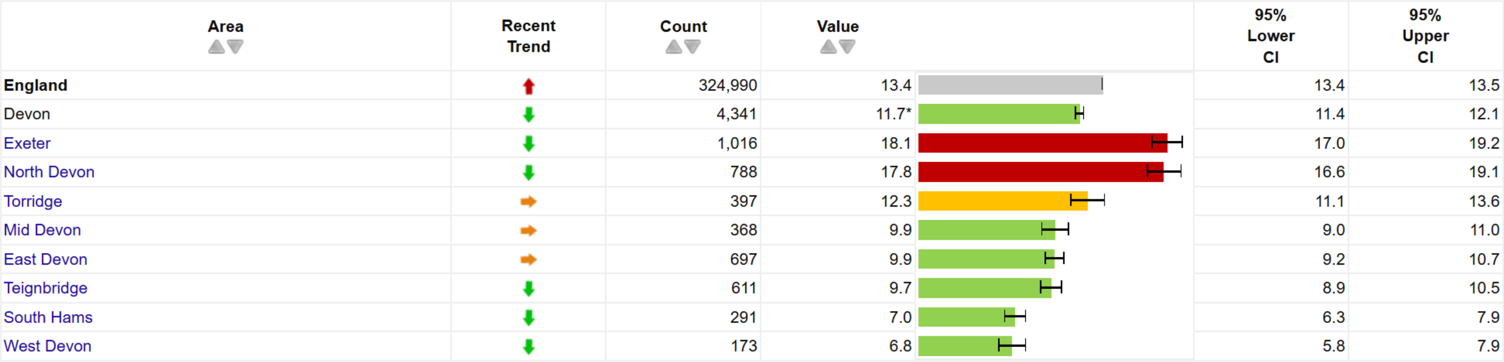
People experiencing homelessness

Areas of Devon experience substantial challenges with levels of housing need. In the more vulnerable situations, residents may seek support from the Local Housing Authority under the Homelessness Reduction Act. Duties owed eligible persons fall under two categories:

- Prevention duties include any activities aimed at preventing a household threatened with homelessness within 56 days from becoming homeless.
- Relief duties are owed to households that are already homeless and require help to secure settled accommodation.

Within Devon, there are particular pressures in Exeter and North Devon.

Homelessness: households owed a duty under the Homelessness Reduction Act, 2023-34 (Crude rate per 1000)



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬆	324,990	13.4	13.4	13.5
Devon	⬇	4,341	11.7*	11.4	12.1
Exeter	⬇	1,016	18.1	17.0	19.2
North Devon	⬇	788	17.8	16.6	19.1
Torridge	➡	397	12.3	11.1	13.6
Mid Devon	➡	368	9.9	9.0	11.0
East Devon	➡	697	9.9	9.2	10.7
Teignbridge	⬇	611	9.7	8.9	10.5
South Hams	⬇	291	7.0	6.3	7.9
West Devon	⬇	173	6.8	5.8	7.9

(Source: Fingertips (OHID, 2025)

MHCLG report quarterly statistics on statutory homelessness assessments. Applicants are assessed on the basis of potential need under the Duty. As an example, for Exeter District (July – September 2024), 251 households were assessed and 244 (97%) were assessed as owed a duty. 89.3% households were identified as having a support need – categories include 'history of mental health problems', 'physical ill health and disability', and 'learning disability' (MHCLG, 2025). A full breakdown is included at Appendix 4.

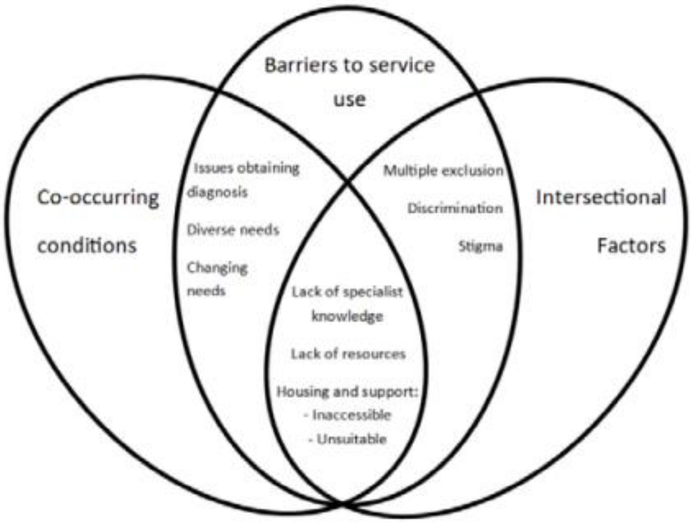
However, neurodivergence is not specifically recorded as a support need (nb. diagnosis is not required to access support). Given what is known in the evidence base, undiagnosed needs may be classified as presenting as mental health problems, and people with a learning disability may also have autism or ADHD. This cannot currently be described with any certainty.

Due to these limitations in the MHCLG dataset, data collection amongst local support services may give a better understanding of prevalence (and with regard to support to other inclusion health related-needs – see below).

Where a person is homeless, eligible, and has a priority need, the Local Authority must provide temporary accommodation. The criteria for Automatic and Vulnerability priority needs do not specifically include neurodivergence and so again cannot be specifically measured (Shelter, 2025).

The experiences of people who are homelessness can range from rough sleeping to usage of precarious housing including staying with family and friends. Prevalence of autism in homeless populations has been estimated at 12.3% in a caseload of a homelessness outreach team, and 18.5% in a sample of people accessing homelessness services. There is some indication in the evidence base of the lifetime experience of homelessness identified during the long term follow up of children diagnosed with ADHD (23.9% of the sample) (Centre for Homelessness Impact, 2023) (García Murillo,et al., 2016).

Social challenges, community levels of understanding, and employment challenges and lack of timely support could contribute to the risks of homelessness. In turn, autism may increase the risk that a person remains vulnerably housed. Once homeless, isolation and difficulty in understanding the behaviour of others, may reduce engagement with support services, and also increase the risk of abuse.



Factors resulting in service inaccessibility for people with disabilities experiencing homelessness

(Centre for Homelessness Impact, 2023)

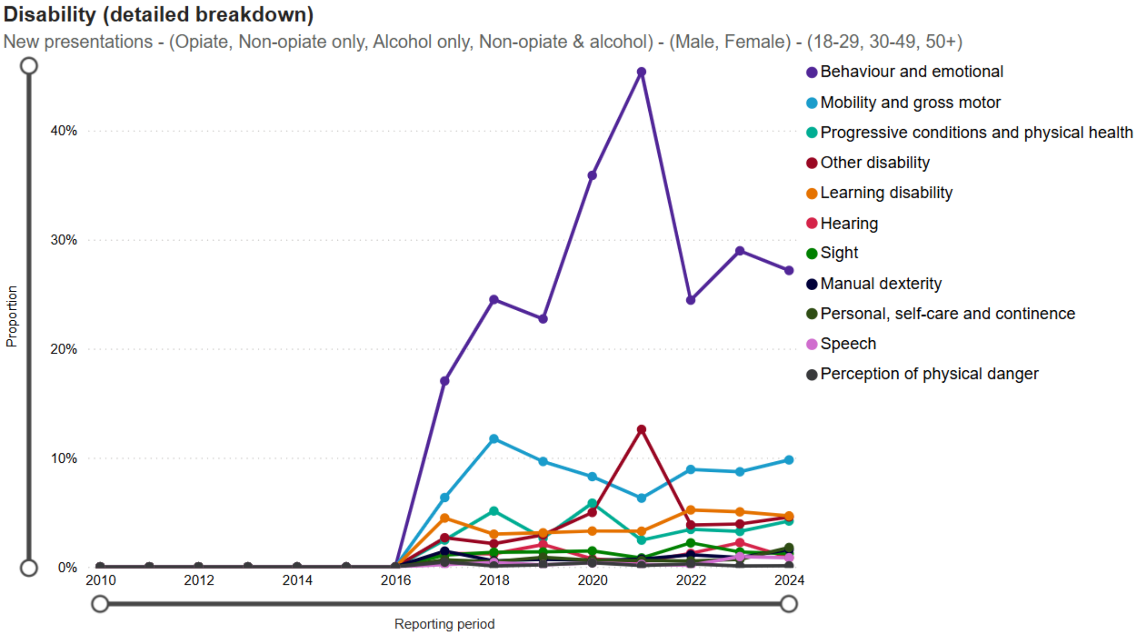
Adults using Drugs and Alcohol

Together is the local drug and alcohol service for Devon. Monitoring reports to the commissioner do not include breakdown by autism or ADHD. There is limited available local information about neurodivergence in the National Drug Treatment Monitoring System.

A disability breakdown of new presentations at the Devon level is available (whilst recognising not all persons with a neurodivergence consider themselves to be disabled). The greatest proportion by disability type is represented is ‘behavioural and emotional’ (and this is consistent across drug types, genders and age bands, aside from the 50+

group where mobility and gross motor needs are more closely aligned to behavioural and emotional needs.)

New presentations recorded in the NDTMS for Devon, 2010-24, by disability type (all genders, age groups and substance types)



(OHID, 2025)

The category of 'Behavioural and Emotional' is defined as 'should be used where the client has times when they lack control over their feelings or actions'. This may include some of the characteristics of autism and ADHD. However, it is not satisfactorily specific and, as described, may also include situations whereby a client has, for example, been placed in situations which are challenging and adjustments may have mitigated this if they had been in place (rather than behaviour representing a direct function of their condition).

The definition of Learning Disability is also relatively broad – 'should be used where the client has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18' – and could comprise characteristics of ADHD or autism alone, or people with a learning disability and autism or ADHD (OHID, 2025).

A range of studies from smaller samples focussing on undiagnosed ADHD in similar populations estimate prevalence at 20% (alcohol inpatient group) and 43% (substance misuse inpatient group) (French et al., 2023).

The Exeter-based STaR Project incorporates enhanced wrap around support and recovery interventions to a cohort of people who are rough sleeping or living in supported accommodation, and who are experiencing substance misuse. The Project is hosted at Co-lab and incorporates local authority, housing, primary care, and substance misuse input. It is based around the MEAM framework (developed to support local partnerships to address multiple disadvantage) and uses a client-centred and trauma informed approach.

An assessment of the mental health conditions and neurodivergence within STaR's caseload has identified 21% of clients have an ADHD diagnosis, although at the time of the deep dive this was thought to be an underestimate as additional clients were awaiting assessment.

STaR Deep Dive (October 2024)

56 people on caseload	
Of which:	
Complex trauma/ cPTSD	>70% of case load
ADHD diagnosis and GP-prescribed treatment	12 people
Alcohol Related Brain Injury	<5 people
Psychosis / schizophrenia diagnosis	6 people
Inclusion on Learning Disability Register	<5 people
Foetal Alcohol Syndrome	<5 person

This relatively small sample would however be supportive of the wider evidence base on ADHD prevalence.

Young People using Drugs and Alcohol

Y-Smart provides Drug and Alcohol Services in Devon for children and young people under the age of 18. Tier 2 support is provided to young people who have experimented with substances occasionally or on a one-off basis. This would typically involve the provision of information around drugs and alcohol. Tier 3 support is provided when a negative impact on a person's life and relationships and may include a multi-agency approach.

Of the newly referred clients receiving Tier 2 support (July-Sept 2024), 19% (n=<5) were reported to have ADHD, and 14% (n=<5) were described as having a behavioural or learning neurodiversity. These factors were not reported for those in Tier 3 support, or for those in families affected by substance use (Source: YSmart Performance Reporting).

Criminal Justice System including Victim Support

The Safer Devon Partnership Community Safety Strategic Assessment 2023-2024 recognised that:

> *It is well evidenced that cohorts susceptible to becoming involved in crime and violence as both victims and perpetrators often have neurological needs and differences including brain injury, ADHD, autism and learning disabilities. It is also documented that services aiding people at heightened risk are under significant financial pressure.*

> *There is also a large cohort of young people and adults who have undiagnosed and therefore often unmet needs relating to neurodiversity. It is indicated that the very nature of these needs being unidentified could create conditions making them more at risk of involvement in crime and violence* (Hinchliffe, 2025).

'Neurodiversity in the criminal justice system: A review of evidence' was published by HMICFRS (2021). In line with the above, this found:

- There were no consistent data collection processes in place, however it was estimated that as many as 50% of the people in prison have a neurodivergence [defined in this instance as all types of 'neurodivergence and learning disability']

- Current services were not suitable to consistently meet the needs of neurodivergent individuals. There were no consistent screening or information sharing policies: '*There is certainly no guarantee that a neurodivergent person coming into contact with the CJS will have their needs identified – let alone met – at any stage of the process'.* The rehabilitative offer for neurodivergent person was very limited; this risks exacerbating inequalities in outcomes following discharge from the CJS.

- Autism was felt to be better understood (particularly within the police) but other conditions including ADHD need additional focus, and overall, there were consistently low levels of awareness and confidence amongst staff groups.

- Individual examples of adaptations were identified, that were often low cost and simple, but these were not universally implemented:

> *'Alongside the need for more formal support and training, people involved in the CJS made a powerful plea for criminal justice staff to simply make full use of their 'soft skills' – listening, empathy and compassion. By routinely asking questions, and listening to the answers, many immediate needs could be understood and met (including those of neurotypical individuals).'* (HMICFRS, 2021)

A supporting engagement exercise with 118 people with a diagnosis of neurodivergence or learning disability and with lived experience of the CJS in England is available. This found that most participants were not asked, assessed or reviewed in relation to their condition at any stage (66%). Few referrals were made to specialist services or interventions (5%) in addition to adjustments such as explaining key documents (70%). Staff were both unaware of needs and not supported to be able to meet them (User Voice, 2021).

A specific review of health and social care in women's prisons (2023) found that neurodiversity was frequently stated as being 'inadequately understood'. Neurodivergent women are '*not routinely identified, are often misunderstood and sometimes poorly managed. Poor understanding of how needs were communicated was found to 'result in depression and anxiety, and behaviour such as self-harm, violence and poor regime compliance'*.

The review found that specifically women who were neurodivergent were amongst those most disadvantaged by a poor environment and sensory challenges. There was also concern that improvements were needed in medicines management and communication. It recommended that: ‘reasonable adjustments should be made for women who are neurodiverse, and information should be accessible for women whose first language is not English’ (NHS England, 2023).

Policing

Within police operations, data on neurodivergence relating to those who interact with the police was not available within the timelines of the HNA. In terms of the process, Devon and Cornwall Police noted that for people taken into the custody suite, additional needs are sought and any self-identified neurodivergence is recorded. It is perceived to be relatively common for ADHD and autism to be recorded in line with the evidence from elsewhere.

It is recognised that when police response is made for a concern for welfare (which may include attempted suicide) this would usually be recorded as mental health need related, and any primary needs that related to neurodivergence may be misclassified.

The importance of suitable training and consistent adjustments for autistic people and people with ADHD within the criminal justice system is underscored by the UK evidence base that identifies:

- lack of knowledge and training amongst police officers;
- a risk that vulnerabilities in autistic adults may be overlooked;
- differences in sensory processing and communication in autistic adults that may be incorrectly identified as non-compliant or deceitful;
- people with ADHD being more vulnerable in police questioning;
- sensory challenges in court settings leading to poor experiences and potentially poor outcomes for autistic adults (Woodhouse et al., 2024).

In these contexts, effective screening, awareness and adjustments has added urgency.

Probation

A snapshot of the Devon Probation caseload for March 2025 has been made available. This type of provision relates to the Devon Probation Service team currently managing the individual. Autism and ADHD is derived from both diagnoses and self-identification.

Type of Probation Provision	Autism	ADHD	Total caseload	Autism (%)	ADHD (%)
Community	22	90	861	2.6%	10%
Prison	n/a	29	229	n/a	13%

Please note Autism and ADHD may co-exist in this sample and disaggregation by that group is not available.

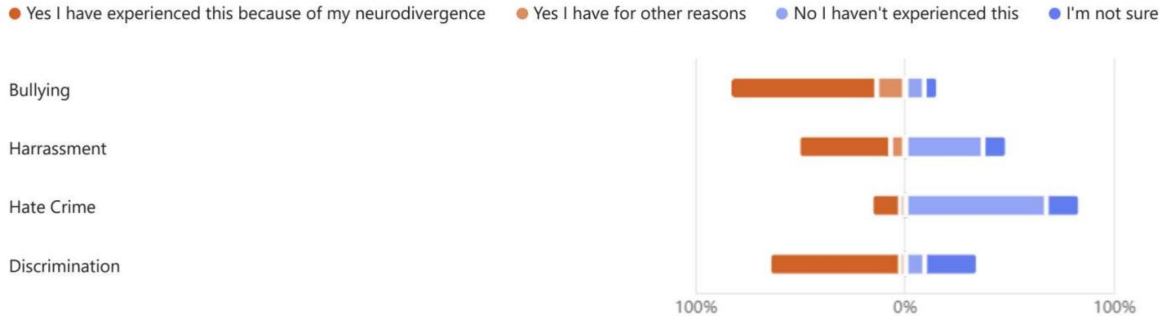
This data is a snapshot but is felt to be indicative of the usual situation and the local Probation Teams recognise the perception of higher prevalence compared to the general population.

Victim Support

An important element as it relates to criminal justice is the role of neurodivergence in victims of crime, and other threatening behaviour that is not criminal.

A majority of respondents to relevant questions in the survey of PWLE had experience of bullying or discrimination linked to their neurodivergence. Hate crime was less likely to have been experienced.

PWLE Survey Response to: 'D you think you have ever experienced any of the below because you are neurodivergent'



For people who have been victims of crimes, the Office of the Police and Crime Commissioner commissions a range of victim support services. It is recognised that victim support referrals have significant wait lists. All commissioned services are required to be trained in trauma supportive approaches, and support to people with disabilities.

The Victim Care Unit undertakes triage and advocacy. Should autistic people or people with ADHD present to services, the VCU may take the lead in their support or refer to specialist services. Devon People First are commissioned to provide victim support for adults with learning disabilities, and Living Options Devon are funded to support disabled and Deaf people.

There is however an element of self-referral and there is therefore a potential some services may not be the most appropriate for a person's needs. Referral data is available by type of disability, but this element is not broken down further.

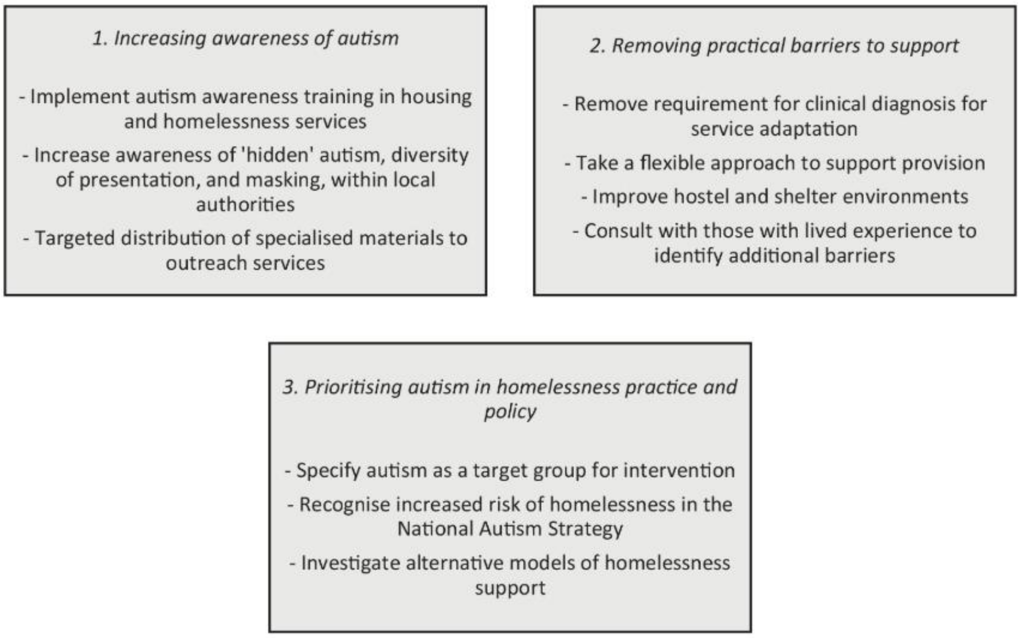
11. Evidence and good practice for support social, emotional and mental wellbeing needs in the inclusion health population

Homelessness

The challenges with diagnostic assessment can be even more acute when addresses change rapidly. Clients of homelessness support are required to maintain co-operation with services and suffer from disadvantage if their presentation is misinterpreted and includes behaviour that challenges.   Housing support is also intended to be short term and may not encompass the time periods required for assessment or enable a full appreciation of a person's needs (Centre for Homelessness Impact, 2023).

Furthermore, sensory challenges may be exacerbated in temporary and potentially chaotic environments. A narrative enquiry with autistic people living in South West England, found that some participants chose to sleep on streets rather than stay in environments that increased social anxiety and sensory challenges.

Suggested principles to adopt in homelessness services:



1. Increasing awareness of autism

- Implement autism awareness training in housing and homelessness services
- Increase awareness of 'hidden' autism, diversity of presentation, and masking, within local authorities
- Targeted distribution of specialised materials to outreach services

2. Removing practical barriers to support

- Remove requirement for clinical diagnosis for service adaptation
- Take a flexible approach to support provision
- Improve hostel and shelter environments
- Consult with those with lived experience to identify additional barriers

3. Prioritising autism in homelessness practice and policy

- Specify autism as a target group for intervention
- Recognise increased risk of homelessness in the National Autism Strategy
- Investigate alternative models of homelessness support

(Stone et al., 2022)

The ‘backdoor accessibility’ concept relates to how expecting people with disabilities to move through service provisions that have not been explicitly designed for them can hinders access and engagement. However, further evidence is required to inform changes to environments. It is suggested that evidence from other fields (including health care) can be of benefit (for example, environmental checklists for autistic people and people with ADHD) (Centre for Homelessness Impact, 2023).

Homeless Link suggests a checklist approach to identify potential needs related to autism, and use of a further checklist with adjustments that can be made including in the absence of a diagnosis (incorporating: routine, sensory sensitivities, communication/social interaction, processing, acceptance, strengths-based approaches) (Homeless Link, 2024).

<u>Inclusion Health Devon – ADHD pathway</u>

Inclusion Health Devon has developed a rapid diagnosis pathway for people served by the service in Exeter. This is provided by a psychiatrist in the DPT Homeless Mental Health Team working in conjunction with GPs.

This recognise the challenges faced by anyone awaiting an ADHD diagnosis can be particularly acute for those experiencing homelessness. A diagnosis provides more rapid access to treatment supported by the Clock Tower, and assists with access to other services including housing applications, benefits, and adult social care assessments and is particularly important for those with complex lives.

This is recognised as an important for provision but limited in scope and geography. Patients supported in this way also do not benefit from the non-prescribing elements of support that people managed by DAANA may receive.

Inclusion Health Devon more broadly is designed to be as flexible as possible; for example, a walk-in service is provided in the mornings (rather than appointments), staff are trauma informed and skilled in working with vulnerable populations, support and reminders to attend appointments, and flexible length of appointments.

Criminal Justice System

Within the South West, the national Health and Justice reviews have been supported by a regional review of current neurodiversity in the CJS provision (2022), and a review of women's provision specifically (2024). A summary has kindly been provided by the NHS England Health and Justice Team. These reports focussed on the provision of health care in the CJS. The key findings/recommendations from this work were:

- Improve data collection: Limited screening and assessment at the point of contact with services means there is a lack of data available to inform service planning.
- Introduce a suite of evidence-based Screening and assessment tools: Limited screening means there are inadequate opportunities for early diagnosis, appropriate treatments, adjustments, support.
- Increase staff training and awareness: Lack of consistent evidence-based training and awareness limits staff effectiveness
- Increase access to Speech and Language Services: these services are essential in supporting the communication needs of people with neurodiversity.

Supporting programmes of work has included improvements to data collection with use of screening tools now included in contracts (including autism and ADHD), training for staff (Oliver McGowan with support from CGL), an improved drug and alcohol pathway, support to reasonable adjustments, and the introduction of a 'communication passport'.

Integrated Non-custodial Services relate to healthcare provided within police, court and community settings. A new service has been commissioned for the South West, and within the contract there are clear expectations around Oliver McGowan Training, use of screening tools, and referrals to Speech and Language Therapy (which is now available in all 11 regional prisons).

During 2025-26, a national ADHD Task Group is due to provide additional focus on models of diagnosis in the CJS. It is also recognised that some people are being removed from community health care ADHD assessment waiting lists whilst they are in prison; this has been flagged as a national and regional concern.

Criminal Justice Drug and Alcohol Provision

CGL provide drug and alcohol services to the South West Prison population. A Neurodiversity Service Redesign Project has been completed in ten regional prisons. This was developed in co-production with people with lived experience. There has been a shift away from punitive approaches when a person is found with drugs towards a more supportive model and this has led to an increase in the number of prisoners accessing CGL provision.

