the Parole Board
working with others to protect the public

Neurodiversity

Member Guidance

October 2024 (V1.0)

Document History

Document version	Date of Issue	Revision description
1.0	11.10.2024	This guidance was created as part of the Parole Board's project to launch fully revised and updated member guidance.

Contents

Executive Summary 4
1. Introduction 6
2. What is Neurodiversity? 6
3. Neurodiversity in the Criminal Justice System 7
Neurodiversity Support Managers *10*
How Could NSMs Contribute to the Parole Process? *11*
Summary of NSMs Remit in Relation to Panels *12*
4. Neurodivergent Diagnoses 12
Diagnosis vs Need *12*
Protected Characteristics *13*
When There is a Diagnosis *13*
When There is Not a Diagnosis *13*
Directing a Formal Diagnostic Assessment *14*
Differential Diagnoses *15*
5. A Needs-Based Approach 16
Communication Need *16*
Emotional Dysregulation *17*
Sensory Overload *18*
Identifying and Supporting Emotional Dysregulation and Sensory Overload .. *18*
Common Behaviours and Presentations *19*
Neurodivergence in Women and Girls *21*
6. Annex A 23
Areas of Need: Cognition and Learning *23*
Areas of Need: Communication and Interaction *26*
Areas of Need: Social, Emotional, Mental Health and Executive Functioning . *29*
Areas of Need: Sensory and Physical *32*

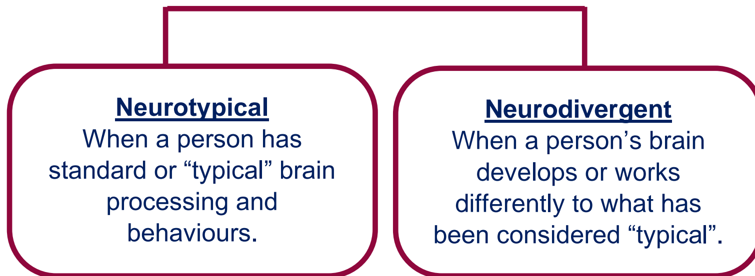
Executive Summary Neurodiversity

The full guidance can be read here.

Definition

Neurodiversity refers to the natural variation in human neurological functioning and cognitive profiles. It encompasses **neurological differences**, such as those seen in the group of conditions that fall under the broad category of neurodevelopmental disorders, as well as those present as a result of acquired brain injury.

Under the umbrella of neurodiversity, people fall into one of **two categories**:



A neurodivergent person may process information differently and have different **strengths** and **struggles** in comparison to neurotypical people.

A review of neurodivergence in the Criminal Justice System (CJS) found that **UK prison populations are disproportionately made up of people with neurodivergent conditions**, and that it would not be unreasonable to assume that **half of the adult prison population are neurodivergent.**

As a result, the government recommended that adjustments to meet the needs of those with neurodivergent conditions should be made throughout the CJS. Relevant departments and bodies are expected to work together to **anticipate needs** and **make adjustments in anticipation of needs**, which is relevant to the work of the Parole Board.

Key Points

Neurodiversity Support Managers (NSMs) (3.9 – 3.20)

- NSMs support prisons in implementing a **whole-prison approach** to neurodiversity.
- This includes improving processes to **identify** and **support** prisoners with neurodivergent needs, and ensuring neurodivergent prisoners can access **education, skills,** and **work opportunities** within prison.
- NSMs are developing one-page "passports" outlining the needs of the prisoners they support. The passports may include things they find difficult, how they wish for others to work with them, prompts for dealing with triggers, and how reasonable adjustments can be implemented to increase the prisoner's ability to engage fairly with their parole hearing.
- **The passports are not diagnoses or assessments of risk**, but if helpful, panels can request that relevant information from the passports be provided in writing via the POM.

NSMs are not risk assessors and should not be asked for a professional opinion or about risk. They should not be directed to attend oral hearings as a witness to provide evidence and should only attend where the panel chair has approved an observer application for them to attend in a **supportive** capacity.