Case studies have identified how adaptations could be made to the prison environment together with staff training to make relatively simple changes with significant impacts. An example of such support enabled a prisoner in solitary confinement for substantial periods of time (5 months out of initial 5.5 month period in prison) to be transferred to a standard wing.

As very few people undertaking neurodivergent champion roles remain in prison for a long period of time, consideration may be given to in-reach from community-based champions. Programmes of work are being considered around environmental audits, the reception experience, review of recruitment processes and support for staff.

Policing

Devon and Cornwall Police has been considering Child First principles in its interactions with young people, recognising the range of issues that may influence while a young person was more marginalised or likely to be involved in crime. This includes a focus on more accessible and probing language to try and understand their experiences to a greater extent (i.e.. using unambiguous language such as ‘do you feel uncomfortable having conversations?’). Discussions with stakeholders suggested that adopting this approach with adults would be helpful to understand autism and ADHD.

Stakeholder feedback and reflections

- Representatives of local Housing Authorities noted that the limitation of the national system used locally means there is no method of capturing neurodivergence and therefore identifying this within the available MCHLG dataset. However, proof of diagnosis is not required to be able to access support.

- Although not reported in NTDMS data, Together note that they do ask whether someone is neurodivergent in local service delivery (and sometimes experience a reluctance to disclose if the person is not clear why they are being asked, or are fearful of what it may mean if this was shared wider – for example, whether it would impact on access to services). The results of these local conversations are included in safety planning and adaptations made where possible.

- Within the South West Probation Delivery Unit, it is recognised that there has been recent work on neurodivergence but there is addition scope for further learning. Recent improvements have included commissioning of a service from the National Autistic Society to provide advice and guidance to practitioners regarding neurodivergence with the potential to undertake work with clients.

Staff training was planned for the middle part of 2025 and would represent a new approach for the service.

- Reasonable adjustments are increasingly being used in offender management plans (and may include for example shorter face to face sessions, or more activity based sessions).

- The improvements outlined above within the CJS provision are felt to be new strengths and the Youth Justice Service has a CAMHS and SLT practitioner. The intention is to build on this to ensure a better transfer of information when young people transfer to the adult CJS, including use of the communication passport.

- A challenge in the CJS relates to young people with an ADHD prescription and support provided in childhood that does not always appear to continue into adulthood / prison, where this would be beneficial.

- Due to the reactive nature of police response work, it is recognised that the ‘fight or flight’ response or other behaviours that challenge, that can be encountered by police officers may in truth be a presentation of emotional dysregulation or a response to sensory stimuli because of a person’s neurodivergence. Individual cases have provided important learning for Devon and Cornwall Police and there is ongoing consideration as to how this can be applied on a tactical basis.

- Due to the nature of physical environments in policing, it is recognised these can be challenging. There is also a need to follow legal obligations that may impact on implementation of reasonable adjustments (for example, expedited processing times). Some newer police stations have larger custody areas and outside areas which could provide helpful learning. There is a national discussion about the role of reasonable adjustments in custody environments.

- Within the police, guidance documents have been shared within specific teams, and there is desire to do more as part of the Service’s Mental Health and Suicide Prevention work. Devon and Cornwall Police would welcome additional support (including opportunities to work with local organisations and learn from programmes such as the Oliver McGowan Training) as part of a wider programme of mental health training. This is planned to include mental health legislation, suicide prevention, and provides a basis to include a focus on neurodivergence.

- The intention is for the Victim Care Unit to oversee all incoming referrals and to establish a trauma hub at the first point of contact to identify victim’s needs at an early stage.

- For people who enter the criminal justice system whilst on a community waiting list for ADHD assessment, they may be at risk of losing their place on the community waiting list (this may be due in part to a loss of contact details upon entry to prison and NHS protocols on lack of response and capacity to follow up).

‘The prison health system needs an overhaul with rapid diagnosis and entry to medication for people with ADHD. Currently if someone is on a long wait list for diagnosis this is lost when they enter prison and so cycle in and out of prison without getting diagnosis/ treatment’

[Stakeholder survey respondent]

Observations for Inclusion Health

a) The estimated higher prevalence in these groups can be anticipated locally and has some level of evidence from local caseloads.

b) Neurodivergence may contribute to and increase likelihood of marginalisation. An example pathway into homelessness could be hypothetically illustrated as: person experiences social challenges > in the context of lack of community understanding > leading to lack of support and employment vulnerability > potential self-medication > creating financial and housing adversity > followed by a lack of co-operation with and/or sensory challenges in support services > higher risk of eviction or withdrawal from support.

c) Some elements of the experience of neurodivergence are particularly challenging for inclusion health groups and those at risk of becoming entrenched within a status of social isolation (for example, those on the edge of homelessness and temporary accommodation).

d) Data collection presents challenges and neurodivergence is not consistently collected (for example, in housing) or if collected locally, is not available in reporting data (for example, drug and alcohol services). Local provision for inclusion health groups is not related to whether a person is autistic or has ADHD, and is dependent on their presenting need (for example, housing or entry in the CJS). However, if needs are not explicitly explored (for example, through routine screening processes) there is a risk they are not understood or met.

e) Although during the delivery of services, specialist referrals and/or adjustments are made when known (including input from the National Autistic Society into Probation delivery, changes made to safety planning in Drug and Alcohol Services, and referrals made within Victim Care Services, and there appears to be a general commitment to using person centred approaches), there is a risk that the total level of need is not yet fully understood and therefore responded to.

f) Service providers display an appetite to do more (including Devon and Cornwall Police, OPPC, Together, Probation) but training budgets and service capacities limited (and have existing waiting list challenges in some cases for the population as a whole). There may be an opportunity to adopt or adapt existing programmes to support staff (e.g. Oliver McGowan Training).

g) Examples of good practice include the dedicated ADHD Pathway at the Clock Tower - but partners recognise that this is provided to a limited part of the population as a whole and this creates geographical inequities.

12 Relationship with suicide and self-harm

Evidence base on suicide and self-harm and neurodivergence

Suicide risk and autism

Prevalence in autistic and possibly autistic people (defined as people with a diagnosis or scoring above a threshold on measure of autistic traits respectively) without co-occurring Learning Disability have been estimated in a systematic review at:

- suicidal ideation (34.2%);
- suicide plans (21.9%);
- attempts and behaviours (24.3%).

Sub group analysis noted some important considerations:

- suicidal ideation was higher in transgender or gender non-conforming participants (63.8%) compared to samples that were not (30.8%);
- suicide plans are higher in autistic adults aged over 20 (22.9%) compared to young people aged under 20 (7.9%);
- there appeared to be no differences between sub groups for attempts and behaviours (Newell et al., 2023).

The finding that ideation was higher in autistic and possibly autistic adults who are transgender or gender non-confirming is both important to highlight and in line with the higher rates of suicide ideation (and behaviours) in this group in the general population, and also the increased likelihood that autistic people are gender diverse, compared to non-autistic people, in the general population (Newell et al., 2023) (Warrier et al., 2020).

A study of coroner records (n=372) in England estimated evidence of autism was 10.8% in people who died by suicide (evidence of autism was defined following a review of symptoms in records using DSM-5 and classed as Possible/Strong /Definite). A smaller subset of participants was identified determined by whether their next of kin were available to be invited to take part in an interview (there was no significant difference in evidence of autism between those cases whose next of kin were able to be invited and those who were not). Of those where the next of kin were interviewed (n=29), 41.4% of the people who died by suicide were found to have higher levels of potential autistic traits (Cassidy et al., 2022). This could indicate a potential underestimate of autism in the remainder of the sample whose next of kin were not interviewed.

Self-harm and autism

A full understanding of self-harm in autistic adults continues to be developed (as with suicide). However a recent systematic review estimates up to 54% of autistic people could experience non suicidal self-injury across the lifetime. The age of onset, methods, and functions of self-harm do not appear different to non-autistic people, and so this is not necessarily in line with perceptions of self-injury being related to challenging or repetitive behaviours (Brown et al, 2024).

Suicide risk and people with learning disabilities

Suicide in people with learning disabilities has not received substantial attention in the evidence base. As with neurodivergence and mental health needs, this may in part be due to diagnostic overshadowing with a person's symptoms of mental health need being associated with their learning disability. Furthermore, there has been an assumption that people with learning disabilities have not been able to conceptualise the impact of actions that would lead to their death, and so not meet conventional definitions of suicide (NIHR, 2023) (Chan and Bhandarkar, 2024).

A systematic review of the available evidence indicated that suicide ideation, self-harm and suicide attempts in people with learning disabilities may be higher than previously identified; however the evidence base remains limited in scope, with under-representation in large scale studies, and a focus in studies of people with a mild learning disability. One US-based study identified that people with co-occurring autism and learning disability had a higher odds of suicide attempt or self-injury than autistic adults without learning disability (Chan and Bhandarkar, 2024).

The findings from the LeDeR programme outlined below indicate a differentiation between the cause of death for autistic adults with and those without a learning disability (with a higher proportion of deaths due to suicide in the latter group); however this is a relatively small sample and subject to selection bias). For the purposes of the HNA, it is important to note that suicide and self-harm may occur in people with learning disabilities, including autistic people with learning disabilities, but this needs to be much better understood (NIHR, 2023).

Suicide and self-harm in people with ADHD

Umbrella reviews and the International Consensus Statement of the evidence base identify that there are associations between people with ADHD and suicide and self-harm across available studies (Faraone et al, 2021) (French et al., 2024).

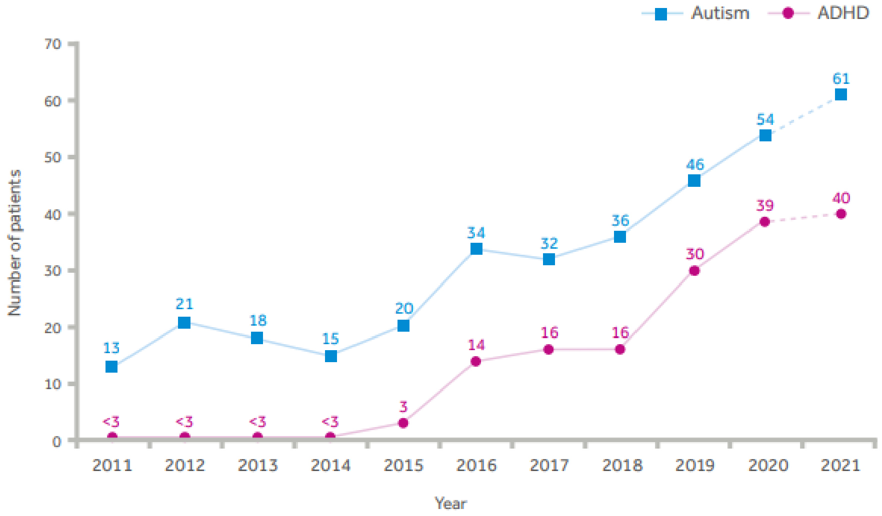
The first meta-analysis (summarised by French et al) to take into account potential confounders, demonstrated a significant association between ADHD and various markers of suicidal behaviour: suicidal attempts (OR; 2.37, 95% CI = 1.64–3.43; I2 = 98.21), suicidal ideations (OR; 3.53, 2.94–4.25; I2 = 73.73), and deaths through suicide (OR; 6.69, 3.24–17.39; I2 = 87.53) (French et al., 2024).

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

The National Confidential Inquiry into Suicide and Safety in Mental Health outlines findings from deaths by suicide in people aged 10 between 2011 and 2021, including a dataset of patients under the care of mental health services. The 2024 report included a specific focus on autism and ADHD.

The dataset for patients demonstrated an increase in diagnosed autistic patients and patients with ADHD recorded by NCISH from 2015 onwards. It is recognised this may reflect an increase in clinical identification and recording.

Patient suicide in the UK: number who received a diagnosis of autism and ADHD



(NCISH, 2024)

Within the NCISH sample, autistic patients who died by suicide, compared to those without autism or ADHD, tend to be younger and more often male. They were more likely to identify as LGBT. They had higher rates of childhood abuse, including emotional and physical abuse (37% versus 30%). Autistic people were more likely to use the internet for suicide-related purposes, and had higher rates of self-harm (70% versus 63) but lower rates of alcohol misuse.

Autistic patients were more likely to be in-patients at the time of death and to be non-adherent with medication. The immediate and long-term risk of suicide was generally viewed as higher among autistic individuals. Drug misuse rates were similar to those of other patients.

Patients with an ADHD diagnosis who died by suicide were more often male and younger compared to other patients who died by suicide and who did not have identified ADHD. People with ADHD were more likely to be under 25 or between 25-44 years old. Nearly half (45% of those with ADHD versus 30% in those that did not) had experienced childhood abuse, including emotional, physical, and sexual abuse. Fewer ADHD patients were under crisis resolution/home treatment services, and their long-term risk was more often viewed as low or not present. They have higher rates of previous self-harm (73% versus 63%) and drug misuse (62% versus 37%).

LeDeR Programme

The national 'Learning from lives and deaths – People with a learning disability and autistic people' review (LeDeR) programme is intended to understand causes and factors contributing to the deaths of people with learning disabilities and/or autism (autistic adults over the age of 18 are in scope). Autistic people without a learning disability were incorporated in the process from 2021. Each review is analysed at a local level to identify learning and areas for improvement, with local findings fed into national oversight to identify wider patterns, trends and systemic issues, with the aim of reducing avoidable deaths and health inequalities.

LeDeR Reviews consider key aspects in the health and social care journey of people with learning disability and autistic people (and not just the care provided immediately before death).

How to Report a Death to LeDeR

Anyone can report the death of a person with a learning disability or an autistic person aged 4 years or older to the LeDeR programme. This can be done through the national LeDeR portal: https://leder.nhs.uk

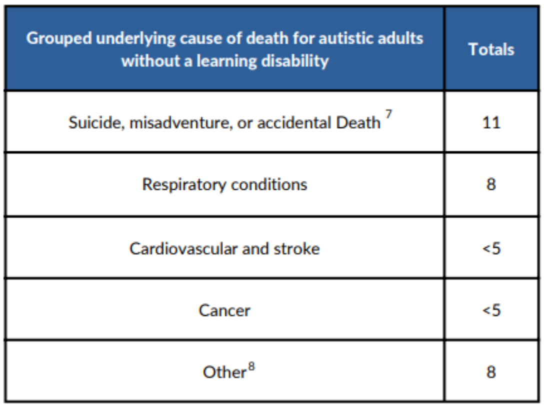
The portal is open to families, carers, friends, and professionals. Referrals from GPs, community health teams, and inpatient services are particularly important in supporting a full picture of care and learning.

The national LeDeR policy and criteria for referrals of autistic people are:

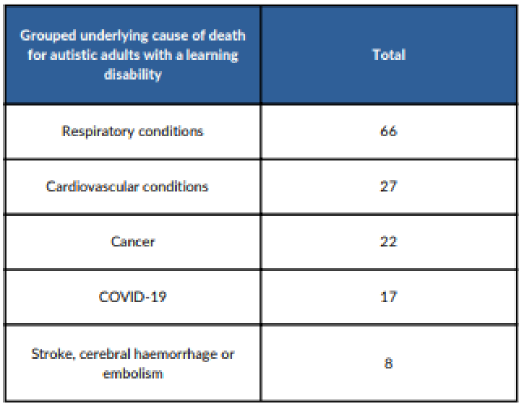
- For an autistic individual to be eligible for a LeDeR review, they must have had a confirmed diagnosis of autism recorded in their clinical records prior to their death;
- The criteria do not include those who self-identify as autistic but have not sought or not received a clinical diagnosis from a qualified health professional;
- The criteria do not include individuals who have been referred for a clinical assessment of autism, but who have died prior to the assessment having been carried out or completed (ICB).

The last available national report was produced by KCL (2022). This identified differences between the underlying causes of death between those with a learning disability and autistic adults without (a smaller sample). It is important to note that in line with the above, this is only based on those people who were referred to LeDeR and so may not be representative.

Grouped underlying cause of death for autistic adults without a learning disability and autistic adults with a learning disability



Grouped underlying cause of death for autistic adults without a learning disability	Totals
Suicide, misadventure, or accidental Death [7]	11
Respiratory conditions	8
Cardiovascular and stroke	<5
Cancer	<5
Other[8]	8



Grouped underlying cause of death for autistic adults with a learning disability	Total
Respiratory conditions	66
Cardiovascular conditions	27
Cancer	22
COVID-19	17
Stroke, cerebral haemorrhage or embolism	8

(White, et al., 2023)

It is important to note that the two groups can have very different needs, and this data may not be representative (there is also potential under-representation of autism in adults with learning disabilities). It is not intended to provide a direct comparison but is included to show the underlying causes of death in those autistic adults that were referred to LeDeR.

This was the first full year of data collection incorporating all autistic adults and KCL noted that future reports will be important to understand whether the findings related to autistic people (with or without a learning disability) can being to be applied more generally, as the new referral criteria embed over time. The report did however note the proportion of deaths due to suicide in the group without a learning disability.

It made recommendations that care needs for this group have specific considerations, and that in terms of research 'Continued efforts are needed to increase data from more marginalised members of society, such as people from ethnic minorities, members of the LGBTQIA+ population, people in the criminal justice system, and people who are homeless' (White, et al., 2023).

The underlying causes of death varied, however there are some important learning points relevant to the HNA in terms of how care and support needs in this population group are, or are not, being met. Where care was indicated as poor, key themes included:

- a lack of high-quality training, awareness, or understanding of the specific needs of autistic people;
- a lack of adequate tailored support services being provided or a lack of support to access services;
- overlooking the potential impact of a change in relationship status for autistic adults;
- lack of crisis escalation plans, or a lack of an awareness of the increased risk of suicide in autistic adults;
- lack of communication between professionals and agencies providing support.
- overshadowing of the impact of autism by other co-occurring mental health conditions

Such themes included the provision of reasonable adjustments and quotes from the reviews included:

> "[name] was significantly failed by services in relation to assessment of [their] health needs in both community and hospital settings....
>
> [name]'s mental health issues were not identified at an early stage and was viewed as largely behavioural..."
>
> "[name]'s autism was rarely taken into account as to the reasons for non-attendance or self-discharging...little evidence of adjustments that may have positively enabled this person to access services, for example, only group therapy was offered, [name] could not cope with group sessions, but no one to one therapy was offered..."
>
> "Organisation systems and processes did not allow for reasonable adjustments."
>
> "Mental health services did not support [name] effectively due to not accepting [their] diagnosis of autism..."
> (White, et al., 2023)

Conversely where a good level of care was provided, awareness, adjustments, appropriate crisis plans, assessment of suicide risk, and person centred approaches were evident (White, et al., 2023).

As national LeDeR learning reports have not been published since 2022, the role of local reviews becomes more important for informing strategic planning and future needs assessment. These reports provide a rich source of more nuanced data in the absence of more consistent data collection elsewhere (as identified by this HNA).

In Devon the process is led by the ICB. The ICB recognises that there have been relatively few referrals of autistic adults without a learning disability in Devon ICB compared to other localities. Although any person is now able to report a death to the national LeDeR portal, referrals are most likely from community health care teams, secondary in-patient care, and GPs. The number of reviews undertaken locally are ultimately dependent on this reporting process (and will not include people who are not diagnosed including those referred but not yet assessed). Local Autism Partnership Boards have been made aware of the 2021 change to include all autistic persons in the LeDeR process; however there appears to be an opportunity to undertake additional promotion to support the opportunities for learning.

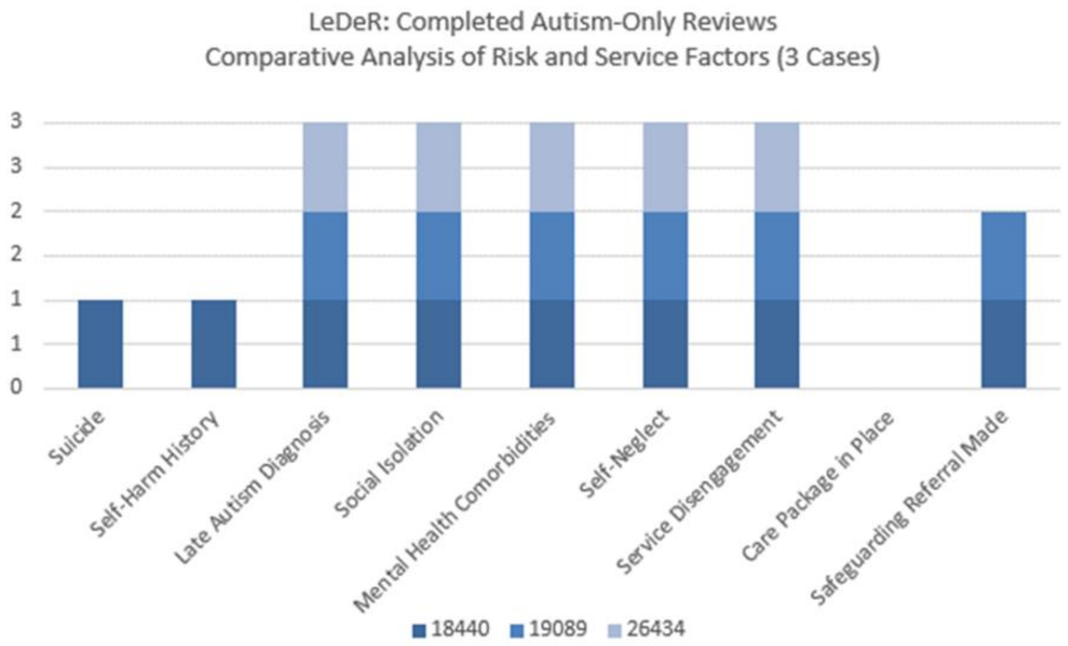
An annual report and monthly highlight reports are produced and shared with Health and Social care systems. The aim is to reflect the needs of the population of Devon and drive change in readdressing health and care inequalities for these groups.

The 2023-24 Devon Annual Report included details of the first autism focussed review that was undertaken locally (reviews take place as either Initial Reviews or a Focused Review – these are undertaken when there are concerns about the care received, local priorities, family requests, or potential learning from the case to inform service improvements). This was in a younger adult man with mild learning disability and atypical autism and identified good practice and levels of care across the multiple agencies that had provided support.

Three reviews have been completed in autistic adults without co-occurring learning disability. One of these deaths was due to suicide and that person had a history of self-harm.

All three demonstrated missed opportunities for early intervention and:

- there was late diagnosis of autism in all three (defined as diagnosis in adulthood)
- services that did not adapt to a person’s needs
- evidence that support was not understood, accessible or followed through when the person was in crisis or under pressure
- common themes of social isolation, mental health needs, self-neglect and disengagement with services.



In relation to the person who died due to suicide, there was evidence that suicide risk had been flagged while the person was in prison but could have been managed better.

As the count of autistic people considered as part of the local LeDeR process is relatively low, it is important to consider these do not represent the totality of need and should be considered with the wider evidence of mental health needs as identified in this HNA (NHS Devon, 2023).

In addition to the ICB LeDeR process, DPT has undertaken mortality reviews following the deaths of autistic patients as part of its Learning from Deaths and Mortality Review Reports. These are reported quarterly to the Trust's Board Meeting. Themes related to these were not available during the timeline of the HNA but may provide a further source of intelligence to inform future work.

Risk factors for suicide and self harm

The most recent Suicide Prevention Strategy for England summarises the social determinants of suicide risk as housing, poverty, employment and education. Within this context it proposes additional focus on the following areas at a population level:

- physical illness
- financial difficulty and economic adversity
- harmful gambling
- substance misuse
- domestic abuse
- social isolation and loneliness

The following groups are identified as priority groups:

- children and young people
- middle-aged men
- people who have self-harmed

- people in contact with mental health services
- people in contact with the justice system
- autistic people
- pregnant women and new mothers (DHSC, 2023)

To support the implementation of the National Suicide Prevention Action Plan, NCISH are undertaking a more detailed study on the characteristics of the autistic patients within its dataset, and this was due for publication in spring 2025.

Given what is known about co-existing physical, mental and psycho-social needs and challenges experienced by the neurodivergent population, there is an overlap with these population-wide risk factors for suicide.

Risk factors for suicide and autism

In their analysis of coroner records Cassidy et al (2022) found a high number of risk markers in those with evidence of autism and those without but no difference in type of characteristics between each group (including mental health and physical health conditions, service contact in year prior to death, and psychosocial risk factors – including but not limited to social isolation, substance use and homelessness).

There is an identified need for additional research into the specific relationship between suicide and autism (and ADHD). However, some important key points are as follows:

- the existence of co-occurring mental and neurodevelopmental conditions (including depression, anxiety and ADHD);
- social, cognitive, and behavioural factors. This includes the role of isolation, bullying, and camouflaging of traits;
- executive function difficulties, higher cognitive ability, lower adaptive functioning, and emotional dysregulation have been identified but require further investigation (Brown et al., 2024).