Neurodivergent Diagnoses (4.1 – 4.26)

- Most neurodivergent individuals who engage with the CJS will not have a diagnosis due to a rise in demand for assessments which has overtaken the NHS' capacity to meet it.
- **It is <u>not</u> necessary for panels to direct a formal diagnostic assessment in every case where there is a suspected neurodivergent condition.** However, there may be occasions where a formal assessment may be a **determinative factor** in the panel's risk assessment.

It is important that panels focus on the prisoner's individual needs, rather than whether they have a diagnosis.

- It is good practice to assume that anybody could be neurodivergent.
- **It is not for panels to diagnose prisoners**, but if they are considering directing a formal assessment, panels should be mindful of the possibility of **differential diagnoses**, where symptoms could be caused by a range of different conditions.

Symptoms and presentations of neurodivergent conditions vary between genders, ages, and cultures.

Needs-Based Approach (5.1 – 5.20)

- Needs can take many forms and sometimes may not be obvious.
- It is possible that other individuals involved in the parole process may be neurodivergent. As such**, it is good practice to make adjustments as standard** to create a more inclusive environment.
- A **communication need** may become apparent in an oral hearing where an individual has difficulty processing certain information – especially where it comes in multiple parts, where multiple people are speaking, or where someone has spoken quickly.
- Panels should be aware of ways in which a communication need may present, and **how they can help to support communication.** This is outlined in the guidance.
- Adopting best practices from the Questioning Vulnerable Prisoners training may be enough, but if there appears to be **exceptional communication issues**, please see the Intermediaries Guidance.
- Some prisoners (even those who are neurotypical) may show signs of emotional dysregulation or sensory overload to varying degrees during their oral hearing. Ways of **identifying** and **supporting** emotional dysregulation and sensory overload are outlined in the guidance.

Common Behaviours and Presentations (5.21- 5.30)

- Panels should consider to what extent the below factors that are commonly associated with neurodivergence apply in individual cases, and **whether the risk management plan has suitably identified proportionate support.** Factors which apply to one neurodivergent person may not apply to another, and they may apply with varying degrees of intensity.
- **Emotional dysregulation**: inability to regulate one's emotions.
- **Sensory overload**: when one's senses take in more information than their brain can process.
- **Complex needs and trauma**: rates of trauma and comorbid psychiatric conditions are higher in those who are neurodivergent.
- **Vulnerability to exploitation**: some neurodivergent individuals are more susceptible to manipulation and exploitation.
- **Reward-seeking**: some neurodivergent individuals have deficiencies in their brain's reward system, resulting in reward-seeking behaviours, hyperactivity and impulsivity.
- **Obsessive**: persistent or recurring thoughts that are experienced as intrusive or distressing.
- **Rigid thinking**: being averse to change, complexity and challenge, may struggle with compromise.
- **Masking**: used to minimise the negative impact of discrimination or social exclusion. It is a deliberate effort to disguise neurodivergent traits whilst simultaneously taking on traits deemed more acceptable to neurotypicals. It can be conscious or unconscious, and the continued effort of masking can be detrimental to mental health.
- **Confabulation**: type of memory error where memories are unconsciously filled with fabricated, misinterpreted, or distorted information.

1. Introduction

1.1 Parole Board panels (the panels) have a duty to ensure fairness and advance equality of opportunity when undertaking Parole reviews. This guidance has been developed to support the panel's understanding of neurodiversity, and how neurodivergent individuals can be best supported throughout the parole process.