Middle aged men in particular are a national priority group. A 2022 study noted that of those aged 50 and above, those with high autistic traits (defined as indicated using the PROTECT Autism Spectrum Traits questionnaire) demonstrated higher suicidal ideation, deliberate self-harm, and suicide self-harm, following control for symptoms of depression (but same likelihood of seeking help after episodes of self-harm) (Stewart et al., 2023).

As can be seen in the local data below, the all age male suicide rate is higher than the female rate. Whilst recognising the caveats regarding possible female under-representation in the data on autism (and ADHD) prevalence, this does highlight a particular level of risk in the male population.

Theoretical models of suicidal thoughts and behaviours are increasingly being explored as they relate to autism, particularly Interpersonal Theory of Suicide (IPTS). There is no clear picture yet emerging; the impact on suicide of thwarted belongingness and perceived burdensomeness is identified in some studies but not all.

Autistic people are more likely to report experiencing thwarted belongingness and perceived burdensomeness, compared to non-autistic people, and in individuals with high autistic traits, camouflaging is associated with increased thwarted belongingness. This is therefore also indicative of social and emotional needs (irrespective of potential specific links to suicide risk). It is also possible that interpersonal conflicts and life transitions are under-recognised as risk factors in this group (Newell et al., 2023).

The heterogeneity in the evidence base is partly thought to be explained due to the variety of experiences of autistic people, and the specific relationship requires further understanding. However, the overall picture of elevated suicide risk is clear, and there are strong commonalities with the drivers of risk in the wider population.

Risk factors for suicide and people with ADHD

As with autism, there is overlap with many of the risk factors for suicide in the general population with the experiences of people with ADHD. It is recognised that additional research is required into the association, this includes the role of co-existing conditions, behavioural challenges and substance use (French et al., 2024).

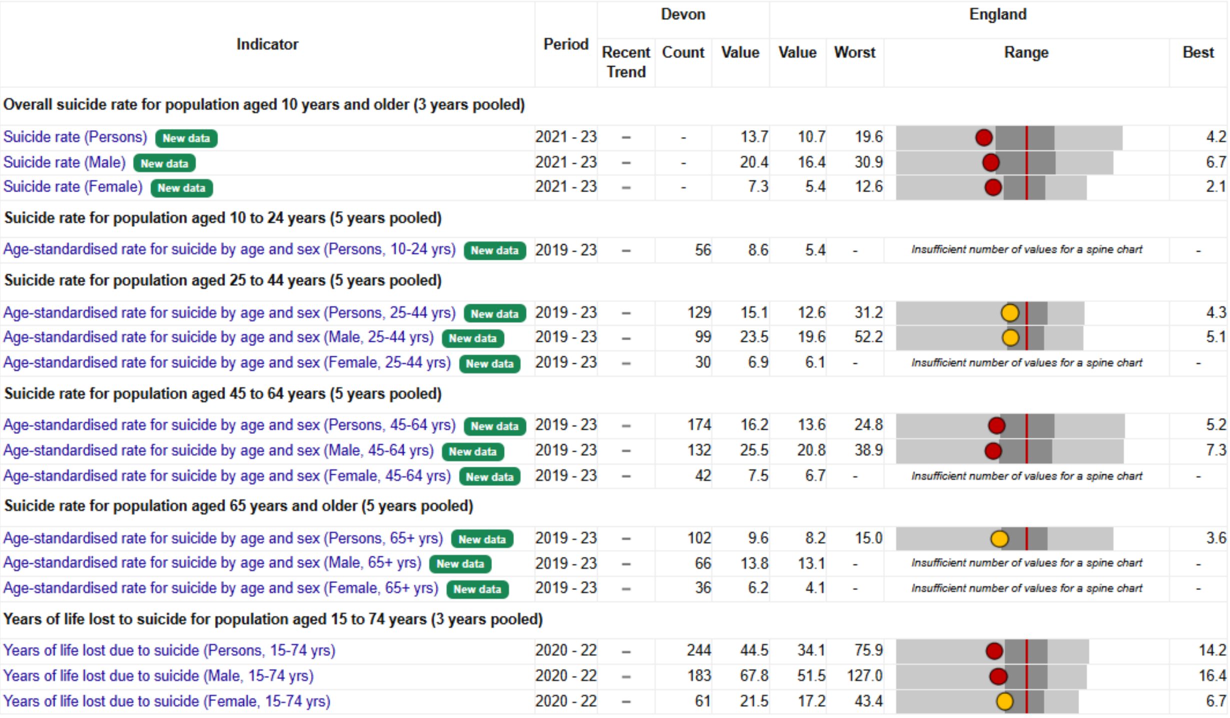
A 2012 study into individuals in in patient substance use services found that patients identified with ADHD (using diagnostic criteria) had higher rates of previous suicide attempts (and greater levels of functional impairment) (Huntley et al., 2012).

A recent small scale qualitative study was completed with eight younger adults (aged 32 and under) living in the UK with experience of suicidal crises. This identified interpersonal, academic and societal challenges, along with the role of internal processes such as rumination and emotional dysregulation and how interplay between these factors may have contributed to their experiences. Another key theme related to the participants' journeys towards self-acceptance (Cleare et al., 2024).

13 Local incidence of self-harm, suicide and suicide ideation and in persons with autism / ADHD

The OHID Fingertips Suicide Prevention Profile represents the national data set as part of a wider set of indicators for Public Mental Health (not all cases will be adults as data also includes those aged 10 and over (15 and over in cases of undermined intent). This data is taken from the ONS which in turn is taken from death registration data which is completed following the Coroner-led inquest.

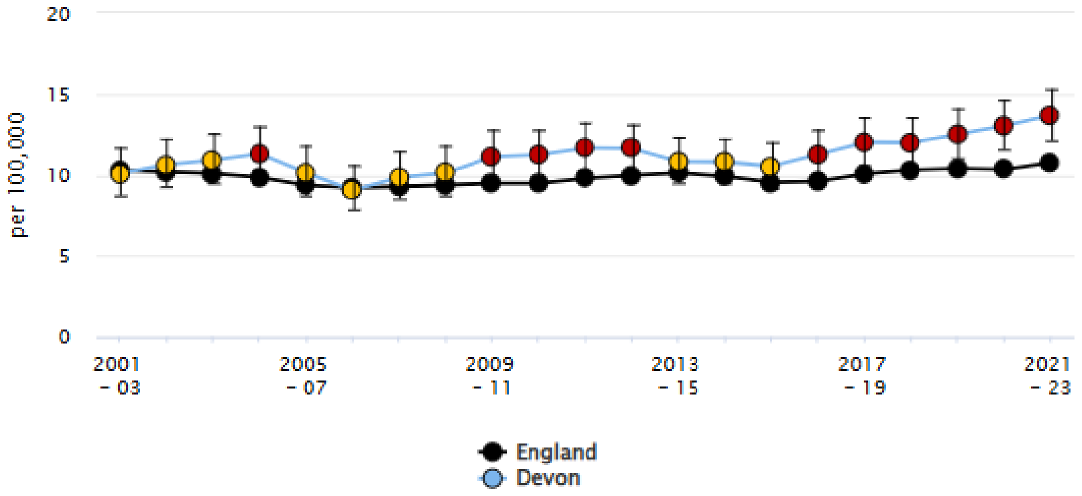
Suicide Count and Rate for Devon CC area by gender and age group for period 2021-23 (Counts and Directly Standardised Rate per 100,000)



Indicator	Period	Devon			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Overall suicide rate for population aged 10 years and older (3 years pooled)								
Suicide rate (Persons) New data	2021 - 23	–	-	13.7	10.7	19.6	●	4.2
Suicide rate (Male) New data	2021 - 23	–	-	20.4	16.4	30.9	●	6.7
Suicide rate (Female) New data	2021 - 23	–	-	7.3	5.4	12.6	●	2.1
Suicide rate for population aged 10 to 24 years (5 years pooled)								
Age-standardised rate for suicide by age and sex (Persons, 10-24 yrs) New data	2019 - 23	–	56	8.6	5.4	-	*Insufficient number of values for a spine chart*	-
Suicide rate for population aged 25 to 44 years (5 years pooled)								
Age-standardised rate for suicide by age and sex (Persons, 25-44 yrs) New data	2019 - 23	–	129	15.1	12.6	31.2	●	4.3
Age-standardised rate for suicide by age and sex (Male, 25-44 yrs) New data	2019 - 23	–	99	23.5	19.6	52.2	●	5.1
Age-standardised rate for suicide by age and sex (Female, 25-44 yrs) New data	2019 - 23	–	30	6.9	6.1	-	*Insufficient number of values for a spine chart*	-
Suicide rate for population aged 45 to 64 years (5 years pooled)								
Age-standardised rate for suicide by age and sex (Persons, 45-64 yrs) New data	2019 - 23	–	174	16.2	13.6	24.8	●	5.2
Age-standardised rate for suicide by age and sex (Male, 45-64 yrs) New data	2019 - 23	–	132	25.5	20.8	38.9	●	7.3
Age-standardised rate for suicide by age and sex (Female, 45-64 yrs) New data	2019 - 23	–	42	7.5	6.7	-	*Insufficient number of values for a spine chart*	-
Suicide rate for population aged 65 years and older (5 years pooled)								
Age-standardised rate for suicide by age and sex (Persons, 65+ yrs) New data	2019 - 23	–	102	9.6	8.2	15.0	●	3.6
Age-standardised rate for suicide by age and sex (Male, 65+ yrs) New data	2019 - 23	–	66	13.8	13.1	-	*Insufficient number of values for a spine chart*	-
Age-standardised rate for suicide by age and sex (Female, 65+ yrs) New data	2019 - 23	–	36	6.2	4.1	-	*Insufficient number of values for a spine chart*	-
Years of life lost to suicide for population aged 15 to 74 years (3 years pooled)								
Years of life lost due to suicide (Persons, 15-74 yrs)	2020 - 22	–	244	44.5	34.1	75.9	●	14.2
Years of life lost due to suicide (Male, 15-74 yrs)	2020 - 22	–	183	67.8	51.5	127.0	●	16.4
Years of life lost due to suicide (Female, 15-74 yrs)	2020 - 22	–	61	21.5	17.2	43.4	●	6.7

(Source: Fingertips (OHID, 2025))

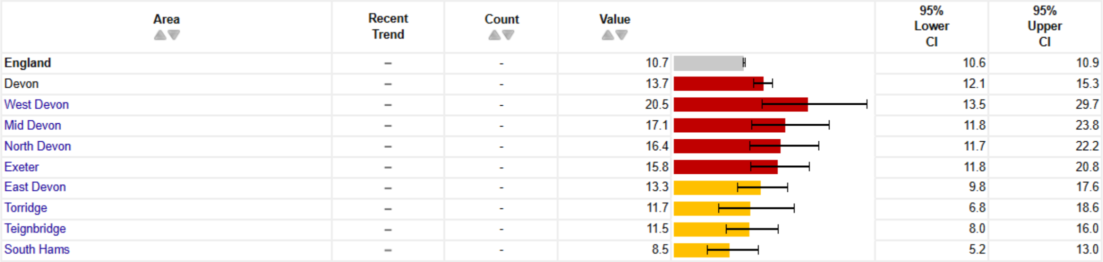
Trend in suicide rate for all persons for Devon LA area and England for period 2021-23 (Directly Standardised Rate per 100,000)



(Source: Fingertips (OHID, 2025))

For Devon LA area, the overall suicide rate and both the male- and female- specific suicide rates are both significantly worse than the England position.

Suicide Rate for all persons - Devon District Areas for period 2021-23 (Directly Standardised Rate per 100,000)



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	10.7	10.6	10.9
Devon	–	-	13.7	12.1	15.3
West Devon	–	-	20.5	13.5	29.7
Mid Devon	–	-	17.1	11.8	23.8
North Devon	–	-	16.4	11.7	22.2
Exeter	–	-	15.8	11.8	20.8
East Devon	–	-	13.3	9.8	17.6
Torridge	–	-	11.7	6.8	18.6
Teignbridge	–	-	11.5	8.0	16.0
South Hams	–	-	8.5	5.2	13.0

(Source: (OHID, 2025)

At the district level, West Devon, Mid Devon, North Devon and Exeter had suicide rates (all persons) that are significantly worse than England.

Self Harm related admissions for Devon (Counts and Directly Standardised Rate per 100,000)

Hospital admissions as a result of self-harm (10 to 24 years) New data	2023/24	↓	625	448.1	266.6	784.9	65.5
Emergency Hospital Admissions for Intentional Self-Harm New data	2023/24	↓	1,255	159.0	117.0	342.5	36.1

(Source: (OHID, 2025))

The Devon LA area is at a significantly worse than England position in relation to available self-harm indicators.

Real Time Surveillance Systems (RTSS) (where they are in operation) enable a rapid collation of information for each unexpected or, in Police terminology, 'sudden self-inflicted deaths'. As a death by suicide is only confirmed following the Coroner process, RTSS data may include deaths that are subsequently identified as unintentional or of undetermined intent; this may include drug-related deaths and other avoidable circumstances.

The primary aim of RTS data is to enable the provision of rapid postvention support, an early indication of trends or new issues of concern, and the identification of potential clusters. It does provide a rich source of contextual, more granular data to inform the local suicide prevention planning response but there are significant caveats.

Devon's RTSS covers the Devon ICS geography and the real time data is sourced through a police-led process. Therefore, the data is reliant on what is collected by the police at the time of the initial report of the death, including what is known or recalled at the time by those close to the person who died. Additional contextual detail may be collected at that time or subsequently added to the record following the provision of postvention support to family and others (also delivered by the provider of the RTS, Pete's Dragons).

The process enables a range of demographic and other relevant factors to be gathered from an early stage in the process (these include employment status, links with domestic abuse, mental health service use).

A Coroner Suicide Audit process is undertaken by some Local Authorities (including Torbay and Plymouth) to review records of people who have died through suicide or undermined intent (UI) to identify important factors. Due to capacity, this process is not currently undertaken by Devon, and the availability of Coronial reports are subject to delays with the Inquest process. Therefore it is considered that the RTS data provides a more contextual and timelier overview for the ICS area as a whole, but with some important limitations as noted above.

Information that a person was known to mental health services may be disclosed to the RTSS, however this does not always include details of a diagnosis. The RTSS process currently does not proactively seek information on neurodivergence specifically. This information may be shared with Pete's Dragons if this is made known by those the police interact with (the police have the option to select neurodivergence as a factor on the system, should this be disclosed). As with other information reported to the RTSS, any additional data collected would remain limited by what was known by those close to the person who died (any undiagnosed or otherwise unrecognised conditions may not be reported, for example).

14 Evidence and good practice for suicide prevention interventions

The evidence base specifically on suicide prevention for autistic people and people with ADHD is limited. This also includes the evidence in relation to effective mental health care for autistic people with learning disabilities. These are particular concerns given the high level of detention of autistic people within mental health in-patients (Loizou et al., 2024).

There is recognition that the current conceptualisation and measurement of suicide and self-harm may not reflect the experience of autistic people. Specific evidence based support for autistic people has not been developed. This has been identified as an international priority for research (Rodgers et al., 2024).

Suicide safety planning is a recommended intervention in a range of settings. Suicide safety plans are a set of hierarchical steps to be followed to help people to stay safe during periods of crisis. They have been demonstrated as effective in reducing self-harm and suicidal behaviour amongst non-autistic people.

A pilot randomised control trial found that the use of safety plans adapted for autism was found to be feasible and acceptable in a sample of UK-based autistic adults recruited from the community and non-NHS (a formal diagnosis was required).
The original plan contained the following sections: '(1) warning signs; (2) internal coping strategies; (3) social contacts and locations; (4) family members or friends that may offer help; (5) professionals or agencies to help and (6) how to keep the environment safe'. This was adapted to reflect autistic thinking and communication (for example, adding "what is important to me" in place of "reasons for living"), and developed with a resource pack to assist with the identification of emotions and availability of support (Rodgers et al., 2024).

A full RCT will be required identify clinical effectiveness and in a larger sample, but this study began to address the evidence gap.

Where evidence on what works in mental healthcare more broadly exists, pathways and models adapted to the needs of autism were found to be acceptable, and importantly, feasible. These included improvements to communication, environmental adjustments, and staff awareness of autism (Loizou et al., 2024).

In the absence of a well understood position on suicide and neurodivergence, an international consultation exercise (UK, US and Netherlands) sought views from autistic people and support services to determine actions that should be taken now, and future research priorities. The key recommendations and findings are included here in full:

Removing barriers to mental health services is the most important issue that autistic people and those who support them have identified. We can help remove these barriers by:

1. Explicitly identifying autistic people and those with elevated autistic traits as high-risk groups in suicide prevention policy and clinical guidelines;
2. Developing research and clinical partnerships with autistic people and those who support them to ensure that future training, intervention and prevention strategies are appropriate;
3. Passing legislation requiring mental health services to provide autistic people, with or without intellectual disabilities, with services for a range of co-occurring conditions, including suicidality screening and prevention;
4. Improving systems of autism identification and diagnosis for older children, adolescents and adults, including appropriate post-diagnostic mental health assessment and treatment;
5. Developing guidelines to ensure that service providers recognize the high risk for suicide in autistic people and having the necessary knowledge and skills to provide appropriate treatment for them (e.g., more and longer therapy sessions, continuity of care, appropriate sensory environments, alternative formats for making emergency appointments that do not involve using a phone or meeting someone face to face);
6. Developing new ways of delivering accessible and personalized support and treatment; and
7. Developing accreditation to recognize mental health service providers who excel in the successful support of autistic people.

Autistic people and those who support them identified a number of issues and recommended numerous ways to improve their experiences of assessment and treatment:

1. Believe the autistic person who tells you that they feel suicidal, even if such information comes in a different or unexpected manner;
2. Listen to what the autistic person is saying;
3. Ask specific and clear questions. Autistic people can have difficulty identifying and describing their feelings, understanding metaphor or reading between the lines;
4. Give time for the autistic person to process what you are asking. Processing speed can vary widely among autistic people, particularly when in crisis;

5. Check that the autistic person has interpreted and responded to your questions in the way you expect. Autistic people can interpret assessment tools differently than intended;
6. Utilise freely available guidelines and tools to support autistic young people and adults and monitor and report on their mental health;
7. Provide support that is flexible, personalisable and tailored to meet an autistic person's unique needs;
8. Promote feelings of belonging, connectedness and self-worth, which could prevent suicidal thoughts and behaviours in autistic people. Social support is associated with reduced risk of suicidal thoughts in this population. Those who report feeling that they do not belong in the world or are a burden to others are more likely than others to feel suicidal. These are important warning signs.

Top 10 Community Priorities for research

In addition to implementing the stopgap measures above, think carefully about addressing the following community priorities over the long term. It is crucial that future policy, clinical practice and research:

1. Identify barriers that autistic people encounter when seeking help, which may increase their risk for suicide;
2. Identify the risk and protective factors for suicide in autism across the lifespan;
3. Examine the extent to which autistic people are not believed when reporting the severity of their distress;
4. Examine the development of suicidality that is not associated with other mental health symptoms across the lifespan;
5. Identify the best ways of assessing suicidal thoughts and behaviours in autistic people in clinical practice and research;
6. Identify how interventions could be adapted for autistic people and individual presentations;
7. Understand the experience of suicidality in autistic people, and determine if it is different from that of the general population;
8. Examine how autistic people seek help when they are in crisis;
9. Examine how well existing models for understanding suicide apply to autistic people; and
10. Study the impact of poor sleep on suicide risk in autistic people.

(Cassidy, et al., 2021)

There are some clear correlations between these findings and the evidence gathered by the HNA. These proposals provide clear steps to take from both a strategic planning perspective and within individual service provision and support the importance of wider efforts in communities to improve awareness and reduce barriers to participation.

Engagement with communities in Devon identified that the elevated suicide risk in autistic people was well known and a concern to local people. This was reflected in the discussion groups, and in comments made in the survey response. The Dimensions for Autism discussion group made the following recommendation:

- Crisis support: Improve crisis support services to ensure they are responsive and effective for autistic individuals.

Given the scale of the problem, it is important to act where possible, and the local Suicide Prevention Strategy provides a clear route to take these issues forward.

In 2025 it was agreed to adopt a Devon ICS-wide Suicide Prevention Strategy, taking advantage of the alignment of organisations that are addressing similar issues. The overarching Suicide Prevention Oversight Group already operates at an ICS-level, but the Suicide Prevention Implementation Group will continue on the geography of Devon County Council.

The 2024-27 DCC Suicide Prevention Strategy and Action Plan contains the following priority areas:

- improving data and evidence;
- tailored, targeted support for priority groups;
- addressing common population level risk factors;
- promoting online safety and responsible media content;
- providing effective crisis support;
- reducing access to means and methods of suicide;
- providing effective bereavement support ('postvention');
- making suicide prevention everybody's business.

Specific priority groups are:

- children and young people;
- all aged men – particular focus on middle-aged men;
- people who have self-harmed;
- people in contact with mental health services;
- people in contact with the justice system;
- autistic and neurodiverse people;
- pregnant women and new mothers;
- people who are unemployed;
- inclusion health groups – particularly homeless and vulnerably housed.

Specific priority population level risk factors are:

- physical illness;
- financial difficulty and economic adversity;
- harmful gambling;
- substance misuse;
- domestic abuse;
- social isolation and loneliness;
- bereavement;
- relationship breakdown.

The associated Action Plan includes the following:

Action	Outcome / measure	Target date	Leads and partners	Comments
3l. Autistic and neurodiverse people - to explore local needs/insights to understand opportunities for suicide prevention	Improved understanding of suicide prevention & collaboration opportunities. Specific work programmes & activities identified and implemented as appropriate	March 2025	Public Health Devon Other relevant stakeholders	New actions and activities to be identified in future refreshed action plan based on needs identified in 2024-25

There was a clear ask from people with lived experience of neurodivergence to be involved in the development of future planning and suicide prevention initiatives.

<u>Observations on suicide risk and prevention</u>

a) There are clear associations in the evidence base between suicide, autism, and ADHD. It is not possible to clearly identify the prevalence of autism or ADHD in local suicide incidence data; however it is a reasonable estimation to consider the application of the evidence base to the local situation.

b) In the wider evidence base, there are similar risk factors for suicide in autistic people compared to the wider population, but with potential added risks due to feelings of poor levels of belonging, and masking of autistic traits. The reasons behind the apparent additional level of risk need to be much better understood in the evidence base as whole; however, in the intervening period, there is a compelling case to take action where possible, and opportunities to do this within local structures, for example, ensuring all relevant services (including secondary care) are clearly informed of the enhanced suicide risk in autistic adults, and using the Devon Suicide Prevention Strategy to co-ordinate approaches.

c) The increased suicide risk is well known and a concern to local people with lived experience, in particular autistic people. There is a desire to be involved in the development of any local interventions.

d) Suicide prevention evidence is limited on specific interventions but there is some evidence that adaptations to suicide safety plans (for example) can be acceptable for autistic adults. There is an opportunity to raise awareness of the associations between neurodivergence and suicide and self-harm in training programmes.

e) Local knowledge on autism and ADHD and suicidality is primarily dependent on data collected by the Real Time Surveillance System around the time of death and dependent on level of knowledge in those involved (i.e. it is not specifically asked for). This represents an opportunity for improved data collection (whilst recognising the sensitivities of the RTSS process).

f) There is an opportunity to integrate learning from the local LeDeR programme and related processes. This is particularly true in the context of limited data elsewhere. There has been relatively little promotion of the incorporation of autistic people without learning disabilities within the LeDeR criteria, and this should be re-stated amongst local partners to maximise the opportunities for learning and prevention.

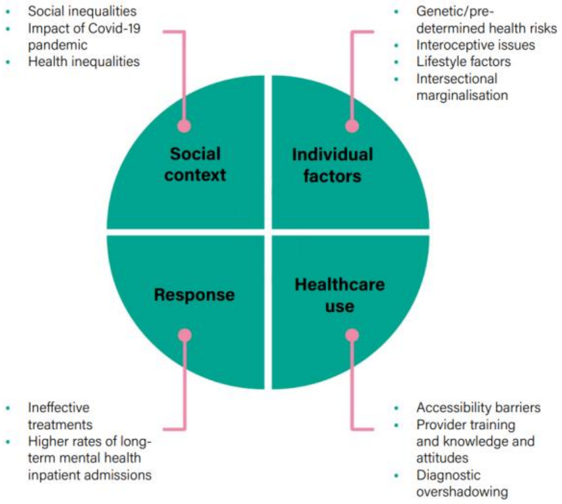
15 Estimating and understanding the neurodivergent population's social, emotional and mental wellbeing needs

Understanding the needs of the local population

It is well evidenced that autistic adults and people with ADHD experience range of social wellbeing challenges.

As outlined above, there is clear correlation with a range of physical and mental health needs that will undoubtedly intersect with social needs and wellbeing. The combination of factors contributing to poorer physical and mental health in autistic people can be summarised as:

A complex combination of factors contributes to poorer physical and mental health in autistic people



(Source : (Autistica, 2023))

People with ADHD are at increased risk for lower quality of life, educational underachievement, unemployment, and difficulties socializing (Faraone et al., 2021). French et al, identified difficulties in intimate relationships, and in parenting (French B. et al., 2024).

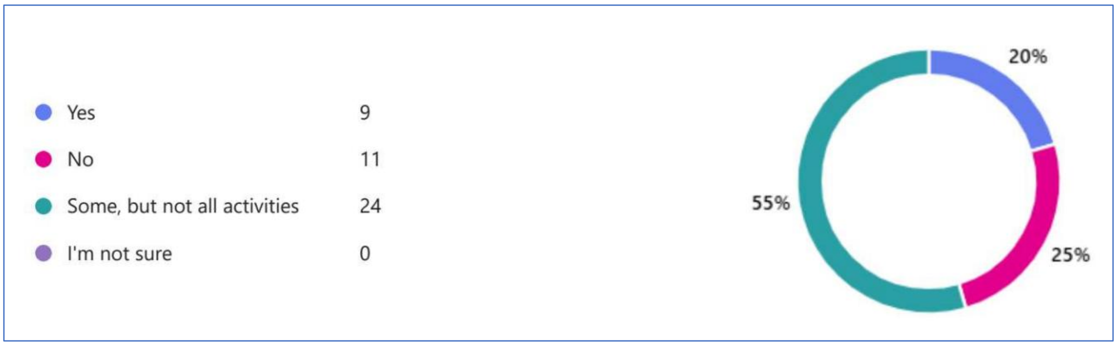
A study based on the Avon Longitudinal Study of Parents and Children (ALSPAC) Cohort found that young people with persistent ADHD (as opposed to child-remitted ADHD) were associated with increased likelihood of not being in education, employment or training (OR=3.71, 95% CI=2.06 to 6.67), and being in receipt of state benefits (OR=2.72, 95% CI=1.62 to 4.57) compared to those without ADHD. These outcomes were identified across income and sex, and were not explicable through co-existing conditions (Riglin et al., 2023).

These impacts can be both related to job stability but also job quality. It is important to recognise these factors affect outcomes across the life course, including where ADHD symptoms lessened in adulthood (French et al., 2024).

Engagement to support this HNA specifically sought views on local people's experiences of living in Devon, interaction with local universal and community services, and what support had been provided.

Awareness and support in the local community

PWLE Survey Response: Do you feel that you can take part in the things that are important to you within the community? This could include shopping, travelling, taking part in sports and other leisure activities.



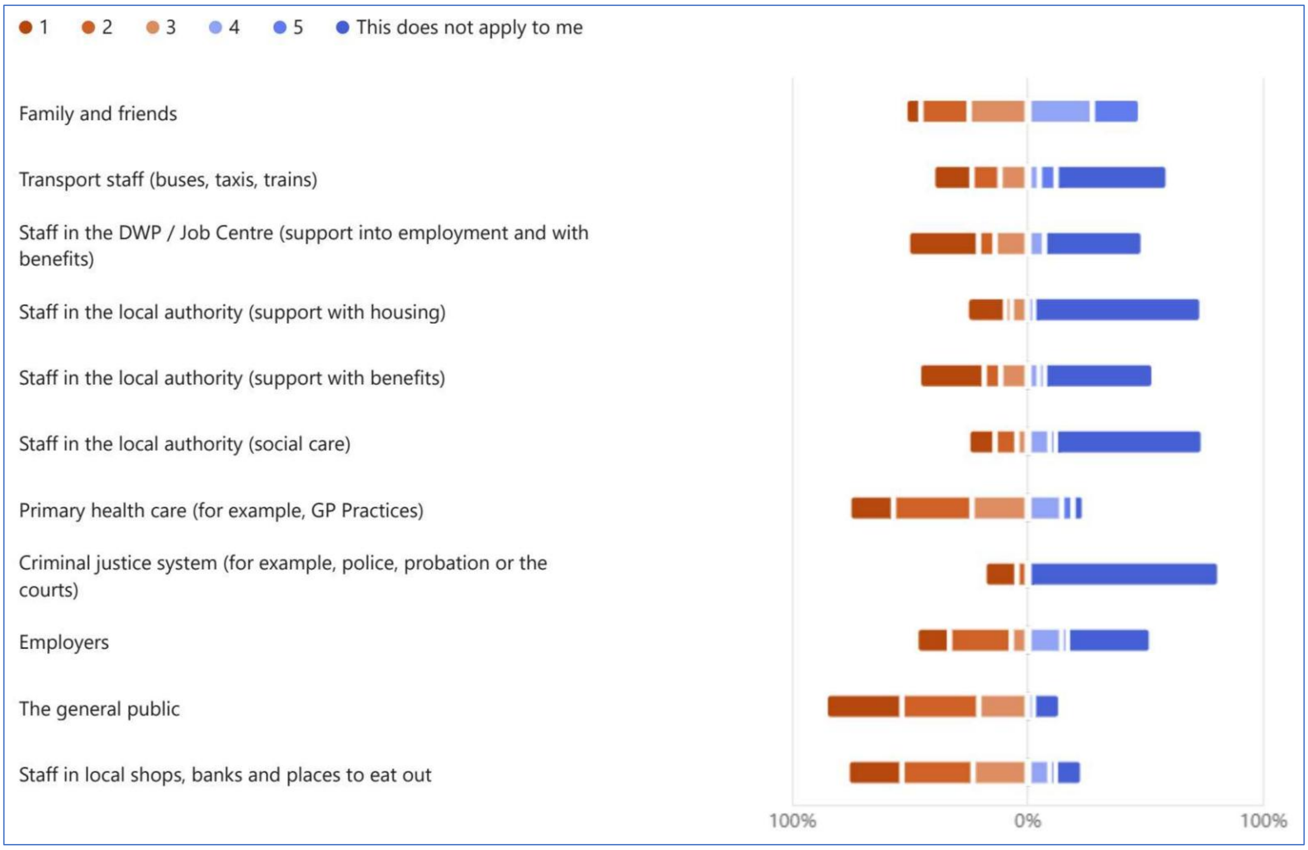
Comments were made on the following themes from autistic people:

- mental health needs or sensory needs (due to busy or chaotic environments) were a barrier;
- having assistance or some level of support to attend would be helpful;
- there are limited social activities available.

People with autism and/or ADHD highlighted the following in addition to the above:

- the personal impact of experiencing challenges with social participation (in some cases this included the impact of having a strong sense of justice and the challenge of witnessing perceived unfairness and law breaking in society and local communities);
- public transport availability was a barrier for some.

PWLE Survey Response: How would you rate the understanding of neurodivergence in the following groups and services?



Themes identified within the comments included:

- lack of understanding, or taking issues seriously (including within health and local authority services);
- lack of consideration or helpfulness (for example, GP systems being hard to use);
- some examples of helpfulness and kindness were shared (including health care, safeguarding, and hospitality).

In discussion groups, the key themes included lack of understanding, and communication barriers that can be addressed through recognising communication preferences.

People involved across the engagement process were asked what supported or negatively impacted their mental health and wellbeing:

Dimensions for Autism discussion group feedback

- Challenges in social interactions: Autistic individuals often face difficulties in social communication, which can lead to misunderstandings and social rejection.
- Masking: The effort to mask autistic traits to fit in socially can be exhausting and lead to a sense of disconnection from one's true self.
- Avoidance of social situations: Sensory sensitivities can make social

environments overwhelming, leading individuals to avoid social interactions and public places.

- Lack of understanding and support from Public Services: A lack of understanding and appropriate support from public services, including healthcare and mental health services, can leave autistic individuals feeling unsupported and isolated.
- Employment and Education: Barriers to accessing employment and education can limit social opportunities and contribute to isolation.
- Anxiety and Depression: High levels of anxiety and depression, often exacerbated by negative social experiences and lack of support, can lead to withdrawal from social interactions.
- Access to Services: Geographical barriers and financial constraints can limit access to social and support services, increasing feelings of isolation.
- Support Networks: Being pressured to move away from support networks can have a significant negative impact on mental health and increase loneliness.

It was felt important to develop:

- Peer support groups to enable mutual support
- Develop community based services that understand and cater for the needs of autistic adults

Supported by:

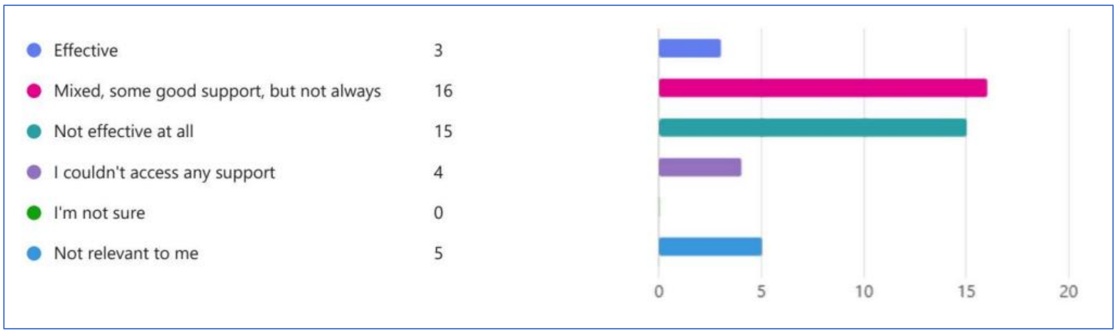
- holistic support hubs that provide a range of services, including social, mental health, and employment support, all in one place.
- a focus on prevention that address the root causes of isolation and loneliness, rather than just responding to crises

In the survey responses, across all respondents, 'what matters and works' for people can be summarised as:

Stable routine, Flexible working hours
Safe spaces to reset
Having someone to confide in, Being understood and accepted,
Carers and Family
Mental Health specific support (including counselling and therapy)
Organisational Support
Self-compassion and awareness
Staying active, nature, animals, hobbies
Nature
Online workshops, courses and training
Health care straight after diagnosis
Independent living support, Housing
Medication

Where survey respondents required care for mental health needs, experiences were mixed:

PWLE Survey: If you have experienced mental health problems, how effective were health care professionals at supporting you to manage these or get better?



Within the detail of the responses, some examples of really positive experiences of care were shared, but more generally there were other concerns about the capacity of services, variable experiences of care (e.g. Talkworks), and levels of staff understanding.

A common concern in discussion groups was the need to ensure Mental Health services had a greater appreciation of the support needs of neurodivergent people and how these should be met including through Crisis support. Some members of the DFA discussion group proposed more tailored mental health services, and a recommendation to develop specialist mental health approaches for autistic people.

Although related to secondary care, it should be noted that experiences of mental health inpatient wards were described as being very challenging from a sensory perspective. They also posed a risk to a person of becoming institutionalised and leading to additional causes of trauma.

Within available local service-based data, an assessment of associated needs can begin to be made as follows.

Adult Care Needs

The adult social care assessment evaluates an individual's ability to live independently and focuses on various aspects of daily functional living. To be eligible for services from any local authority, an individual must meet at least two of the defined outcomes.

Adult social care records include an autism flag which is added to records when autism is recorded as a person's main or secondary 'health condition'. Adding the autism flag does not require a diagnosis. ADHD is not able to be selected in the same way in the current system.

A deep dive of current social care clients with the autism flag was undertaken in November 2024. Data was arranged by provision of support, Primary Support Reason and Main Health Condition.

Clients with Autism Flag	**<18**	**18-25**	**26-64**	**65+**	**Total**
Currently supported by Autism and ADHD Team		152	203	<5	<360
Not currently supported by Autism Team	<5	223	733	83	<1050

Total	<5	375	936	<90	<1405

Primary Support Reason	**<18**	**18-25**	**26-64**	**65+**	**Total**
Learning Disability Support	<5	167	632	55	<860
Mental Health support		48	130	10	188
Physical Support / Access & Mobility		6	20	5	31
Physical Support /Personal care support		8	19	8	35
Sensory Support / Support for dual impairment		<5	<5		<10
Sensory Support / Support for hearing impairment		<5	<5		<10
Sensory Support / Support for visual impairment		<5	<5		<10
Social Support / Social Isolation Support / Other		128	111	<5	<250
Social Support / Substance misuse support			<5		<5
Social Support / Support to carer		<5	<5		<10
Support with Memory and Cognition		8	9	6	23
(blank)			<5		<5
Total	<5	375	936	<90	<1405

Main Health Condition	**<18**	**18-25**	**26-64**	**65+**	**Total**
Acquired physical injury			<5		<5
Asperger's or High Functioning Autism		53	155	9	217
Autism	<5	197	211	14	<430
Cardiac condition				<5	<5
Cerebral Palsy			6		6
COPD or respiratory condition			<5		<5
Dementia (inc. Alzheimer's)			<5	<5	5
Depression and/or anxiety		<5	<5		<5
Diabetes			<5		<5
Epilepsy		<5	5		<10
Head injury (inc. Acquired brain injury)		<5	<5	<5	<20
Hearing impairment		<5	<5		<5
Learning disability		82	471	45	598
Multiple Sclerosis			<5		<5
Other learning, developmental/intellectual disability		13	24	<5	<40
Other mental health condition		<5	10	5	<20
Other neurological condition		9	19		28
Other physical impairment, illness or injury		<5	7	<5	15
Other sensory impairment including DUAL			<5		<5
Severe mental illness		<5	<5		5
Stroke				<5	<5
Substance misuse			<5		<5
Visual impairment		<5	<5		7
(blank)			5		5
Total	<5	375	936	<90	<1405

Service Type	**<18**	**18-25**	**26-64**	**65+**	**Total**
Community	<5	355	771	53	<1200
Nursing			5	<5	<10
Residential		20	160	30	210
Total	<5	375	936	<90	<1405

Of note is the number of people requiring social support or mental health support as the primary support reason (in the group that does not have learning disability as their Primary Support Reason).

A real strength of the Devon system is the dedicated Autism and ADHD Adult Social Care Team. A diagnosis of autism or ADHD is expected to be able to receive support from the Autism and ADHD Health and Social Care Team. However, the majority of social care clients with an autism flag (and not all of the people with autism as their Main Health Condition) are not open to the Autism and ADHD Team, and this reflects the heterogeneity of need in this client group with care provided across adult social teams.

Of the <360 clients supported by the Autism and ADHD Team, 27 did not have a main or secondary health condition of Autism or Asperger's or High Functioning Autism recorded. Therefore it is a relatively small proportion of the team's caseload that provides support due to ADHD alone.

In consultation, adult social care colleagues have highlighted key themes as follows:

- The overall perception is of not enough housing provision and lower end services in supported living is needed. Together with a lack of understanding of those who may have both autism and mental health needs.

- It is felt important to note that many autistic people in contact with social care can manage self-care if other needs are addressed.

- Some of the most complex groups for adult social care include two distinct groups of people including younger autistic female individuals at risk of self-harm, and autistic males with probable mental health needs but with challenging behaviour towards property or other people. These behaviours may fall within the spectrum of toxic masculinity once a formal mental health diagnosis is made, often including overlap with complex emotional needs or other mental health concerns.

- Where people have autism, whether diagnosed or undiagnosed, Adult Social Care have identified difficulty obtaining the right level of mental health input through mental health services whether those be in Devon or Plymouth, and perceive that often all behaviours are associated with autism and there seems to be a lack of recognition that some of the behaviours might be attributed to other mental health disorders including complex emotional needs for example.

- Adult social care eligibility criteria generally does not pertain to public protection, except in specific circumstances, and often, individuals in this group do not meet the eligibility criteria for adult social care. However the resulting issue is that Adult Social Care is often required to support these groups as there is limited involvement from other services, and these individuals present with extremely complex needs which need a more holistic approach to manage and support.

- Adult Safeguarding Review of 'Hermione' demonstrates some related findings and recommendations. These included the need for reasonable adjustments, detailed support plans for people with learning disabilities and/or autism with challenging behaviours when transferring between agencies, together with better understanding of legal frameworks and management plans.

Safeguarding Adults Review (SAR) Hermione

The Torbay and Devon Safeguarding Adults Board commissioned a SAR for "Hermione". Hermione was from Devon and experienced serious harm in circumstances where agencies could have worked together more effectively to prevent this.

Hermione has a love of the outdoors, undertakes voluntary work, and has been working to improve services for young people with autism. She was 21 in early 2021.

Hermione has diagnoses of autism, Tourette's Syndrome, Post Traumatic Stress Disorder (PTSD), and ADHD. The autism and ADHD diagnoses were provided at the age of 14 which means she struggled for a significant period of time at school without specific support tools.

As a young person and young adult, Hermione attended residential colleges for autistic young people in Somerset and Dorset, and was also placed in a Devon hotel with a support package. During this period, Hermione experienced self-harm and suicide ideation and attempts. She received care in a children's psychiatric units (Devon), CAMHS paediatric intensive care unit (Berkshire), emergency and acute healthcare after leaving the hotel and travelling to Wiltshire, and in a Dorset psychiatric unit. After care in a high dependency rehabilitation unit she was diagnosed with Emotionally Unstable Personality Traits and her mental health had stabilised after lengthy treatment.

The SAR focussed on a range of issues whether the support during transition to adult services was appropriate, including the coordination of care for people who are neurodivergent.

The review made recommendations including the need to ensure reasonable adjustments are in place across health and care provision, and the development of a bespoke protocol for young people with neurodiversity and complex behavioural or mental health needs, to consider the range of potential health and social care support needs that may present. 19 recommendations were made in total.

(Source: https://www.devonsafeguardingadultspartnership.org.uk/document/sar-hermione/#mental-health-services-for-people-with-autism)

In response to the HNA engagement, it was also recognised by NHS secondary mental health care that there is a cohort of autistic individuals often with a history of trauma and complex needs that fall between the gap in support between primary and secondary mental health services.

This is indicative of gaps between primary and secondary health and care provision and demonstrates the complexity of meeting needs in this group. Without a specific commissioned service, such needs may be currently addressed (but not fully met) through universal and community services.

There are also clear links to housing provision and this reinforces the perception that needs should be considered holistically. Colleagues in Adult Social Care noted the County Council’s responsibilities regarding housing are limited and typically relate to addressing needs through residential care. Many individuals have housing-related needs, which are usually addressed by District Councils, while social care provides support within the person's home.

Housing

As noted above, neurodivergent people may be at greater risk of being vulnerably housed and having poor experiences when receiving homelessness support.

Not all autistic people or people with ADHD will experience significant housing challenges, or require a specialist type of housing provision either on a short or long term basis.

However it is well recognised that Devon has specific housing challenges in terms of choice, affordability and as outlined above homelessness, particularly in (but not limited to) northern Devon and Exeter. Housing-related stress due to high costs and events such as evictions impact sections of the population as a whole, and autistic adults and people with ADHD are no less affected (Devon Housing Commission, 2024).

Engagement for this HNA has identified housing as an important concern for people with lived experience, although was not relevant to all which may reflect the number of people living with family members:

PWLE Survey Response: If you needed support to make decisions about your housing arrangements, how well were you supported?

The majority of the comments in the survey described individual housing situations (including support primarily from family), but a small number of comments highlighted that support in terms of guidance was limited.

Within discussion groups where this was raised, housing was an important issue:

Key themes from Dimensions for Autism discussion group

Eligibility and Support

- Eligibility criteria: Participants expressed concerns about the eligibility criteria for social housing. Many autistic individuals are unaware that their diagnosis may contribute to eligibility for social housing.
- Support in navigating the system: There is a significant need for support in navigating the housing system, including help with filling out forms and understanding the application process. Many participants mentioned the lack of practical support and the challenges they face due to executive functioning issues.

Sensory Issues

- Noise sensitivity: Many participants highlighted the importance of considering sensory issues, particularly noise sensitivity, when allocating housing. Living in noisy environments can exacerbate anxiety and other sensory issues, making it difficult for autistic individuals to feel safe and comfortable in their homes.
- Housing options: There is a need for housing options that accommodate sensory needs, such as single-occupancy housing or ground-floor flats. Participants mentioned that communal access and shared spaces can be problematic for those with sensory sensitivities.

Housing Allocation and Flexibility:

- Flexibility in housing offers: The current system often penalises individuals for refusing housing offers, even if the offered housing does not meet their sensory or other needs. Participants suggested that there should be more flexibility and understanding in the housing allocation process.
- Temporary accommodation: Concerns were raised about the suitability of temporary accommodation, especially when it is far from support networks. Being placed in unfamiliar areas can increase anxiety and isolation.

Communication and Advocacy

- Communication with Housing Authorities: Participants reported difficulties in communicating their needs to housing authorities. There is a need for better understanding and responsiveness from housing staff.
- Advocacy and support services: The importance of having access to advocacy and support services was emphasised. Many participants felt that they needed an advocate to help them navigate the housing system and ensure their needs were met.

Impact on Mental Health

- Stress and anxiety: The process of applying for and securing appropriate housing can be extremely stressful and anxiety-inducing for autistic individuals. The lack of suitable housing options and support exacerbates these issues.
- Isolation and safety: Inappropriate housing placements can lead to increased isolation and feelings of unsafety. Participants stressed the need for housing that allows them to feel secure and supported.

The DFA group recommended:

a) Tailored housing solutions: Ensure housing allocations take into account the specific needs of autistic individuals, including sensory and social requirements.
b) Support Workers: Provide housing support workers to assist with form filling and navigating the housing system.

The MHLDN Collaborative commissioned a report from HACT into planning and working arrangements for housing and related support needs (Understanding the opportunities of developing a more strategic approach to housing – a Discovery Report). The Collaborative includes NHS Devon Integrated Care Board, DPT and Livewell Southwest.

The driver was an identified need to better understand discharge pathways and housing challenges as they related to the core services delivered by MHLDN members. The project also recognised that supported housing and long term community living options can be different across people with complex Learning Disability and/or Autism (LDA) group, and people with complex mental health needs.

The focus was to support improved planning, integration and working around housing for people with serious mental illness, learning disability and autism. This was in the context of the national ambitions to reduce inpatient provision for people with a learning disability and autistic people (to less than half of the 2015 level) (HACT, 2024).

The purpose of quality supported housing can be summarised by: ‘providing a safe, stable and supportive place to live can be the key to unlocking better outcomes for vulnerable people, from tackling poverty and disadvantage to managing crises, rehabilitation or maintaining people’s independence’ (taken from the Supported Housing: National Statement of Expectations) (MHCLG, 2020).

Under the Supported Housing (Regulatory Oversight) Act 2023, local housing authorities are under a duty to produce supported housing strategies including the availability and future need for supported housing. Supported housing under the scope of the Act will also be required to be licensed. This will include supported living housing for people with a learning disability and/or autistic people; this could for example be a self-contained flat for a person who is autistic and requires support to live independently (MHCLG, 2025).

The focus of the HACT report was people being discharged from hospital, but the frameworks used in the production of the report were recognised to apply to community based provision.

The report was informed by workshops including representation from Devon CC, the ICB and mental health providers, and District Councils. It noted that for people being discharged from mental health, autism and learning disability inpatient care:

> *‘the process should involve all people with LDN/A and mental health needs* [being] *registered with Devon Home Choice; however front-line practitioners are not always aware of this expectation and therefore it does not happen in every case. Devon County Council has a local policy in place which states that all people with learning disability and or Autism should be registered on the relevant District Council Housing*

> *Register. District Councils have an obligation to register them, however, this does not always happen in every case. The view held by some practitioners, is that people with LDN/A needs will not be able to access the accommodation they require using this route.'*

People who are autistic but do not a learning disability, do not meet criteria for social care and have a mental health condition, have limited access to commissioned services upon discharge. There is a limited supply of suitable accommodation and this in turns leads to a lack of choice (HACT, 2024).

The report found that overall across the themes of the HACT review including mental health, the main challenges could be summarised by:

- system complexity and integration;
- inconsistent data;
- accommodation supply;
- appropriate placement identification and tenancy security.

Local Government Reorganisation provides an opportunity to address some of the identified issues including the challenges two-tier split between adult social care and multiple local housing authorities.

The recommendations from the HACT report are summarised in appendix 8. A key proposal was to develop an overarching mental health, learning disability and neurodiversity (autism) housing strategy and for this to be owned at system level.

Stakeholder feedback from housing colleagues indicated the way in which challenges with accessing diagnoses was having a direct impact on clients including where some people who could not access treatment and medication for ADHD appeared to be self-medicating with illicit amphetamines. This led to subsequent negative impacts including eviction from temporary accommodation leading to severely limited housing support.

The development of housing support plans in homelessness support can be overwhelming for some people, and as noted in section 10 support to those who are vulnerably housed in this group can be challenging.