1.2 This guidance sets out:

- What neurodiversity is, as well as common terms used in relation to neurodiversity
- The Government's position on neurodiversity and the various initiatives under the Ministry of Justice to address neurodivergence in the Criminal Justice System (CJS)
- The key principles that panels should follow when reviewing the case of a prisoner whose neurodivergent needs meet the criteria for disability
- Good practice for working with prisoners with needs akin to neurodivergence, even if they do not have any formal diagnoses
- When the panel should consider directing for a formal diagnostic assessment with a view to obtain a diagnosis, and whether this is necessary to determine if the legal test for release / directions for a move to open conditions has been met
- Issues for consideration in hearings, including specific advice on different neurodivergent conditions and needs which may be relevant to anyone involved in the parole process.[1]

2. What is Neurodiversity?

2.1 Neurodiversity refers to the natural variation in human neurological functioning and cognitive profiles. This variation in our brain development is natural and evolutionarily purposeful and affects how individuals experience and interact with the world.

2.2 Neurodiversity also encompasses neurological differences such as those seen in the group of conditions that fall under the broad category of neurodevelopmental disorders (intellectual disabilities, communication disorders, autism spectrum disorder, attention deficit hyperactivity disorder, specific learning disorders and motor disorders), as well as those present as a result of acquired brain injury.

2.3 Under the umbrella of neurodiversity, people fall into one of two categories: **neurotypical** or **neurodivergent**.

[1] *Members may find the following a useful reference as it includes information and advice on adjustments for case preparation and hearings that involve neurodivergent individuals - [Equal Treatment Bench Book (July 2024) (judiciary.uk)]*

Term	Description
Neurotype	The type of brain processing that a person has.
Neurotypical	A neurotypical person is someone who has standard or "typical" brain processing and behaviours.
Neurodivergent	Neurodivergent is a non-medical term for people whose brains develop or work differently to what has been considered "typical". The person may process information differently and have different strengths and struggles in comparison to neurotypical people.
Neurodivergence	Neurodivergence describes an inclusive list of difficulties, differences, conditions and disorders including, but not limited to: learning disabilities, learning difficulties, Acquired Brain Injury (ABI), Autism Spectrum Condition (autism), Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia, Dyspraxia and Tourettes syndrome. A breakdown of these conditions and more is included in Annex A.

2.4 The broad range of neurodivergent conditions reflects the wide variation of their impact on daily life. There is significant variation in the way that neurodivergent people present and the support they may require.

2.5 Comorbidity, which is the presence of more than one condition in the same individual, adds further complexity. Many neurodivergent individuals will experience more than one neurodivergent condition; for example, a recent meta-analysis indicated that the prevalence of ADHD amongst autistic people is approximately 40%[2]. It can be hard to differentiate between some neurodivergent conditions due to overlapping traits associated with more than one neurodivergent condition[3]. In addition, some neurodivergent conditions are better understood, or advocated for, than others.

2.6 Comorbidity will not be limited to other neurodivergent conditions. There are also high rates of comorbid psychiatric disorders for neurodivergent individuals; for example, depression and anxiety are common comorbidities with neurodivergent conditions such as autism and ADHD[4].

2.7 Please see Annex A for more information on different neurodivergent conditions.

3. Neurodiversity in the Criminal Justice System

[2] *Prevalence of attention-deficit/hyperactivity disorder in individuals with autism spectrum disorder: A meta-analysis - ScienceDirect*
[3] *A transdiagnostic approach to neurodiversity in a representative population sample: The N+ 4 model - Apperly - 2024 - JCPP Advances - Wiley Online Library*
[4] *Neurodiversity glossary of terms | College of Policing*

3.1 According to a large-scale review of evidence on neurodivergence in the CJS[5], UK prison populations are disproportionately made up of people with neurodivergent conditions. **The review stated that it would not be unreasonable to assume that half of the adult prison population are neurodivergent.** However, with deficits and inconsistencies in the screening processes for neurodivergence, as well as the limitations around obtaining diagnoses, this number could be much higher[6]. While children (under 18s) were out of scope for this review, several contributors mentioned that CJS services for children were far more attuned to neurodivergence issues than adult services, but little relevant information about young people transferring from youth custody to the adult prison estate was routinely picked up.