The challenges with access to a range of suitable and affordable housing options was also raised by social care colleagues.

Employment and training

A key strand of the national autism strategy focusses on support into employment. Autistic people experience significant inequalities in this area. It is estimated that only 3 in 10 autistic people are in any employment (at least 1 hour of paid work per week); this compares to 5 in 10 for disabled people, and 8 in 10 for people who are not disabled (Buckland, 2024).

Autistic adults report poor experiences from the beginning of the employment process, including additional perceived pressures to mask and concerns about stigmatisation.

with a desire for greater flexibility and clarity in the recruitment process (Davies et al., 2023).

National surveys indicate that once in employment there is not a consistent application of support or adjustments for autistic people, and a reluctance to be open about autism (35% of autistic employees were fully open, 10% did not disclose to anyone at work). Of those who did disclose to their employer, only 4 out of 10 reported a positive impact.

Employer perceptions about barriers to hiring disabled people more broadly included the costs and practicalities of making workplace adjustments.

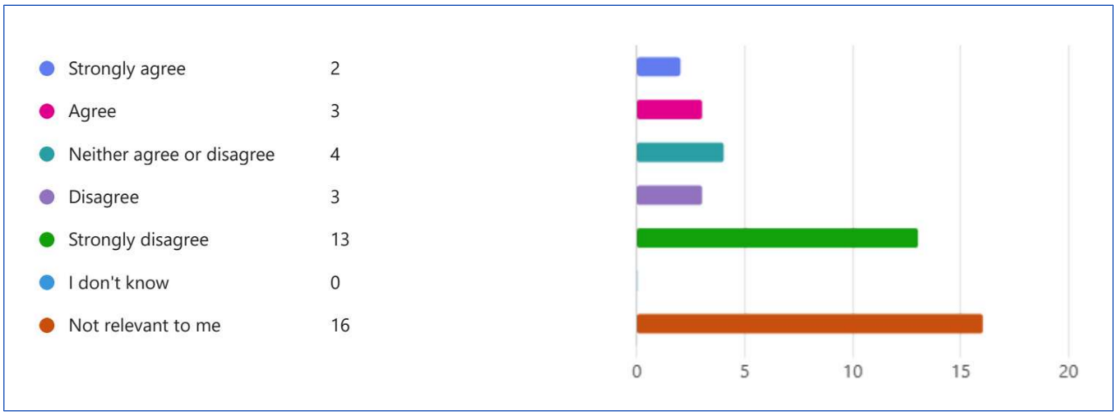
The Buckland Review recommendations are summarised as:

1. To create a national campaign aimed at employers with initiatives to raise awareness, reduce stigma and capitalise on productivity, including raising awareness of the benefits that employing autistic people have brought to the businesses,
2. To support autistic people to begin or return to a career by promoting employment support programmes and ensuring these are designed to meet the needs of autistic people.
3. To put in place recruitment practices that appropriately support autistic applicants, including training of careers advisors.
4. To support autistic people already in the workforce, ensuring the 2018 Neurodiversity at Work guidance, and autism 'design guides' are promoted
5. To encourage and support career progression, by promoting the value of support networks within larger organisations, and by developing packages of training focused on helping autistic staff to progress (Buckland, 2024).

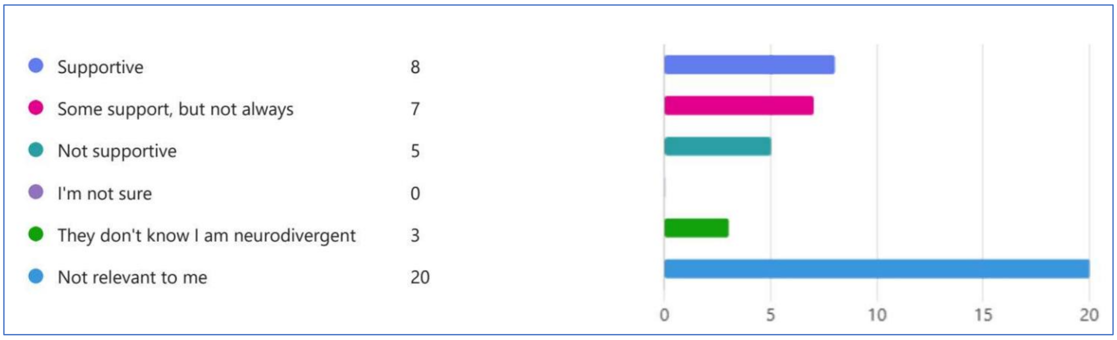
Autistica is developing a Neurodiversity Employers Index to support organisations to self-assess against best practice; the Buckland Review included reference to this in its recommendations (Autistica, 2025).

The HNA survey for people with lived experience included a focus on training and employment.

PWLE Survey Response: How much do you agree or disagree that you have been supported to get a job, training or further education?



PWLE Survey Response: If you have a job, how supportive have your employer and the people you work with been?



Within the detailed comments provided, the majority focussed on negative experiences across all respondents, including a lack of support and understanding – because of this some felt they did not feel able to disclose a neurodivergence.

A small number of comments reflected positive impacts because of staff networks and diversity initiatives in the workplace, or having other people with neurodivergence in a particular workplace.

Discussion groups highlighted concerns but also examples of good practice and positive outcomes:

- In one group, Talkworks, the DPT Together team, and the Workways offer were all highlighted as supportive services. Workways (nb. access is dependent on having a mental health need) had helped a participant explore reasonable adjustments in the workplace.
- It was highlighted that self-employment was an option for some people which enabled them to design their work around their own needs (however this still came with challenges).
- Challenges in the DFA group focussed on lack of understanding and in some cases bullying and discrimination. This led to autistic people often masking their characteristics.
- Access to Work scheme: the Access to Work scheme was mentioned as a valuable resource, but there were concerns about the lack of awareness and promotion of this scheme among employers and employees.
- It was felt that reasonable adjustments could very often be relatively simple to provide but were not consistently implemented, in part due to lack of awareness.

The key recommendations made by the DFA groups focussed on:

a) Reasonable adjustments in the workplace: Promote the implementation of reasonable adjustments in the workplace and provide ongoing support to autistic employees.
b) Disability Employment Advisors: Increase the visibility and availability of disability employment advisors in job centres.

Stakeholders recognise the need for reasonable adjustments but highlight variation in the definition of 'reasonable' and the potential gap between what an employer considers reasonable adjustments and what an employee finds reasonable for their needs.

Welfare

Some level of assessment can be made of the provision of welfare support to the local population.

The Universal Credit data system is more suited for benefit payments than data extraction. Postcode level claimant data is available, but it cannot identify other demographics or health conditions, and so this is not available at the local level.

Personal Independence Payment (PIP - which is non-means tested and paid whether a person is able to, or is in, work) is intended to meet the additional costs arising from long term disability and health conditions. PIP assessments are based on a person's ability to reliably undertake a) Daily Living and b) Mobility tasks, with a payment made for each element if eligible (gov.uk, 2025).

Importantly, eligibility for PIP 'passports' people to other benefits and supports (and so gain or loss of PIP may lead to additional impacts). Claimant data is available by type of disability (nb. PIP assessments do not require a diagnosis and should be based against the ability to maintain independent living). As can be seen, persons with Autism or ADHD represent a significant proportion of the total Devon PIP claimants, particularly in the younger age groups, and with respect to autism.

PIP Claimants from 2019 as of January 2025, total Devon Districts, with stated disability

	Total PIP Claimants	Autism (including Aspergers)	% of total claimants per age group	ADHD	% of total claimants per age group
16-19	2768	1393	50%	237	9%
20-24	2662	901	34%	184	7%
25-29	2557	496	19%	124	5%
30-34	2705	282	10%	119	4%
35-39	2919	165	6%	83	3%
40-44	2916	93	3%	27	1%
45-49	3065	57	2%	27	1%
50-54	4032	58	1%	21	1%
55-59	5167	46	1%	17	0%
60-64	5770	32	1%		0%
65-69	4678	23	0%		0%
70-74	2422	6	0%		0%
75-79	771				
Total	42436	3548	8.3%	855	2%

(Totals may not sum due to statistical disclosure controls)

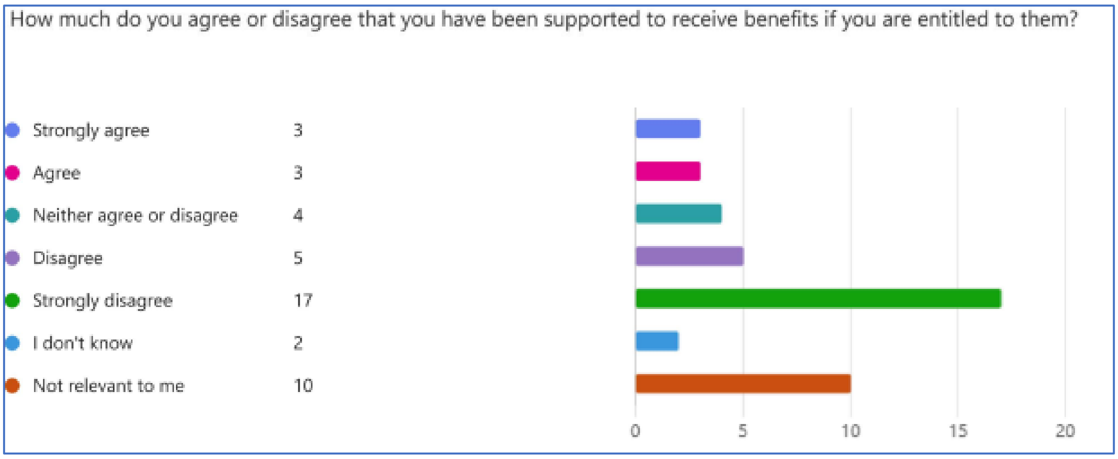
(DWP, 2025)

At the national level, as of January 2024, 56% of autistic claimants were receiving the highest level of award (the enhanced rates of the Daily Living and Mobility component).

Between April 2013 and January 2024, 49% of people with autism as their main condition were awarded PIP compared to 44% for all conditions (Parliament, 2024) .

Engagement feedback that people with lived experience had generally poor experiences of navigating the current benefit system.

PWLE Survey Response: How much do you agree or disagree that you have been supported to receive benefits if you are entitled to them?



Comments highlighted the stressful nature of PIP assessments, and a lack of help and support to navigate the system.

Positive experiences focussed on individual examples of help from family, care teams, and employers.

During the development of the HNA, significant Government policy changes were announced regarding the welfare system across Universal Credit including the health element, and PIP. In summary, this included:

- Removing the Work Capability Assessment;
- Introducing the ‘right to try’ work for people with health and disability benefits without an automatic re-assessment of benefit eligibility;
- Reducing the differential between health element of Universal Credit and the standard allowance (with the Conditionality requirements [eg. work related activity] for those remaining on the health element to be determined);
- Eligibility for the health element of Universal Credit will be aligned with eligibility for the Daily Living component of PIP;
- Reducing eligibility for PIP. This is a points based assessment and in the Daily Living component, applicants will need to score a minimum of 4 points in at least one daily living activity to be eligible;
- Increasing numbers of face to face assessments, including for PIP, but with a maintenance of alternatives under reasonable adjustments;
- Development of a Pathways to Work offer. This needs further design but includes a focus on early ‘support conversation’ to understand how those with a health condition or disability can be supported to reach their goals. This will in future include signposting to new support options in the Pathways, linking to new existing provision such as Connect to Work and Individual Placement and Support;

- Supporting actions including how health and care support can be provided to those who would lose eligibility to PIP.

Some elements of the Green Paper were open for consultation at the time of the HNA (including the provision of support to those who would lose PIP). Changes to PIP eligibility were intended for roll out from 2026-27 (DWP, 2025).

The Green Paper does not specifically mention neurodivergence aside from the following extract relating to its rationale for the changes to PIP:

> *'The PIP assessment needs modernising. It is over a decade since PIP was introduced, during which time there have been significant shifts in the nature of long-term conditions and disability, as well as changes in wider society and the workplace. People reporting mental health or neurodiverse conditions as their primary condition have increased more rapidly than those reporting other conditions, and increases in disability have been more marked among younger adults than older people, although older working-age people are still more likely to be disabled.'* (DWP, 2025)

The associated Equality Impact Assessment does not specifically identify neurodivergence in the totality of groups that may be affected (DWP, 2025). Within the Health and Disability Reforms Impact Statement published with the Spring Statement, it does however state:

'The most significant estimated impacts (in 2029/30) come from:
a) changes to PIP entitlement rules where we expect 370,000 current recipients to lose entitlement (when they have an award review) and 430,000 future PIP recipients who do not get the PIP they would otherwise have been entitled.
The average loss is £4,500 per year.

[…]

A further 150,000 people will not receive Carer's Allowance or the UC Carer Element as a result.' (DWP, 2025)

The impact of the reforms remains to be seen at the time of publication of the HNA. The Resolution Foundation noted the high proportion of autistic clients receiving enhanced PIP eligibility and noted that this reduces the probability of being amongst the most impacted by the reforms (and to a lesser extent people with ADHD).

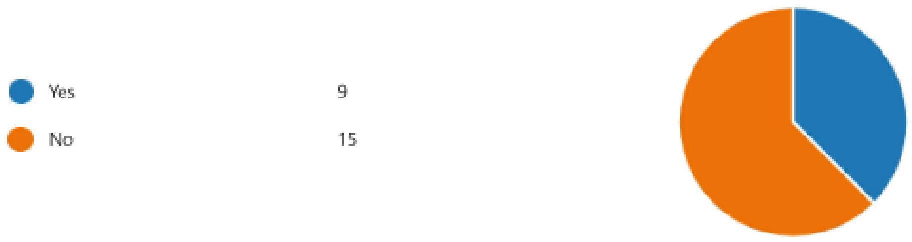
People receiving a score of 21 or more under the Daily Living element of the assessment are very unlikely to have not 'scored' 4 or more points in one of the sections. 34% of PIP claimants who were autistic (as their primary health condition) received a score of 21 points. This was only exceeded by people with cerebral palsy or similar (44%) and people with learning disabilities (71%). 15% of people with ADHD as their main health condition received 21 or more points in their assessment (all based on January 2024) (Resolution Foundation, 2025).

This data also provides additional indication of the level of support needs (as met by PIP) in autistic people and to a lesser extent people with ADHD.

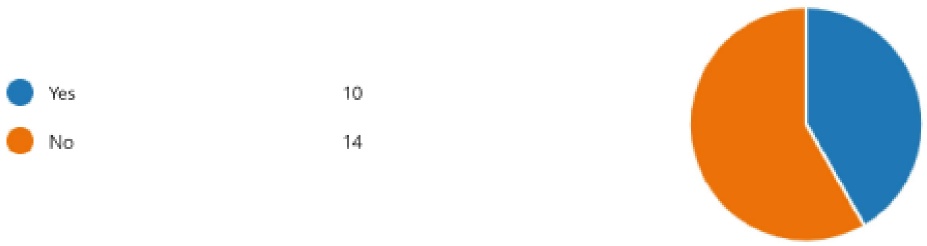
Service Developments in Stakeholder Survey Respondents

In stakeholder engagement, partners were asked to describe service developments to support autistic adults and those with ADHD. The overall conclusion was that services were making progress in this area (some for the first time) but would welcome additional support, and others were well established at meeting neurodivergent needs (mainly due to being specialist services).

Has your service area / organisation recently reviewed your provision for people with Autism or ADHD?



Has your service area / organisation recently provided dedicated training and support for staff in relation to provision for people with Autism or ADHD?



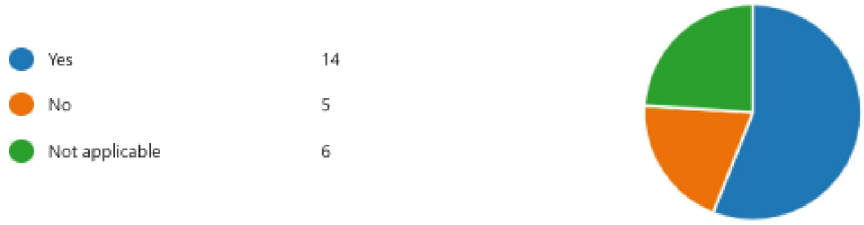
Training undertaken locally has ranged from mandated Oliver McGowan Training in health and care sector, training by the National Autistic Society, and provision of advice from specialist services to other internal and external teams.

An example of good practice from a VCSE provider:

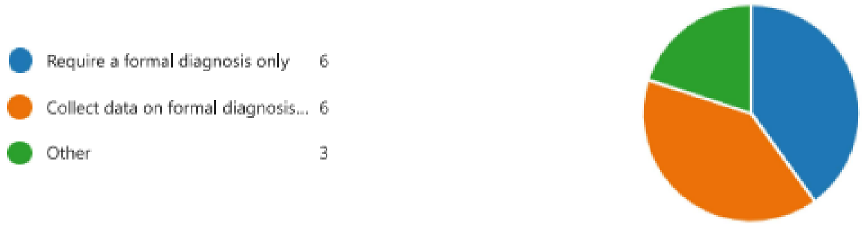
> ‘*Our service is aimed at autistic/ADHD/AuDHD individuals so everything about it is adapted to be accessible and inclusive: ensuring we communicate that we support those who self-identify and experience certain needs even if there's uncertainty about what these relate to; inviting people to share how they'd prefer us to communicate with them (e.g. email/phone/WhatsApp); sending visual follow-up records after each coaching session to support working memory and information processing; working from a neuroaffirming model that validates individual experiences, presumes competence and promotes autonomy; offering options for in-person/remote meetings, in a setting that suits the client.’*

Data Collection

If you are a service provider do you routinely collect data on whether a person accessing your service is neurodivergent including autism or ADHD?



If yes, how do you define this data collection?



A number of challenges have been identified with data collection including local investment would be required to add to Government systems (Housing), suspected neurodivergence cannot be recorded on primary care records, GDPR and the intended purpose of any collected data. It is also recognised that there are a wide spectrum of experiences that data coding alone would not be able to fully capture, and additional data collection requirements may also add barriers to accessing support. Ultimately it is for an individual person to choose to share their own experiences.

16 Evidence and local priorities to inform interventions in / delivery or services in a way that promotes social, emotional and mental wellbeing needs

As part of the engagement process, both people with lived experience and stakeholders were asked to identify the key priorities they wished to see in Devon. These are summarised as follows:

Priorities for people with lived experience	Priorities for stakeholders
Comprehensive training for all public service staff on both autism and ADHD	A cultural shift amongst employers to recognise the talents, needs and value of all staff

Reasonable adjustments should be consistently applied in the workplace and elsewhere	Whilst recognising there is finite funding and capacity issues with training, service providers should recognise reasonable adjustment may be relatively straightforward but have substantial impact
Recognise that sometimes professional advocacy and/or or low-level support can be required and impactful. Consider the development of a 'central hub' to co-ordinate this advice provision	Ensure the voice of people with lived experience is included in assessment reports
Include neurodivergence flags on medical records	Services should adopt a curious approach that may identify significant unmet needs
Support pre- and post- diagnosis	Introduce specialist workers or enhanced level of training in universal and community services
Recognise the variety of abilities within people with autism and ADHD	Respect differences and normalise interactions
Involve people with lived experience in the design of services	Develop social care and enabling support for independent living, including stimulating independent sector provision
Access to transport, especially in rural areas	Avoid gatekeeping in voluntary and primary care support services where possible (ie. avoid a diagnosis being required for access)
Support to community organisations to enable stability of provision	Provision of clear advice on what an individual needs to stay well in the community
Consistent use of autism ID cards and health passports	

Common priorities for both groups
Development of neurodivergence-informed social, cultural and physical environments
Raise public and community awareness and understanding (an accreditation scheme similar to the Dementia Friendly scheme offers a potential way forward)
Recognise that autism and ADHD frequently co-occur with other physical and mental health conditions
Take a holistic, trauma-informed and curious approach to understanding and meeting needs, and explore how these needs can be met much earlier in people's lives
Employers should not require a diagnosis before discussing reasonable adjustments (this can ameliorate delays, e.g. with Access to Work applications)
Specialist training for mental health professionals to ensure support is provided and needs are not overshadowed by co-occurring autism or ADHD
Utilise and value the role of peer support, and peer support workers

Support the development of social and support groups across the population (e.g. younger adults, LGBTQI+) using a variety of venues and modes (nb. this should include dedicated provision but recognise that some people do not like to be 'labelled')
Safe, suitable and affordable housing options
A kinder and more compassionate society

To take forward these priorities will require action in several areas preferably in a co-ordinated manner. The sense that greater co-ordination was required was demonstrated in discussion groups during the engagement:

'Who is 'owning' neurodiversity across Devon?'

(PWLE discussion group participant]

And the DFA group made a recommendation regarding the [national] Autism Strategy:

> *Ensure the timely and effective implementation of the autism strategy, with clear accountability and regular progress updates.*

Training has been a consistent theme of the HNA process although some stakeholders felt that available training focussed on awareness and advocacy rather than the specifics of strategies that can be used. Appendix 9 includes examples of what is felt to be good practice and reasonable adjustments in operation across various organisations in Devon. Future training opportunities should include a focus on what can be practically done at the point of service provision (in addition to awareness).

There is both local and national guidance available to support local provider organisations. It is not the purpose of this document to list all of these here however attention is drawn to some key examples as follows.

These include:

- The Yellow Brick Road 2024 (DFA with support from Devon County Council) (accessible via https://www.dimensionsforautism.life/devon-autism-guide). This is comprehensive document sets out a range of advice on autism and the law, assessment, and available support services and groups. This includes accessing community services and when additional support is required, mental health and housing support (for example).

- ADHD Resources (Devon Partnership NHS Trust). These cover a range of topics including work and education (accessible via https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/adhd)

- Autistica has published a range of policy briefings. These focus on areas for additional research but also highlight what is currently known and what support does/does not work (accessible at https://www.autistica.org.uk/our-research/policy-recommendations-briefings)

- The Local Government Association has published a Must Know Guide for Autism. This is primarily aimed at elected Councillors but provides a useful overview of the key steps that can be taken including the development of an 'everybody's business approach' and adoption of supportive practices for employees (accessible at: https://www.local.gov.uk/publications/must-know-guide-autism#what-are-likely-to-be-the-key-challenges) (nb. Devon County Council has a comprehensive e-learning offer covering neurodiversity and specific types of neurodivergence, together with promotion of a Neurodiversity Staff Network)

- Existing support groups can be found (but not limited to) as follows:
  DFA Groups - https://www.dimensionsforautism.life/what-we-do
  National Autistic Society - https://www.autism.org.uk/what-we-do/branches
  North Devon Forum for Autistic Spectrum Conditions and ADHD - https://ndfautism.co.uk/

The Devon Autism Card is available free of charge to people living in Devon or Cornwall and who identify as autistic. This supports local people to inform others including public services of their needs and includes suggested steps to take:


Hello
I'm Autistic
Turn this card over to learn more about me

Your behaviour might seem confusing or threatening to me
Ask me before approaching or touching me
I may not be able to communicate clearly when I'm stressed
Give me extra time to respond to questions or instructions
You may need to help me find somewhere calm and/or quiet
To learn more, visit: www.dimensionsforautism.life
If I need help
Please contact:
Relationship to me:
Telephone No:

(Source: https://www.dimensionsforautism.life/autism-card)

The Autism awareness cards received positive feedback in the discussion groups; one example was shared whereby the cards were very helpful in interactions with the police.

> *'Have had to use that card very recently when accessing healthcare due to losing my speech function temporarily in the appointment. They are great for moments when communicating is hard/impossible.'*
>
> (PWLE discussion group participant]

The sunflower lanyard scheme is also well regarded by local people. However, members of the Experts by Experience discussion group were keen to stress that if there were higher levels of awareness there would be less need for Cards and Lanyards to be used, and for as long as they are necessary more could be done to raise awareness of them.

Within specific thematic areas the following areas of good practice and potential interventions are outlined below.

Accessing (non-specialist) health care

Within the engagement for the HNA, concerns were raised about variable experiences of accessing health care, including but not limited to primary care.

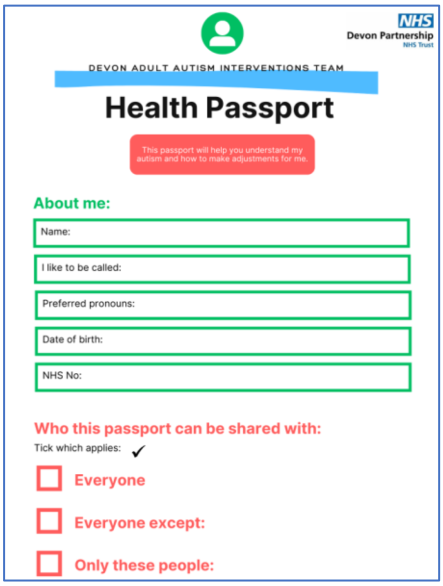
> "[I] *dread hospital environments* […] *Perhaps one day someone will put those virtual head goggles into hospitals for people like me so that I see a totally different environment whilst getting treated!"*
>
> [Participant from Devon Carers Peer Support Group]

A significant development within NHS services is the planned roll out of the Reasonable Adjustments Digital Flag (RADF) within patient record systems. The intention of this programme is that for all patients where a Reasonable Adjustment is required, this is clearly visible to health and care workers at the point of care (with the option of including details of a person's impairment and underlying conditions). The service is live but there is ongoing roll out of the RDAF across NHS organisations; there is a national deadline for full conformance by the end of December 2025 (NHS England, 2025).

Torbay and South Devon NHS Foundation Trust have engaged with the Torbay Autism Partnership in the development of it approach, including their evaluation. This development has the potential to improve care and reduce stress for patients, carers and support staff in meeting a person's needs.

Health passports for use by autistic adults when accessing health care settings are recommended in NICE Guidance (NICE, 2021).

The DPT DAAIT Team has developed a health passport proforma. This include details on how a person with autism would like to be addressed and communicated with, medical information, emergency contacts, what may cause distress, and how pain is communicated and experienced.



NHS Devon Partnership NHS Trust

DEVON ADULT AUTISM INTERVENTIONS TEAM

Health Passport

This passport will help you understand my autism and how to make adjustments for me.

About me:

Name:

I like to be called:

Preferred pronouns:

Date of birth:

NHS No:

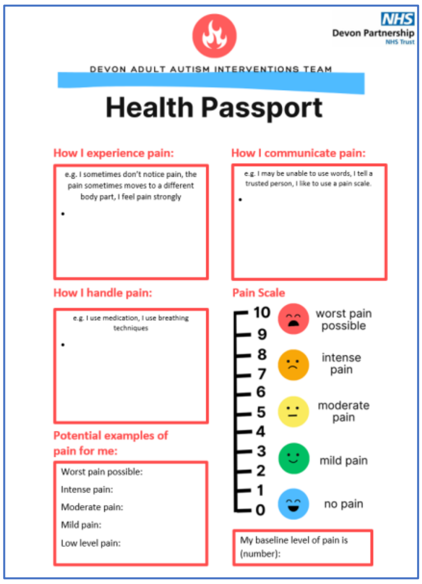
Who this passport can be shared with:

Tick which applies: ✓

☐ Everyone

☐ Everyone except:

☐ Only these people:



NHS Devon Partnership NHS Trust

DEVON ADULT AUTISM INTERVENTIONS TEAM

Health Passport

How I experience pain:

e.g. I sometimes don't notice pain, the pain sometimes moves to a different body part, I feel pain strongly

-

How I communicate pain:

e.g. I may be unable to use words, I tell a trusted person, I like to use a pain scale.

-

How I handle pain:

e.g. I use medication, I use breathing techniques

-

Pain Scale

10 worst pain possible
9
8 intense pain
7
6
5 moderate pain
4
3 mild pain
2
1
0 no pain

My baseline level of pain is (number):

Potential examples of pain for me:

Worst pain possible:
Intense pain:
Moderate pain:
Mild pain:
Low level pain:

However, there is some concern that health passports may not reduce health inequalities; health passports alone do not: address staff knowledge and understanding of how to proceed when shown a passport, affect the wider health care sensory environment, or change the broader societal levels of stigma (Ellis et al., 2023). Locally, engagement has indicated they can be helpful but '*only when read by the health professional'* (PWLE). This intervention may therefore be of benefit but needs to be part of a wider approach to ensure the key messages contained within can be acted upon in a timely and effective manner. This also applies to the use of Autism Cards shown above.

People with a learning disability and are aged 14 and over should be offered and receive an annual Health Check (identification is based on inclusion on a GP's Learning Disability Register) (NHS England, 2025).

A health check for autistic adults without a learning disability is being researched by Autistic, in conjunction with NHS England. The trialled approach included an assessment of personal life and services and support, alongside physical and mental health. Autistica has a stated aim of introducing a holistic check by 2030. This continues to be evaluated and would need aligning with future local strategies if and when introduced (Autistica, 2023).

Social support

In the population as a whole, the 'most acceptable definition of wellbeing comprises intrapersonal domains (e.g. life satisfaction and physical and mental health), interpersonal factors (e.g. relationships and loneliness), employment, leisure activities, living standards, and wider factors such as the economy and environment (ONS) (Featherstone et al., 2023).

The concept of wellbeing in autistic adults in particular has been identified as aligning with these overall themes and being as multi-dimensional as in the general population; however lived experience has led autistic people to highlight additional elements that are important, particularly, autonomy, the potential role of external support (to facilitate wellbeing), and connecting with others (Featherstone et al., 2023).

A recent scoping review of resilience in neurodivergent populations identified the importance of families and friends, community participation and acceptance, and individual capabilities for resilience (the findings stress the need for a cautious approach recognising the variability of experiences across neurodivergence and recognise the interplay of biological, psychological, activity, participation, and environmental factors) (Black et al., 2024).

These themes broadly align with the views gathered during this HNA. A key consideration is how social and peer supports can be nurtured and supported.

Social prescribing is an increasingly well embedded intervention and is based on the concept of referrals from primary care into local non-medical support services in order to address the needs of a person in a more holistic manner. This can include referrals to local voluntary sector organisations and support groups. This intention is that through this mechanism, social needs including housing, community participation and financial assistance can be met, to support a person's wellbeing as a whole. This process is support by Social Prescribers (sometimes called Community Connectors or Link

Workers), based in primary care and who develop a close understanding of the local support available (One Devon, 2025) (One Northern Devon, 2022).

It has the potential to enable more personalised support and provide elements of the community connection for neurodivergent adults. Specifically in relation to autism, these is limited evaluation on the role of low level support services, however evidence is suggestive of how social prescribing could be adapted:

- co-production of initiatives with autistic people including the upskilling of social prescriber worker knowledge of autism;
- environmental adaptations;
- a tailored approach to goal setting that both meets individual preferences and manages third party expectations;
- together with appropriate methods of identifying people suitable for social prescribing (recognising the barriers commonly reported regarding access to and understanding in primary care) and communication (Featherstone et al., 2021) (Cornwall Council, 2024).

In Scotland, an 'autism hub' setup has been developed with eight 'One Stop Shops' (integrated information hubs and advice services, offering advice, access to services, and training for autistic people and their families) (Norris et al., 2024). Such a hub-based approach may begin to address some of the desires expressed in the engagement relating to the need for 'holistic hub of support'.

The role of peer-based support was consistent in both the evidence base and feedback from the community, with positive benefits identified on quality of life for autistic adults. A systematic review of interaction between people without a learning disability identified themes focussing on the quality of connection, impact of connection, and the diverse experiences of how connection could be facilitated (e.g. online versus offline). It should be recognised this does not work for all people but was a clear desire for many (Wigham et al., 2022) (Watts et al., 2024).

Although social camouflaging (for example, through masking of autistic behaviours) has been identified as leading to some social 'benefits' through social conformity, protection from the effects of stigma, and ability to make connections, it can have longer term impacts on mental health and missed opportunities to address needs (especially for women and girls who are more likely to camouflage), and may have developed as a response to trauma.

Therefore although there is a desire to develop peer support forums which create environments in which neurodivergent people feel less likely to need to mask, this should not be at the expense of efforts to create a more inclusive society as a whole (Zhuang S, 2023) (Summerill J, 2025) (Autistica, 2019).

Feedback from people with lived experience also demonstrates recognition of the changes proposed to DAANA Post Diagnostic Support Groups (some of whom have been members for several years), and the increasing reliance on community provision to address these needs. There is an awareness that there is a pressure on the voluntary and community sector and that it is often subject to short term funding arrangements which can impact stability of provision. The development of future or maintenance of current support groups will therefore take place in this challenging context.

Employment

Within employment support services, there are schemes in place to specifically support people with neurodivergence, people with disabilities more broadly, and people in the population as a whole who require additional support to enter or re-enter the labour market.

DWP has commissioned a specific Neurodivergence Support programme covering Devon, Plymouth and Torbay, in response to local needs. This is delivered by Plus and uses a British Association for Supported Employment learning approach. There are 25 places in northern Devon, 100 in the remainder of Devon and Torbay, and a further cohort in Plymouth. The majority of recipients will be receiving Universal Credit and access is not dependent on having a diagnosis (some clients may be on Employment and Support Allowance - ESA). Support is provided in community settings.

The intended approach includes:

- 6 month 1:1 support (virtual if needed but prefer face to face) from an individual mentor experienced in supporting neurodivergent clients;
- Exploring employer expectations, developing self-awareness and communication of needs, approaches to disclosure, and exploration of Access to Work and reasonable adjustments;
- All participants receive a tailored action plan;
- If clients are already working, they can receive specialist support to increase their hours.

Local examples of projects include the work of TTVS with Bideford's Job Centre, with a focus on supporting people into voluntary roles. The support is provided at a much slower pace to get the individuals used to the environment. Although a small pilot, of interest was the relatively high proportion of participants who disclosed they were, or suspected they were, neurodivergent.

Access to Work is an example of broader national initiatives to support disabled people into work and is the most widely used programme for supporting autistic people into work and is available to people with ADHD.

The range of potential personalised support to assist people into or retain employment includes workplace assessments, travel to/ for work, support workers, and specialist aids and equipment. Access to Work can fund up to £66,000 worth of flexible, personalised support per person per year. It is focussed on supporting small to medium employers. There is currently significant demand on the processing of these applications.

Disability Support Advisers are based in Job Centre Plus (and aim to work closely with social prescribers in primary care), and DWP has been exploring how autism accreditation can be implemented within Job Centres (gov.uk, 2025) (Buckland, 2024).

Connect to Work will be a key support provision in Devon going forward and will be funded by DWP but managed by Devon County Council as lead authority for the Devon Combined Authority with provision from September 2025. This represents some of devolved approaches to employment support and is part of the next phase of support, building on previous schemes such as the Work and Health Programme.

The Connect to Work programme has been introduced to support specific cohorts with disabilities, health conditions or other complex circumstances that find it difficult to enter the labour market. The aim in Devon (including Plymouth and Torbay) is to support 1900 people per year, and to support 50% of this group into 'permanent employment'. This is supported by availability of significant funding of £6-7m per year.

Importantly, the definition of permanent employment in terms of measuring outcomes from this programme has been changed to reflect income generated over a 12 month period (as opposed to maintenance of a minimum 13 week's participation).

The programme will incorporate two approaches each with a supporting quality assured framework: Individual Placement and Support, and Supported Employment.

The local approach will need to be externally quality assured and developed against best practice (for example, using the framework for drug and alcohol services).

The 'place and train' model is based on a person being supported to be rapidly placed in work on the open market and then receive wrap around support that may include social support and adaptations. Support to the employer will be provided as part of this process, in addition to existing programmes such as Access to Work.

Devon is adopting a blended approach with mental health support being commissioned, intensive employment support being provided by Learn Devon and Reaching Independence Teams, and with the ability to commission support for specific groups where additional skills are needed.

The current provision of DCC Employment Hubs (with physical locations in Exeter and Bideford libraries, Tiverton and Exmouth) act as a landing place for partners, staff, and those seeking support. The aim is to promote co-location and support 'warm handovers' between services. The aim is not to replicate provision elsewhere (e.g. online support).

Employment Hubs will act as a gateway into Connect to Work and will accept referrals and open access. The funding will support a wider role out of the Employment Hub approach, and address some of the patchwork provision that can be experienced in employment programmes.

More broadly Employment Hubs are exploring increased links to health services including primary care and occupational health, to meet needs including but not limited to people with musculoskeletal conditions affecting their ability to work.

Learn Devon is the adult education provision for Devon. This is designed to be inclusive and accessible for all learners. There has been a recent noticeable increase (c.60-70%) in adults presenting with various additional needs (including learning difficulties, learning disabilities, and visual impairments). This appears to be for two main reasons: a review of how people with additional needs can be better identified and supported, and a conscious effort to identify cohorts that may require additional support and improved links with a wider variety of Council and external services.

Learners with additional needs are supported with an individual support plan, including learning support assistants. Total outcomes are broadly similar in those who have additional needs and those who do not. Outcomes are measured mainly through 'success measures' which are in turn based on achievement of qualifications. The intention is to develop this over time with more granular data.

The following Combined Authority strategies will include a key focus on inclusion and are currently in development:

- Skills Strategy
- Growth Strategy

Within planned programmes and strategies there is an opportunity to ensure the needs of neurodivergent people are fully take into account given the clear inequalities with regard to employment outcomes.

Observations - Universal / Community-based provision

a) To support the development of local provision, and through engagement for this HNA, a set of clear priorities have been identified for the local population.

b) There are pockets of good practice and some specific commissioned interventions (e.g. DWP Neurodivergence project). VCSE provision is well regarded where it is in place.

c) There is a strong desire for improved training and awareness in community based services. There is feedback suggestive of limited understanding of reasonable adjustments / awareness in universal and community services including employers. There are a range of sources of support for local organisations available in both local and national guidance.

d) Suitable and affordable housing options are key but there is an identified need to develop improved housing need data.

e) Benefit processes are already described as challenging by people with lived experience although there is relatively high likelihood of receiving support compared to other groups (in relation to PIP). Welfare proposals announced during the production of the HNA may have a potentially significant impact on the local population but the precise impact is to be determined.

f) There is a risk that post diagnostic support relies primarily on community provision. There is a desire for community provision more broadly to be supported (including financially) but also through central hubs of advice and specialist advice where required.

g) Social (and peer) support is in general an important need in these population groups, and the development of networks and groups should be supported. Social prescribing may be effective for these groups, as adapted, in order to draw together existing community supports, and mitigate some of the barriers in access that people may face alone.

h) There is a balance to be had between promoting inclusive and person-centred approaches irrespective of specific needs and neurodivergent-specific considerations.

i) An identified gap is a specific autism or neurodivergence strategy that covers the Devon LA area relating to adults (a CYP 2025-30 Strategy has been developed by Devon ICS and this adopts a needs led approach).

j) The wider policy environment is both challenging (with potential significant impacts from changes to welfare provision), and may provide additional clarity (for example, the learning from the NHS ADHD Taskforce).

Adopting training and awareness programmes, supported by co-produced solutions, can be felt to make a noticeable difference:

> *'I do believe that slight progress has been made in Torbay, I think general understanding is increasing, even if slowly, and we're incredibly lucky to have an Autism Partnership Board that runs in full co-production including the Torbay Autism Ambassadors. The Oliver McGowan Mandatory Training is improving understanding at Torbay Hospital and private companies are also seeking the training. Again, it's far from a significant improvement, but the scales have definitely shifted if even a little'*
>
> [Participant in PWLE discussion group]

17 Limitations and evidence gaps

This HNA is subject to a number of limitations.

These include:

- Data availability – data relating to whether a person has an Autism or ADHD diagnosis is not routinely collected by all service providers. For example, within Local Authority commissioned Drug and Alcohol Services. The National Drug Treatment Management Service includes data at the Devon LA geographical level including New Presentations grouped by Disability status. A person may be included within one of these categories if they have a learning disability (for example) *and* autism (or ADHD), but the data is not available at that level of granularity;
- Data consistency – there is variation in where a person's status is based on self-identification or formal diagnosis. This is shown where known within the HNA, but does mean a consistent interpretation is not possible and caution must be taken when interpreting data in this topic area more broadly;
- There is a recognised national gap in the quality of data on NHS ADHD provision;
- More broadly in the evidence base, there is a more limited understanding of neurodivergence in population level sub groups including in women.

Therefore, the HNA has identified a number of areas where a more nuanced understanding of autism and ADHD is not yet possible. This is primarily due to data collection or the constraints of the HNA process which has provided a wide overview but may mean some specific issues have not yet been explored in more depth at the local level.

Further exploration of the One Devon Dataset will address some of these issues, especially with regard to a more localised overview of rates of autism and ADHD, and exploration of their relationships with factors such as socio-economic deprivation, and co-existing conditions (as represented by those reported in the NHS Quality and Outcomes Framework).

18 Recommendations

The following recommendations are made:

Recommendation	Potential lead
Strategic and core principles	
1. Throughout future work to support these population groups, a key principle should be co-production of interventions and programmes with autistic persons and persons with ADHD.	All organisations as applicable
2. Development of a strategy for adults in Devon (this should consider both Autism and other neurodivergence), and as part of this process: c) identify opportunities to provide holistic approaches to support between and across agencies; d) integrate the role of people with lived experience into decision making processes associated with the strategy and its implementation.	Within an appropriate system-wide approach
3. The findings of the HNA should inform the refresh of appropriate commissioning strategies, delivery plans and social care Market Position statements, and consider priority groups within this. This should include the Housing Needs Assessment that is being led by Adult Social Care.	Devon County Council Adult Care / Devon Public Health / MHLDN / NHS Devon Integrated Care Board (ICB)
Suicide Prevention	
4. To support Suicide Prevention as a priority within autistic adults and people with ADHD: a) Adopt the findings of the HNA within the local Suicide Prevention Strategy and Action Plan (including alignment with the 'Suicide is Everyone's Business' strand). This should include explicit consideration of awareness raising of the additional risk in autistic adults and adults with ADHD.	Suicide Prevention Oversight Group / Devon Public Health

b) Ensure a focus on neurodivergence within suicide prevention training. This should include: i) organisations most likely to be providing support at the point of crisis (including organisations providing universal support and specific support groups for neurodivergent people) ii) organisations providing support in the community on a universal basis (these groups will include support to neurodivergent adults at multiple life stages and through various means). c) Support and build in opportunities for ongoing learning eg. from the NHS Devon ICB-led Learning from lives and Deaths (LeDeR) process, and Devon Partnership Trust-led Learning Disability and Autism mortality reviews d) Support NHS Devon to ensure local organisations and partnerships are aware that LeDeR process now includes a focus on autistic adults without learning disabilities e) Consider support to social connectivity initiatives through funding programmes with consideration of priority risk groups (for example, through Communities: Local Action on Suicide Prevention - CLASP). This could include support to groups that specifically support neurodivergent people or ensuring initiatives with universal access are accessible and adopt neurodivergent-inclusive approaches. f) Consider how data collection relating to neurodivergence can be improved within the scope of the Real Time Suicide Surveillance (RTSS) and Postvention Support provision g) Continue to review the emerging evidence base (including in relation to safety planning) and ensure the development of suicide prevention tools and interventions is neurodivergent-informed.	
Social and peer support	
5. Support effective access to social support and peer support, including through funding opportunities, during the commissioning of relevant programmes, or other support as appropriate.	Devon County Council / NHS Devon / All relevant funding organisations
Universal and Community Service Provision	
6. Respond to the identified need for training and in particular: neurodivergence awareness; autism, ADHD and Mental Health; reasonable adjustments; examples of adaptations; best practice and availability of support. This should include: a) A review of training needs across local community service providers, including services supported or commissioned by Devon County Council for Inclusion Health groups.	Commissioned and partner providers

b) Promotion of training and awareness of the needs of adults with ADHD and autistic adults (including specific reference to the role, obligations and benefits of reasonable adjustments) in all organisations for staff and those they serve. c) Consideration of development of new training provision, using existing courses, programmes and local expertise as a basis, and local experience including organisations and people with lived experience.	All relevant organisations
7. Promotion of diagnosis-neutral approaches for all people accessing support across local community service providers.	All relevant organisations
8. Emerging opportunities and service developments should be supported to explicitly consider and meet the needs of neurodivergent people (for example but not limited to the Connect to Work Programme).	All relevant organisations as appropriate
Next Phases	
9. As part of future phases of this work, continue to build on the One Devon Dataset (ODD) Use Request, including: a) Understanding of the impact of challenges to accessing assessment, care and treatment, including any variation in shared care and/or prescribing for ADHD; b) And related inequalities.	Devon Public Health
10. As part of future phases of this work: a) consider any emerging and final findings and reports from the national ADHD Taskforce and how these may be applied in Devon; b) consider the results of the focussed report into autism and suicide due to be published by National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) in 2025.	All relevant organisations

19 Acknowledgements

This HNA would not have been possible without the support and insight from local people of lived experience. The Steering Group sincerely thanks the following groups:

- Members of Dimensions for Autism
- Devon Partnership NHS Trust and Devon Mental Health Alliance Experts by Experience and Peer Support Team
- Devon Carers Autism Peer Support Group
- All other local people with lived experience who responded to the online survey
- Torbay Autism Partnership Board.

The Steering Group would also like to thank the wide range of stakeholders that provided valuable insights through the provision of data and signposting to sources of evidence,

completion of the online survey, and attendance at stakeholder discussion groups and semi-structured interviews.

This included representatives of:

Department of Work and Pensions
Devon and Cornwall Police
Devon County Council Adult and Children's Social Care, Economy & Skills
Devon Housing Options Partnership
Devon Mental Health Learning Disability and Neurodiversity Provider Collaborative
Devon Partnership NHS Trust
Devon Suicide Prevention Implementation Group
FearFree Devon
HM Prison and Probation Service
Inclusion Health Devon Primary Care Service
Living Options
NHS Devon Integrated Care Board (including Clinical Lead for Learning Disability and Neurodivergence, Clinical Lead for Primary Care, LeDeR Review Team, Population Health Management Team)
Members of the System Change Action Alliance
National Autistic Society – West Devon
National Confidential Inquiry into Suicide and Safety in Mental Health (University of Manchester)
NHS England South West Health and Justice Team
Pete's Dragons
Office of the Police and Crime Commissioner for Devon and Cornwall
Together Drug and Alcohol Service
Torbay Council Adult Social Care
University of Exeter
Waymakers Devon Community Interest Company

20 Steering Group

Peter Mennear, Public Health Registrar, Devon County Council (lead author)
Lex Gainsbury, Consultant in Public Health
Lucie Spiers, Senior Commissioning Officer, Adult Social Care
James Sheffield, Senior Information Analyst
Natalie Winterton, Advanced Public Health Practitioner
Nicki Glassbrook, Public Health Specialist
Honey Drury, Apprentice Public Health Practitioner
Dr Sam Cole, Clinical Advisor
Melanie Burke, Senior Management Information Officer, Adult Social Care
Miranda Montano, Apprentice Population Health Intelligence Specialist

21 References

Price, A.,Becker, K.,Ward, JH.,Ukoumunne,OC., Gudka,R., Salimi,A.,Mughal,F.,Melendez-Torres,GJ., Smith,JR., Newlove-Delgado,T., (2024). Support for primary care prescribing for adult ADHD in England: national survey. *British Journal of General Practice, 74*. doi.org/10.3399/BJGP.2023.0595

Autistica (2019). *Autistica Action Briefing: Diagnosing Autistic Women and Girls.* Retrieved from Autistica: https://www.autistica.org.uk/downloads/files/Autistica-Action-Briefing-Diagnosing-Autistic-Women-And-Girls.pdf

Autistica (2023). *Autistica Health Checks Plan: How to ensure every autistic adult is offered a yearly, tailored health check, by 2030.* Retrieved from https://www.autistica.org.uk/downloads/files/Health-Checks-Plan.pdf

Autistica (2025). *Creating a neuroinclusion index for employers*. Retrieved from Autistica: https://www.autistica.org.uk/our-research/research-projects/employers-index

BMJ (2023). *Autism spectrum disorder*. Retrieved from BMJ Best Practice: https://bestpractice.bmj.com/topics/en-gb/379/aetiology

BMJ (2024). *BMJ Best Practice - Attention deficit hyperactivity disorder in adults*. Retrieved from BMJ Best Practice: https://bestpractice.bmj.com/topics/en-gb/814/criteria

Brown, CM., Newell,V., Sahin,E., Hedley,D. (2024). Updated Systematic Review of Suicide in Autism: 2018–2024. *Curr Dev Disord Rep, 11*. doi.org/10.1007/s40474-024-00308-9

Buckland, R. (2024). *The Buckland Review of Autism Employment: report and recommendations.* Retrieved from DWP: https://www.gov.uk/government/publications/the-buckland-review-of-autism-employment-report-and-recommendations/the-buckland-review-of-autism-employment-report-and-recommendations#the-current-situation

Cassidy, S., Au-Yeung,S., Robertson, A., Cogger-Ward, H., Richards,G.,Allison, C., Bradley,L., Kenny,R., O'Connor,R., Mosse,D.,Rodgers,J.,Baron-Cohen,S.(2022). Autism and autistic traits in those who died by suicide in England. *The British Journal of Psychiatry, 221*(5). doi:10.1192/bjp.2022.21

Cassidy, S., Goodwin, J., Robertson, A., Cogger-Ward, H., & Rodgers, J. (2021). *Autism community priorities for suicide prevention.* Policy Brief, International Society for Autism Research. doi:10.13140/RG.2.2.16668.82568

Centre for Homelessness Impact. (2023). *Homelessness and disability in the UK.* Retrieved from Centre for Homelessness Impact: https://www.homelessnessimpact.org/publication/homelessness-and-disability-in-the-uk

Chamberlain, SR., Cortese,S., Grant, JE. (2021). Screening for adult ADHD using brief rating tools: What can we conclude from a positive screen? Some caveats. *Comprehensive Psychiatry, 106*. doi:doi.org/10.1016/j.comppsych.2021.152224

Chan, WM.,Bhandarkar,R. (2024). Suicidality and Intellectual Disability: A Systematic Review. *Journal of Mental Health Research in Intellectual Disabilities, 18*(1). doi.org/10.1080/19315864.2024.2397403

Cleare,S.,Belkadi, N., O'Connor,R. (2024). *Understanding the relationship between ADHD and suicidal thoughts and behaviours.* Retrieved from University of Glasgow: https://suicideresearch.info/wp-content/uploads/2024/03/v1.0-adhd-and-sr-interview-study.pdf

Cornwall Council. (2024). *Autism Focus Paper.* Retrieved from https://www.cornwall.gov.uk/media/ui3byhty/cios-autism-focus-paper_2024.pdf

Darzi, A. (2024). *Independent investigation of the National Health Service in England.* DHSC. DHSC. Retrieved from https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

Darzi, A. (2024). *Independent Investigation of the National Health Service in England:Technical Annex.* DHSC. DHSC. Retrieved from https://assets.publishing.service.gov.uk/media/66e1b517dd4e6b59f0cb2553/Independent-Investigation-of-the-National-Health-Service-in-England-Technical-Annex.pdf

Davies, J., Heasman, B., Livesey,A., Walker,A., Pellicano,E., Remington,A., (2023). Access to employment: A comparison of autistic, neurodivergent and neurotypical adults' experiences of hiring processes in the United Kingdom. *Autism,, 27*(6). doi.org/10.1177/13623613221145377

Department for Health and Social Care. (2023). *Suicide prevention in England: 5-year cross-sector strategy*. Retrieved from DHSC: https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy#addressing-risk-factors

Department for Health and Social Care. (2023). *Suicide prevention strategy for England: 2023 to 2028.* Retrieved from https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

Department for Health and Social Care / Department for Education. (2021). *The national strategy for autistic children, young people and adults: 2021 to 2026*. Retrieved from DHSC / DFE: https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026

Department for Work and Pensions. (2025). *Pathways to Work: Reforming Benefits and Support to Get Britain Working Green Paper*. Retrieved from DWP: https://www.gov.uk/government/consultations/pathways-to-work-reforming-benefits-and-support-to-get-britain-working-green-paper/pathways-to-work-reforming-benefits-and-support-to-get-britain-working-green-paper

Department for Work and Pensions. (2025). *Spring Statement 2025 health and disability benefit reforms - Equality Analysis.* Retrieved from assets.publishing.service.gov.uk: https://assets.publishing.service.gov.uk/media/67e3fbe29c9de963bc39b4b5/spring-statement-2025-health-and-disability-benefit-reforms-equality-analysis.pdf

Department for Work and Pensions. (2025). *Spring Statement 2025 health and disability benefit reforms - Impacts.* Retrieved from assets.publishing.service.gov.uk: https://assets.publishing.service.gov.uk/media/67e667fe4a226ab6c41b1fe2/spring-statement-2025-health-and-disability-benefit-reforms-impacts.pdf

Department for Work and Pensions. (2025). *Stat-Xplore*. Retrieved from Stat-Xplore: https://stat-xplore.dwp.gov.uk/webapi/jsf/dataCatalogueExplorer.xhtml

Devon County Council. (2025). *The Oliver McGowan Mandatory Training on Learning Disability and Autism*. Retrieved from Devon County Council: https://www.devon.gov.uk/providerengagementnetwork/workforce-development/the-oliver-mcgowan-mandatory-training-on-learning-disability-and-autism/

Devon County Council. (2025). *Helping autistic people to find support*. Retrieved from Care and support: https://www.devon.gov.uk/adult-social-care/care-and-support/disabilities/autism-adhd/

Devon Housing Commission (2024). *The Report of the Devon Housing Commission.* University of Exeter. Retrieved from https://news.exeter.ac.uk/wp-content/uploads/2024/07/2024EI047-Devon-Housing-Commission-Final-Report-v8.pdf

Devon Partnership Trust. (2025). *Autism*. Retrieved from DPT: https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/autism

Devon Partnership Trust. (2025). *What is ADHD*. Retrieved from DPT: https://www.dpt.nhs.uk/our-services/adult-autism-and-adhd/adhd

Disability Rights UK. (2025). *Social Model of Disability: Language*. Retrieved from Disabilty Rights UK: https://www.disabilityrightsuk.org/social-model-disability-language?srsltid=AfmBOoqDmXpp4tfLaf-A3rkQjI6EltYznYxXgpOm22TAqMYcOgiiL7hD

Disability Wales Anabledd Cymru. (2023). *Neurodiversity and the Social Model of Disability* . Retrieved from Disability Wales Anabledd Cymru: https://www.disabilitywales.org/neurodiversity-and-the-social-model-of-disability/

Equality and Human Rights Commission. (2020). *Your rights under the Equality Act 2010*. Retrieved from Equality and Human Rights Commission: https://www.equalityhumanrights.com/equality/equality-act-2010/your-rights-under-equality-act-2010

Ellis R, Williams, K., Brown, A., Healer, E., Grant, A. (2023). A realist review of health passports for Autistic adults. *PLoS ONE, 18*(9). https://doi.org/10.1371/journal.pone.0279214

Faraone, SV., Banaschewski,T., Coghill,D., Zheng,Y., Biederman,J., Bellgrove,MA., Newcorn,JH., Gignac,M., Al Saud,NM, Manor,I., Rohde,LA., Yang,L., Cortese,S., Almagor,D., Stein,MA., Albatti,TH., Aljoudi,HF., Alqahtani,MMJ., Asherson,P., Atwoli,L., (2021). The World Federation of ADHD International Consensus Statement: 208 Evidence-based conclusions about the disorder. *Neuroscience & Biobehavioral Reviews, 128*. doi.org/10.1016/j.neubiorev.2021.01.022

Featherstone C, Sharpe, R., Axford,N., Asthana,S., Husk,K. (2021). Health and wellbeing outcomes and social prescribing pathways in community-based support for autistic adults: A systematic mapping review of reviews. *Health and Social Care in the Community*. https://doi.org/10.1111/hsc.13635

Featherstone C, Sharpe, R., Axford,N., Asthana,S., Husk,K. (2023). Autistic adults' experiences of managing wellbeing and implications for social prescribing. *Disability & Society, 39*(12). doi.org/10.1080/09687599.2023.2263628

French, B., Daley,D.,Groom,M., Cassidy,S. (2023). Risks Associated With Undiagnosed ADHD and/or Autism: A Mixed-Method Systematic Review. *Journal of Attention Disorders, 27*(12). doi.org/10.1177/10870547231176

French, B., Nalbant,G., Wright,H., Sayal,K.,Daley,D., Groom,MJ., Cassidy,S., Hall,CL. (2024). The impacts associated with having ADHD: an umbrella review. *Frontiers Psychiatry, 15.* doi.org/10.3389/fpsyt.2024.1343314

Gov.uk. (2025). *Access to Work: get support if you have a disability or health condition*. Retrieved from gov.uk: https://www.gov.uk/access-to-work/eligibility

Gov.uk. (2025). *Personal Independence Payment (PIP)*. Retrieved from gov.uk: https://www.gov.uk/pip

HACT. (2024). *Understanding the opportunities of developing a more strategic approach to housing – a Discovery Report.*

Hinchliffe, R. (2025). *Community Safety Strategic Assessment 2023-24.* Retrieved from Safer Devon: https://saferdevon.co.uk/safetypartner/uploads/2025/01/Community-Safety-Strategic-Assessment-2023-24.pdf#:~:text=The%20assessment%20intends%20to%20inform%20and%20support%20the,identify%20any%20gaps%20or%20areas%20for%20improvement%2C%20systemwide

HM Inspectorate of Constabulatry and Fire and Rescue Services. (2021). *Neurodiversity in the criminal justice system: A review of evidence.* Retrieved from HMICFRS: https://hmicfrs.justiceinspectorates.gov.uk/publications/neurodiversity-in-the-criminal-justice-system/

Homeless Link. (2024). *Autism and Homelessness Toolkit.* Retrieved from Homeless Link: https://homelesslink-1b54.kxcdn.com/media/documents/Autism_and_Homelessness_Toolkit_Edition_2.pdf

Homeless Link. (2024). *Autism and Homelessness Toolkit 2nd Edition.* Retrieved from Homeless Link: https://homeless.org.uk/knowledge-hub/autism-and-homelessness/

Huntley,Z.,Maltezos,S., Williams,C., Morinan,A., Hammon,A., Ball,D., Marshall,EJ., Keaney,F., Young,S., Bolton,P.,Glaser,K., Howe-Forbes,R.,Kuntsi,J. Xenitidis,K.,Murphy,D., Asherson,PJ.(2012). Rates of undiagnosed attention deficit hyperactivity disorder in London drug and alcohol detoxification units. *BMC Psychiatry, 12*(23). doi.org/10.1186/1471-244X-12-223

Local Government Association. (2022). *Must-know guide – Autism*. Retrieved from LGA: https://www.local.gov.uk/publications/must-know-guide-autism#how-to-actively-support-autistic-people-of-all-ages-their-families-and-carers

Loizou, S., Pemovska, T., Stefanidou, T., Foye, U., Cooper, R., Kular, A., Greenburgh, A., Baldwin, H., Griffiths, J., Saunders, K. R. K., Barnett, P., Minchin, M., Brady, G., Ahmed, N., Parker, J., Chipp, B., Olive, R. R., Jackson, R., Timmerman, A., Sapiets, S., … Johnson, S. (. (2024). Approaches to improving mental healthcare for autistic people: systematic review. *BJPsych Open, 10*(4). doi:10.1192/bjo.2024.707

McKechnie, D. G. J., O'Nions, E., Dunsmuir, S., & Petersen, I. (2023). Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: population-based cohort study. *BJPsych Open, 9*(4). doi:10.1192/bjo.2023.512

Black, MH., Helander, J., Segers,J., Ingard, C., Bervoets, J. Grimaldi de Puget,V. Bölte,S. (2024). Resilience in the face of neurodivergence: A scoping review of resilience and factors promoting positive outcomes. *Clinical Psychology Review, 113*. https://doi.org/10.1016/j.cpr.2024.102487

Ministry for Housing Communities and Local Government. (2020). *MHCLG*. Retrieved from Supported housing: national statement of expectations: https://www.gov.uk/government/publications/supported-housing-national-statement-of-expectations/supported-housing-national-statement-of-expectations

Ministry for Housing Communities and Local Government. (2025). *Statutory homelessness in England: July to September 2024*. Retrieved from gov.uk: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-july-to-september-2024/statutory-homelessness-in-england-july-to-september-2024#about-our-statistics

Ministry for Housing Communities and Local Government. (2025). *Supported Housing regulation: consultation*. Retrieved from MHCLG: https://www.gov.uk/government/consultations/supported-housing-regulation-consultation/supported-housing-regulation-consultation

Ministry of Justice. (2022). *A Response to the Criminal Justice Joint Inspection: Neurodiversity in the Criminal Justice System, A Review of Evidence.* Retrieved from assets.publishing.service.gov.uk: https://assets.publishing.service.gov.uk/media/62bd9c26e90e075f2ac6045d/MoJ_Neurodiversity_Action_Plan_30_06_2022__001_.pdf

Ministry of Justice. (2023). *12-month update to the cross-Government Neurodiversity Action Plan.* Retrieved from assets.publishing.service.gov.uk: https://assets.publishing.service.gov.uk/media/65085a4d22a783000d43e7c6/ND_Update_Action_Plan_Letter_September_2023.pdf

Murillo, LG, Ramos-Olazagasti,MA., Mannuzza,S.,Castellanos,FX., Klein, RG. (2016). Childhood Attention-Deficit/Hyperactivity Disorder and Homelessness: A 33-Year Follow-Up Study. Journal of the American Academy of Child & Adolescent Psychiatry, 55(11). https://doi.org/10.1016/j.jaac.2016.07.772

National Autistic Society. (2025). *Autism and neurodiversity*. Retrieved from https://www.autism.org.uk/advice-and-guidance/topics/identity/autism-and-neurodiversity#Neurodiversity,%20the%20medical%20model%20and%20the%20social%20model

National Autistic Society. (2025). *Deciding whether to seek an assessment.* Retrieved from National Autistic Society: https://www.autism.org.uk/advice-and-guidance/topics/diagnosis/before-diagnosis/deciding-whether-to-seek-an-autism-assessment

National Confidential Inquiry into Suicide and Safety in Mental Health (2024). *Annual report 2024: UK patient and general population data 2011-2021.* Retrieved from National Confidential Inquiry into Suicide and Safety in Mental Health: https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

Newell, V., Phillips, L., Jones, C., Townsend, E., Richards, C., & Cassidy, S. (2023). A systematic review and meta-analysis of suicidality in autistic and possibly autistic people without co-occurring intellectual disability. *Molecular Autism, 14*(12). doi.org/10.1186/s13229-023-00544-7

NHS. (2022). *What is autism*. Retrieved from NHS: https://www.nhs.uk/conditions/autism/what-is-autism/

NHS Devon ICB (2023). *Learning from lives and deaths of people with a learning disability or autistic people - LeDeR Annual Report.*

NHS Digital. (2016). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.* Retrieved from NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

NHS Digital. (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4. Retrieved from NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24

NHS Digital. (2024). *Autism Prevalence in England, March 2024.* Retrieved from NHS Digital: https://digital.nhs.uk/supplementary-information/2024/autism-prevalence-in-england-march-2024

NHS Digital. (2024). *Health and Care of People with Learning Disabilities, Experimental Statistics 2023 to 2024*. Retrieved from NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2023-to-2024

NHS England. (2023). *A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards*. Retrieved from NHS England: https://www.england.nhs.uk/long-read/a-national-framework-to-deliver-improved-outcomes-in-all-age-autism-assessment-pathways-guidance-for-integrated-care-boards/

NHS England. (2023). *A national framework for NHS action on Inclusion Health*. Retrieved from https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

NHS England. (2023). *A review of health and social care in women's prisons*. Retrieved from NHS England: https://www.england.nhs.uk/long-read/a-review-of-health-and-social-care-in-womens-prisons/#5-overarching-themes

NHS England. (2024). *Attention deficit hyperactivity disorder (ADHD) Programme update*. Retrieved from NHS England: https://www.england.nhs.uk/long-read/attention-deficit-hyperactivity-disorder-adhd-programme-update/

NHS England. (2025). *Annual Health Checks*. Retrieved from NHS England: https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/

NHS England. (2025). *Reasonable Adjustments Flag*. Retrieved from NHS Digital: https://digital.nhs.uk/services/reasonable-adjustment-flag

NICE. (2021). *Autism spectrum disorder in adults: diagnosis and management*. Retrieved from NICE: https://www.nice.org.uk/guidance/CG142/chapter/Recommendations#organisation-and-delivery-of-care-2

NICE. (2025). *Clinical Knowledge Summary - Attention deficit hyperactivity disorder*. Retrieved from NICE: https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/

NICE. (2025). *Clinical Knowledge Summary - Autism in Adults*. Retrieved from NICE: https://cks.nice.org.uk/topics/autism-in-adults/

NICE. (2025). *Clinical Knowledge Summary: Learning Disabilities*. Retrieved from NICE: https://cks.nice.org.uk/topics/learning-disabilities/

NIHR. (2023). *People with learning disabilities and suicide - Project outputs*. Retrieved from NIHR School for Primary Care Research: https://www.spcr.nihr.ac.uk/news/blog/people-with-learning-disabilities-and-suicide-project-outputs

NIHR. (2024). *Young adults 'postcode lottery' for ADHD treatment*. Retrieved from NIHR Applied Research Collaboration South West Peninsula: https://arc-swp.nihr.ac.uk/news/young-adults-postcode-lottery-for-adhd-treatment/

Norris, J. E., Harvey, R., & Hull, L. (2024). Post-diagnostic support for adults diagnosed with autism in adulthood in the UK: A systematic review with narrative synthesis. *Autism, 29*(2). doi.org/10.1177/13623613241273073

Nuffield Trust. (2024). *The rapidly growing waiting lists for autism and ADHD assessments*. Retrieved from Nuffield Trust: https://www.nuffieldtrust.org.uk/news-item/the-rapidly-growing-waiting-lists-for-autism-and-adhd-assessments

Office for Health Improvement and Disparities. (2024). *Health Equity Assessment Tool (HEAT): what it is and how to use it*. Retrieved from https://www.gov.uk/government/publications/health-equity-assessment-tool-heat/health-equity-assessment-tool-heat-executive-summary

Office for Health Improvement and Disparities (2025). *Community Adult Profiles*. Retrieved from National Drug Treatment Monitoring System: https://www.ndtms.net/ViewIt/Adult

Office for Health Improvement and Disparities. (2025). *Fingertips Suicide Prevention Profile*. Retrieved from Fingertips: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/1/gid/1938132828/ati/502/iid/41001/age/285/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Office for Health Improvement and Disparities. (2025). *Local Authority Health Profiles*. Retrieved from Fingertips: https://fingertips.phe.org.uk/profile/health-profiles/data#page/3/gid/1938132701/pat/502/par/E10000008/ati/501/are/E07000040/iid/93736/age/-1/sex/-1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Office for Health Improvement and Disparities. (2025). *NDTMS Community Adult Business Definitions (Dataset R).* Retrieved from NDTMS: https://www.ndtms.net/resources/public/Event%20and%20Training%20Documentation/CDS-R/NDTMS%20Community%20Adult%20Business%20Definitions%20CDS-R%20v1.3.pdf

One Devon. (2025). *Social Prescribing*. Retrieved from One Devon: https://onedevon.org.uk/our-work/services-and-support/social-prescribing/

One Northern Devon. (2022). *One Northern Devon Social Prescribing Network*. Retrieved from One Northern Devon: https://onenortherndevon.co.uk/system/ond-social-prescribing-network /

O'Nions, E., El Baou, C., John, A., Lewer, D., Mandy, W., McKechnie, D. G. J., Petersen, I., & Stott, J. (2025). Life expectancy and years of life lost for adults with diagnosed ADHD in the UK: matched cohort study. *The British Journal of Psychiatry, 226*(5). doi:10.1192/bjp.2024.199

O'Nions, E., Petersen, I., Buckman, J. E. J., Charlton, R., Cooper, C., Corbett, A., Happé, F., Manthorpe, J., Richards, M., Saunders, R., Zanker, C., Mandy, W., & Stott, J. (2023). Autism in England: assessing underdiagnosis in a population-based cohort study of prospectively collected primary care data. *The Lancet Regional Health – Europe, 29*. https://doi.org/10.1016/j.lanepe.2023.100626

O'Nions, E., Lewer, D., Petersen, I., Brown, J., Buckman, J. E. J., Charlton, R., Cooper, C., El Baou, C., Happé, F., Manthorpe, J., McKechnie, D. G. J., Richards, M., Saunders, R., Zanker, C., Mandy, W., & Stott, J. (2024). Estimating life expectancy and years of life lost for autistic people in the UK: a matched cohort study. *The Lancet Regional Health – Europe, 36*. https://doi.org/10.1016/j.lanepe.2023.100776

Ostinelli, E. G., Schulze, M., Zangani, C., Farhat, L. C., Tomlinson, A., Del Giovane, C., Chamberlain, S. R., Philipsen, A., Young, S., Cowen, P. J., Bilbow, A., Cipriani, A., & Cortese, S. (2025). Comparative efficacy and acceptability of pharmacological, psychological, and neurostimulatory interventions for ADHD in adults: a systematic review and component network meta-analysis. *The Lancet Psychiatry, 12*(1). doi.org/10.1016/S2215-0366(24)00360-2

Resolution Foundation. (2025). *A dangerous road? Examining the 'Pathways to Work' Green Paper.* Retrieved from Resolution Foundation: https://www.resolutionfoundation.org/app/uploads/2025/03/A-dangerous-road.pdf

Riglin, L., Todd, A., Blakey, R., Shakeshaft, A., Stergiakouli, E., Davey Smith, G., Tilling, K., & Thapar, A. (2023). Investigating young-adult social outcomes of attention deficit hyperactivity disorder. *J Clin Psychiatry, 84*(2). doi:10.4088/jcp.22m14379

Rodgers, J., Cassidy, S., Pelton, M., Goodwin, J., Wagnild, J., Bhattarai, N., Gordon, I., Wilson, C., Heslop, P., Ogundimu, E., O'Connor, R. C., Ramsay, S. E., Townsend, E., & Vale, L. (2024). Feasibility and acceptability of autism adapted safety plans: an external pilot randomised controlled trial. *eClinicalMedicine, 73*. doi: 10.1016/j.eclinm.2024.102662

Rydzewska, E., Hughes-McCormack, L. A., Gillberg, C., Henderson, A., MacIntyre, C., Rintoul, J., & Cooper, S. A.. (2018). Prevalence of long-term health conditions in adults with autism: observational study of a whole country population. *BMJ Open, 8*(8). doi: 10.1136/bmjopen-2018-023945

Shelter. (2025). *Who has priority need when applying as homeless*. Retrieved from Shelter: https://england.shelter.org.uk/professional_resources/legal/homelessness_applications/priority_need_in_homelessness_applications/who_has_a_priority_need_when_applying_as_homeless

Stewart, G. R., Corbett, A., Ballard, C., Creese, B., Aarsland, D., Hampshire, A., Charlton, R. A., & Happé, F. (2023). Self-harm and Suicidality Experiences of Middle-Age and Older Adults With vs. Without High Autistic Traits. *J Autism Dev Disord, 53*. doi.org/10.1007/s10803-022-05595-y

Stone, B., Cameron, A., & Dowling, S. (2022). The autistic experience of homelessness: Implications from a narrative enquiry. *Autism, 27*(2). doi.org/10.1177/13623613221105091

Summerill,J., Summers, SJ. (2025). The consequences of social camouflaging in autistic adults: A systematic review. *Research in Autism, 121-122*. doi.org/10.1016/j.reia.2025.202556

The King's Fund. (2022). *What are health inequalities*. Retrieved from The King's Fund: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities

UK Parliament. (2024). *Autism: Overview of policy and services.* Retrieved from House of Commons Library: https://commonslibrary.parliament.uk/research-briefings/cbp-7172/

User Voice. (2021). *“NEURO…WHAT?” Neurodiversity in the Criminal Justice System.* Retrieved from User Voice: https://www.uservoice.org/wp-content/uploads/2021/07/Neurodiversity-in-the-Criminal-Justice-System.pdf

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M. C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications, 11*. doi.org/10.1038/s41467-020-17794-1

Watts, G., Crompton, C., Grainger, C., Long, J., Botha, M., Somerville, M., & Cage, E. (2024). 'A certain magic' - autistic adults' experiences of interacting with other autistic people and its relation to Quality of Life: A systematic review and thematic meta-synthesis. Autism : the international journal of research and practice, 13623613241255811. https://doi.org/10.1177/13623613241255811

White, A., Sheehan, R., Ding, J., Roberts, C., Magill, N., Keagan-Bull, R., Carter, B., Chauhan, U., Tuffrey-Wijne,I., Strydom,A. (2023). *Learning from Lives and Deaths - People with a learning disability and autistic people (LeDeR) report for 2022.* Retrieved from KCL: https://www.kcl.ac.uk/ioppn/assets/fans-dept/leder-2022-v2.0.pdf

Wigham, S. I. (2022). Consensus statements on optimal adult post-autism diagnosis support and services: Delphi process following a UK survey of autistic adults, relatives and clinicians. *Autism, 27*(2). doi:doi.org/10.1177/13623613221097502

Woodhouse, E., Hollingdale, J., Davies, L., Al-Attar, Z., Young, S., Vinter, L. P., Agyemang, K., Bartlett, C., Berryessa, C., Chaplin, E., Deeley, Q., Freckelton, I., Gerry, F., Gudjonsson, G., Maras, K., Mattison, M., McCarthy, J., Mills, R., Misch, P., Murphy, D., Allely, C. (2024). Identification and support of autistic individuals within the UK Criminal Justice System: a practical approach based upon professional consensus with input from lived experience. *BMC Medicine, 22*(157). doi.org/10.1186/s12916-024-03320-3

Young, S., Gudjonsson, G., Chitsabesan, P., Colley, B., Farrag, E., Forrester, A., Hollingdale, J., Kim, K., Lewis, A., Maginn, S., Mason, P., Ryan, S., Smith, J., Woodhouse, E., & Asherson, P. (2018). Identification and treatment of offenders with attention-deficit/hyperactivity disorder in the prison population: a practical approach based upon expert consensus. *BMC Psychiatry, 18*. doi.org/10.1186/s12888-018-1858-9

Zhuang, S., Tan, D. W., Reddrop, S., Dean, L., Maybery, M., & Magiati, I. (2023). Psychosocial factors associated with camouflaging in autistic people and its relationship with mental health and well-being: A mixed methods systematic review. *Clinical Psychology Review, 105*. https://doi.org/10.1016/j.cpr.2023.102335

Appendices

Appendix 1 - National Policy and Legislation

Equality Act 2010

The Equality Act protects all persons in England, Scotland and Wales from discrimination (which may be direct or indirect or take the form of harassment or victimisation). It specifies nine protected characteristics. These are

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

The Act applies in the workplace, using public or commercial services, transport, or when taking part in social activities like joining a club.

Through the Public Sector Equality Duty, the Act also requires public sector bodies to consider how their decisions and policy making affect people with different protected characteristics.

Employers are prevented from asking pre-employment health screening questions during recruitment, unless in specific circumstances this is necessary for the application or job role (EHRC, 2020).

Social Security Welfare Provision

The welfare system was under close scrutiny and proposed national review during the period of this HNA. This is covered in more detail below. In summary, the current system includes two main areas of support that people with a neurodivergence may access if they have eligible support needs:

- Support for the extra costs of a disability irrespective of whether a person is able to work (Personal Independence Payment - PIP);
- Benefits to support day to day living costs (Universal Credit, or Employment and Support Allowance).

During the assessment for PIP, a record will be made of a person's 'main disabling condition'.

Universal Credit provides support for working age persons, in and out of work. Concerns had been raised regarding the ability of persons subject to ‘conditionality’ requirements in terms of managing appointments and preparing for work. DWP should ensure that procedures are in place to support those with additional needs (Parliament, 2024).

Adult Social Care

Under the Care Act 2014, all adults with apparent needs of care and support (or carers with possible support needs) are eligible for a social care assessment. This eligibility for assessment applies to adults with autism or ADHD.

Where assessed care and support needs meet eligibility criteria, these needs should be met (subject to conditions). It may also choose to provide for needs that do not meet the criteria. A care and support plan should then be produced, outlining how need will be met, and which elements will be funded by the Local Authority or the eligible person. Plans may recommend access to commissioned services, or the use of a direct payment to support the person to arrange their own care services. Adult Social Care should also identify a lead commissioner for autistic adults (Parliament, 2024).

Devon County Council Adult Social Care includes a dedicated Autism and ADHD Team. This specialist team undertakes Care Act Assessments and supporting work for autistic adults or people with ADHD without a learning disability. Social workers are supported by Occupational Therapists trained in sensory assessments.

Criminal Justice System (CJS)

A review of ‘Neurodiversity in the criminal justice system’ was published in July 2021. The review found too little was being done to meet the needs of neurodivergent people in the CJS; it recommended improved screening and data collection, specialised training, implementation of adjustments, and efforts to prevent offending. The Ministry of Justice responded by publishing a neurodiversity action plan (updated in January and September 2023). The first version identified that guidelines had been issued to magistrates and judges to take neurodivergence into account. Subsequent versions have included: plans to have neurodiversity support managers in every prison across England and Wales by 2024; autism accreditation is being promoted across the prison estate; and e-learning for police has been produced to support individuals at the point of first contact with the CJS (Parliament, 2024) (MoJ, 2022) (MoJ, 2023).

Autism-specific policy

The **Autism Act 2009** requires Government to publish an adult autism strategy and make associated guidance for NHS and local authorities. Government is required to under the Act to publish an adult **autism strategy**. The first joint strategy including both children and young people and adults was produced for the period 2021-26. The key areas of the strategy (and extracts from the associated implementation plan) include:

a) Improving understanding and acceptance of autism within society (including a focus on training in central government departments, and testing an autism public understanding initiative;
b) Improving autistic children and young people's access to education, and supporting positive transitions into adulthood;
c) Supporting more autistic people into employment (including promotion of Disability Confident Scheme and Access to work, and JCP accessibility);
d) Tackling health and care inequalities for autistic people (including inclusion of autism in people without a learning disability in the LeDeR mortality reviews, trial of an autism health check, and trial of reasonable adjustment flags in patient records);
e) Building the right support in the community and supporting people in inpatient care;
f) Improving support within the criminal and youth justice systems (including staff toolkits, manager support, safety training, and adjustments in court and tribunal environments).

Importantly it also identifies improvements in data collection and reporting across Government and public services, and stated:

> '*At the local level, our expectation is that local authorities and the NHS must work in collaboration with each other and relevant local partners to take forward the key priorities in this strategy. This should be done in accordance with their legal duties to identify and support autistic adults, children and young people as stipulated in the following legislation and underpinning statutory guidance:*
>
> *Autism Act 2009*
>
> *Care Act 2014*
>
> *Children and Families Act 2014*
>
> *Children Act 1989*
>
> *Equality Act 2010'*

(DHSC / DFE, 2021)

LGA Guidance recommends that each area should have its own Autism Strategy (LGA, 2022).

Previous adult-focussed strategies were published in 2010 and 2014 and notable common themes include the promotion of awareness in services and communities and joined up and consistent access to services (Parliament, 2024).

The **NHS Long Term Plan 2019** committed to:

- Piloting an autism health check, and reducing over-medication of people with autism and learning disabilities
- Introducing the reasonable adjustments flag on digital patient records

- Reducing inpatient provision for autistic people and people with a learning disability by half by 23-24
- Improving inpatient care, and investment in specialist MDT services and crisis care.

A new NHS Long Term Plan was in development at the time of HNA production.

The Health and Care Act 2022 required all Care Quality Commission-registered health and care services to provide staff receive training on autism and learning disability relevant to their role. The preferred route for this is the Oliver McGowan Training programme. The Devon offer is summarised here: https://www.devon.gov.uk/providerengagementnetwork/workforce-development/the-oliver-mcgowan-mandatory-training-on-learning-disability-and-autism/

As a minimum, Tier 1 training should be provided to all staff who require an understanding. This is defined as ‘people who require general awareness of the support autistic people or people with a learning disability may need’. This includes staff in organisations that do not care for or design services for these groups. Staff who are patient facing and may provide care or make decisions on/help design services for these groups, are required to undertake Tier 2 training.

Tier 1 covers:

- Understanding learning disability;
- Understanding autism;
- Reasonable adjustments;
- Self-reflection on our own attitudes and behaviours.

(Parliament, 2024) (Devon County Council, 2025)

Appendix 2 – Summary of emerging findings from NHS England ADHD Taskforce

The summary was as follows:

> ‘a. ADHD service provision and interrelated policies need a joined-up approach across health, care, education, and the justice system. Improving access, experience, and outcomes for people cannot be done by health focused work alone.
>
> b. The lack of good ADHD data sources means it is difficult to fully understand the size of the problem. There is a lack of evidence explaining what is driving recent increases in demand for ADHD services. The drivers are complex, spanning wider societal issues and education policy. There is limited international data and evidence to draw on.
>
> c. As our services have not kept pace with demand and need, there has been a rapid growth of independent sector provision in the market for ADHD services. There is a need to work with systems and providers (including non-NHS providers) to better understand the different service models being used and the challenges being experienced at different points of the pathway.
>
> d. Service models need to do more to keep pace with the needs of the people seeking support. ADHD service models should consider a range of therapeutic and non-clinical interventions, in addition to prescribing options. Services should be set up in a way that is informed by need and better consider comorbidities and neurodevelopmental conditions. We need to make sure that a variety of care pathways exist, with people placed on the right care pathway, and that those providing care are appropriately trained and supported. For children, the service should be an integrated offer with education and children’s services.
>
> e. Data suggests that some populations are at increased risk of experiencing inequalities in access, experience, and outcomes. At-risk cohorts include both victims and perpetrators of crime, those facing broader social and economic deprivation, and those from marginalised groups.’ (NHS England, 2024)

Appendix 3 - Right to Choose Services commissioned and available to Devon ICB-registered patients

Providers contracted with Devon ICB to provide assessments with a Devon Contract Devon Tariff and Devon Shared Care Agreement	**Adults**		**CYP**	
	ADHD	**Autism**	**ADHD**	**Autism**
Problem Shared (ADHD referrals to include shared care as per the Devon specification)	X	X		X
ADHD 360	X	X	X	X
Evolve Psychology Services Ltd		X		X
Harrow Health	X			
Held Health			X	X
Help4psychology			X	X
KT Healthcare		X		X
LaTahzan	X			
Paloma Health				X
Psychiatry-UK Ltd		X		
RTN Mental Health Solutions Ltd		X		X
RTN Medical	X			

Right to Choose Providers with contracts with ICBs nationally accepting referrals for assessment, **There is no "Devon" Shared care Agreement in place with these providers**	**Adults**		**CYP**	
	ADHD	**Autism**	**ADHD**	**Autism**
Axia		X		
Clinical Partners	X	X		X
Dr J & Colleagues	X	X		X
Oakdale Centre CIC	X	X	X	
Skylight Psychiatry		X		
Care ADHD	X			
Harrow Health CIC	X			
Holistic ADHD Solutions Ltd	X			
Psychiatry UK	X			

Provide Wellbeing				X

Both tables adapted from https://southwest.devonformularyguidance.nhs.uk/referral-guidance/key-messages/adhd-and-autism-faq (accessed 29.3.25)

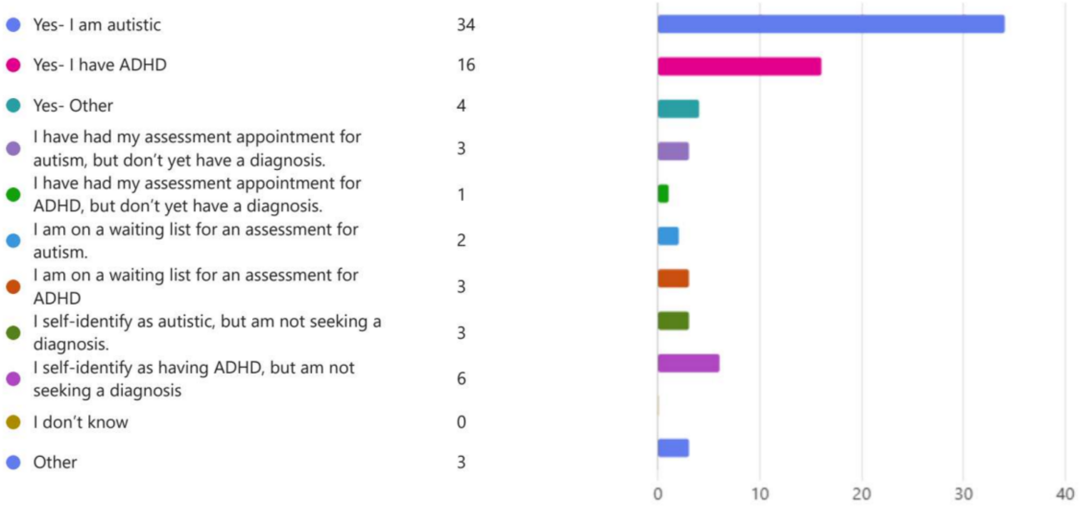
Appendix 4 - MHCLG report quarterly statistics on statutory homelessness assessments (Exeter District, July – September 2024)

Support needs of households owed a prevention or relief duty7:		
History of mental health problems	153	*62.7%*
Physical ill health and disability	98	*40.2%*
At risk of / has experienced domestic abuse	58	*23.8%*
Offending history	78	*32.0%*
History of repeat homelessness	96	*39.3%*
Drug dependency needs	63	*25.8%*
History of rough sleeping	66	*27.0%*
Alcohol dependency needs	42	*17.2%*
Learning disability	51	*20.9%*
Young person aged 18-25 years requiring support to manage independently	25	*10.2%*
Access to education, employment or training	51	*20.9%*
At risk of / has experienced abuse (non-domestic abuse)	36	*14.8%*
At risk of / has experienced sexual abuse / exploitation	24	*9.8%*
Old age	6	*2.5%*
Care leaver aged 18-20 years	13	*5.3%*
Care leaver aged 21-24 years	9	*3.7%*
Care leaver aged 25+ years	8	*3.3%*
Care leaver aged 21+ years (retired option)	4	*1.6%*
Young person aged 16-17 years	9	*3.7%*
Young parent requiring support to manage independently	6	*2.5%*
Former asylum seeker	11	*4.5%*
Served in HM Forces	5	*2.0%*
Victim of modern slavery	0	*0.0%*
Difficulties budgeting	46	*18.9%*

(MHCLG, 2025)

Appendix 5 - Survey of People with Lived Experience Demographics

Have you received a diagnosis relating to neurodivergence? By a diagnosis we mean a clinical diagnosis provided by a healthcare professional.

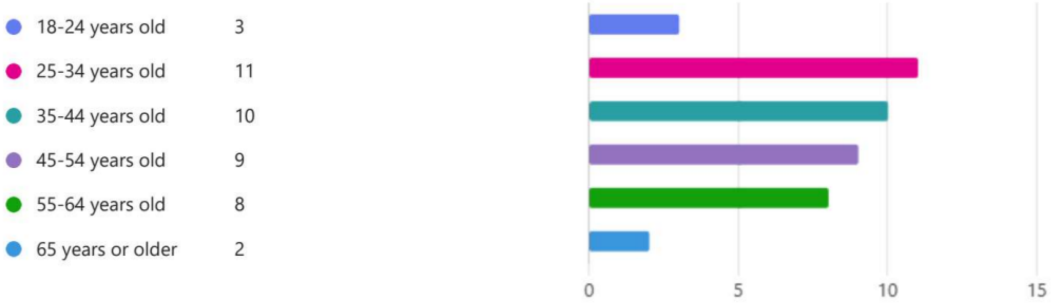


Yes- I am autistic	34
Yes- I have ADHD	16
Yes- Other	4
I have had my assessment appointment for autism, but don't yet have a diagnosis.	3
I have had my assessment appointment for ADHD, but don't yet have a diagnosis.	1
I am on a waiting list for an assessment for autism.	2
I am on a waiting list for an assessment for ADHD	3
I self-identify as autistic, but am not seeking a diagnosis.	3
I self-identify as having ADHD, but am not seeking a diagnosis	6
I don't know	0
Other	3

If you have had a diagnosis for Autism or ADHD, was this following an assessment through the NHS or a private provider?

I have an autism diagnosis and the assessment was provided by the NHS	31
I have an autism diagnosis and the assessment was provided by a private diagnostic service	4
I have an ADHD diagnosis and the assessment was provided by the NHS	13
I have an ADHD diagnosis and the assessment was provided by a private diagnostic service	0

How old are you?

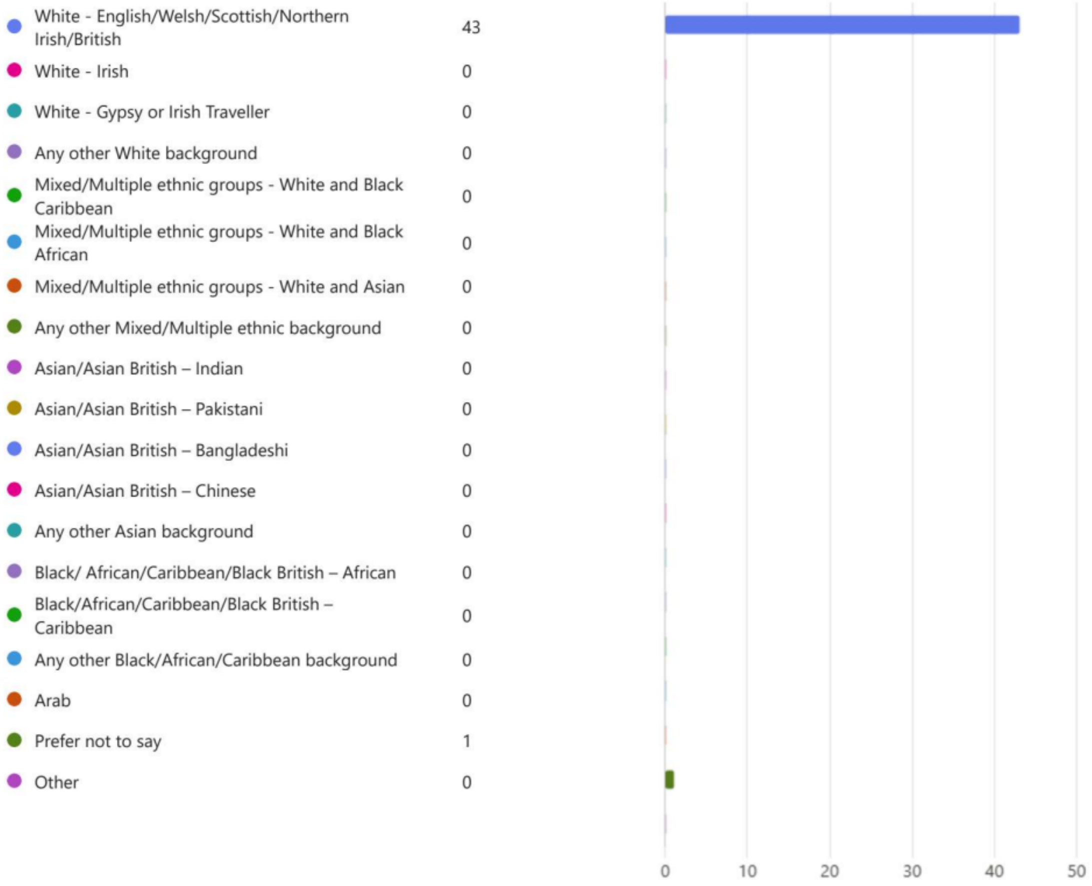


18-24 years old	3
25-34 years old	11
35-44 years old	10
45-54 years old	9
55-64 years old	8
65 years or older	2

What gender do you identify as?

● Female	30
● Male	10
● Non-binary	1
● Prefer not to say	2
● Other	1

What is your ethnic origin?



● White - English/Welsh/Scottish/Northern Irish/British	43
● White - Irish	0
● White - Gypsy or Irish Traveller	0
● Any other White background	0
● Mixed/Multiple ethnic groups - White and Black Caribbean	0
● Mixed/Multiple ethnic groups - White and Black African	0
● Mixed/Multiple ethnic groups - White and Asian	0
● Any other Mixed/Multiple ethnic background	0
● Asian/Asian British – Indian	0
● Asian/Asian British – Pakistani	0
● Asian/Asian British – Bangladeshi	0
● Asian/Asian British – Chinese	0
● Any other Asian background	0
● Black/ African/Caribbean/Black British – African	0
● Black/African/Caribbean/Black British – Caribbean	0
● Any other Black/African/Caribbean background	0
● Arab	0
● Prefer not to say	1
● Other	0

Do you have a learning disability?

Appendix 6 - Summary and Recommendations from the Dimensions for Autism Discussion Group

Summary and Key Recommendations

“I do believe that slight progress has been made in Torbay, I think general understanding is increasing, even if slowly, and we're incredibly lucky to have an Autism Partnership Board that runs in full co-production including the Torbay Autism Ambassadors. The Oliver McGowan Mandatory Training is improving understanding at Torbay Hospital and private companies are also seeking the training. Again, it's far from a significant improvement, but the scales have definitely shifted if even a little”.

This breath of feedback clearly highlights significant gaps in understanding and support for autistic individuals across various public services. Addressing these issues through targeted training, flexible communication, and specialist services could significantly improve the wellbeing of autistic individuals. The recommendations provided would help to create a more inclusive and supportive environment that meets the diverse needs of the autistic community.

Training and Awareness

- Comprehensive Autism/ADHD Training: Implement comprehensive autism training for all public service staff, including healthcare professionals, emergency services, and housing officers, to improve understanding and responses to autistic individuals.
- Specialist training for Mental Health professionals: Ensure that mental health professionals receive specialist training in autism to provide appropriate and effective support.

Service Accessibility

- Flexible communication methods: Develop flexible communication methods that accommodate the needs of autistic individuals, including the use of video calls and written communication.
- Advocacy support: Provide access to advocacy services to help autistic individuals navigate public services and ensure their needs are met.

Employment Support

Reasonable adjustments in the workplace: Promote the implementation of reasonable adjustments in the workplace and provide ongoing support to autistic employees.

- Disability Employment Advisors: Increase the visibility and availability of disability employment advisors in job centres.

Housing Support

- Tailored housing solutions: Ensure housing allocations consider the specific needs of autistic individuals, including sensory and social requirements.
- Housing Support Workers: Provide housing support workers to assist with

form filling and navigating the housing system.

Mental Health Services

- Specialist Mental Health services: Develop specialist mental health services for autistic individuals that understand and address their unique needs.
- Crisis support: Improve crisis support services to ensure they are responsive and effective for autistic individuals.

Systemic Improvements

- Effective Autism Partnership Board: Restructure the Autism Partnership Board to ensure it is effective, inclusive, and responsive to the needs of the autistic community. This includes involving autistic individuals in decisionmaking and ensuring regular communication and feedback.
- Multi-agency coordination: Improve coordination between multiple agencies, including healthcare, social care, housing, and employment services, to provide holistic and integrated support for autistic individuals.

Specialist Services and Hubs

- Holistic support hubs: Establish holistic support hubs that provide a range of flexible support services for autistic individuals, including healthcare, social care, and employment support, all in one place.
- Preventative services: Focus on preventative services that address the root causes of issues faced by autistic individuals, rather than just responding to crises.

Community and Peer Support

- Peer Support groups: Strengthen peer support networks for autistic individuals, providing opportunities for social interaction and mutual support.
- Community-based services: Develop community-based services that understand and cater to the specific needs of autistic individuals.

Policy and Strategy Implementation

- Autism Strategy: Ensure the timely and effective implementation of the autism strategy, with clear accountability and regular progress updates.
- Involvement in policy design: Involve autistic individuals in the design and implementation of policies and services that affect them, ensuring their voices are heard and their needs are met.

These recommendations would foster a more inclusive and supportive environment for autistic individuals, addressing the specific challenges they face and improving their overall wellbeing.

Appendix 7 - Stakeholder Survey Respondents

Probation	1
LA Housing	2
LA Social Care	4
LA Community Safety	1
Drug and Alcohol Service	1
Police	1
DPT	6
ICB including Clinical Leads – Primary Care, and LD and ND	3
VCSE	3
Inclusion Health Devon	3
University of Exeter	1
Total	**26**

Appendix 8 - HACT Report Recommendations (2024)

1. Develop an overarching mental health, learning disability and neurodiversity (autism) housing strategy led by the Collaborative and owned at system level. Building on from the findings of the Devon Housing Commission, this work would also support the Devolution Deal housing priority.

2. Establish a programme of work to ensure clinical pathways use every opportunity to consider accommodation needs and supports relationships with providers including risk tolerance and quality and outcome monitoring. This programme should ensure this intelligence forms part of the development of system pathway and effective housing solutions.

3. Further embedding access to housing expertise and improving housing needs data across community and inpatient provision.

4. Pilot and embed a consistent Housing Needs Assessment Framework within pathways so service users have their housing needs captured at the earliest opportunity.

5. Undertake a review of the interfaces with housing and the need for integrated transitional step-down/step-up accommodation across the Urgent and Emergency Care (UEC) and Acute pathways

(HACT, 2024)

Appendix 9 - Good Practice and Examples of Reasonable Adjustments being used in the Devon System

These are not intended to be a comprehensive list of actions to take but are summarised from stakeholder feedback.

Regular reviews of guidance and training for staff and volunteers
Consistent use of client feedback to identify opportunities to improve
Provision of training and consultations (by specialist health and social care autism and ADHD teams) to other internal and external organisations to support wider understanding
Adopting environment, communication and models that are neurodivergence-affirmative
Care Act assessments in person, online or mostly via email with carers involved as much as desired
Develop and explore different methods of communication, use a positive framing to determine what is possible, and check levels of understanding
Maintain communication passports where these are previously in place and have
Encourage stimming and autistic communication
Use photos to give directions to support groups or other meeting places
Undertake sensory audits of meeting places, and make environmental adjustments as required.
Send visual follow up records after coaching sessions (or similar) to support information processing
Ensure any agreed reasonable adjustments are clearly flagged on a person’s records to inform interactions with services
For staff, use of single work stations and working from home.
Enable staff to leave meetings when overstimulated, and reduced exposure to long meetings and supervision
Encourage hydration, and provide interesting work
In adult and higher education, support students with specialist mentoring, disability advisors, and careers support. Adopt an inclusive design for teaching, assessment and accommodation.

Where appropriate and required, adopt safety planning that looks at a person’s behaviours and personal triggers
Offering flexible walk in morning service, flexible length of appointments, use of trauma informed and experienced staff, and support to patient to attend appointments (in specialist primary care)
Offer quiet appointments and adopt high tolerance for dysregulated behaviours