3.2 This large-scale review urged the government to develop more coordinated and effective support for neurodivergent people in the CJS through six recommendations[7]. In response, the Cross-Government Neurodiversity in the Criminal Justice System Action Plan[8] was published, and a 12-month update was published in September 2023[9].

3.3 The recommendation which is of relevance to the Parole Board states:

"Adjustments to meet the needs of those with neurodivergent conditions should be made throughout the criminal justice system. Relevant departments and bodies should work together to anticipate needs and make adjustments in anticipation of needs. Simple and largely low-cost changes to create neurodiversity-friendly environments, communications and staff culture are likely to benefit those coming into contact with the criminal justice system, regardless of neurodivergent conditions, and should be made as soon as possible."

3.4 Significant progress has already been made against commitments to increase support for neurodivergent people encountering the CJS. Some of the key new developments in prisons are outlined below:

- Recruitment of more than 100 Neurodiversity Support Managers (NSMs), with the intention of having one NSM in every prison in the adult estate.
- Introduction of 'Neurodiversity Rep' job roles within some prisons, which is a paid role undertaken by neurodivergent prisoners to raise awareness of the support available.
- Prison and mental health providers working in greater partnership to create a space in prison that focuses on the sensory and mental health requirements of prisoners with complex needs.

---

[5] *Neurodiversity in criminal justice system – more effective support needed, say inspectorates (justiceinspectorates.gov.uk)*
[6] *Neurodiversity-in-the-Criminal-Justice-System.pdf (uservoice.org)*
[7] *Neurodiversity in the criminal justice system: a review of evidence (justiceinspectorates.gov.uk)*
[8] *MoJ_Neurodiversity_Action_Plan_30_06_2022__001_.pdf (publishing.service.gov.uk)*
[9] *ND_Update_Action_Plan_Letter_September_2023.pdf (publishing.service.gov.uk)*

- Introduction of *Easy-Read* versions of key prison documents, including a *Prison Induction Handbook* for prisoners with low literacy.
- Embedding neurodiversity training into the staff induction process to ensure every new member of staff understands neurodiversity and is able to provide the right support to neurodivergent prisoners.

3.5 To improve continuity of care for neurodivergent individuals being released into the community, NHS England's national Health and Justice Team are promoting and embedding the new RECONNECT[10] neurodiversity pathway within these respective services. This is an NHS care after custody service targeted at people over 18 years old leaving prison with an identified health need which means they would otherwise find it difficult to engage with community-based healthcare services and/or relevant support services. The programme will help to ensure a standardised approach, aiming to give individuals with neurodivergent needs equal access to RECONNECT services and equal outcomes from these services. More information on this can be found under the Vulnerable Prisoners SharePoint page.

3.6 A study by User Voice (2023)[11] investigated the lived experiences of neurodivergent individuals in the CJS by interviewing 104 service users nationwide (94 individuals across 11 prisons, 10 in the community). They found that 78% of the individuals interviewed had been diagnosed with, or had self-diagnosed, more than one neurodivergent condition. The study's key findings highlighted:

- Most of the people interviewed had not been educated about their neurodivergent condition or how it impacted their emotions, feelings, or ways to communicate
- The majority had continuously been labelled 'stupid', 'bad' or 'naughty' when they were children and lived their lives according to this label
- The majority of those interviewed had experienced childhood adversity and/or trauma
- Many had been over-medicated throughout their lives, and no other support for their neurodivergent needs had been offered
- Many reported being susceptible to peer pressure and/or manipulation, which has got them in trouble and in contact with the CJS
- The majority had not been offered any adjustments or support in the CJS
- CJS and NHS staff in prisons lacked qualifications and information about neurodiversity and neurodivergent people, and were not able to provide suitable support.

3.7 As a result of the study's findings, User Voice has since published a list of recommendations to help address these issues, including those that called

[10] *NHS commissioning » RECONNECT (england.nhs.uk)*
[11] *User_Voice_Neurodiversity_Dec_2023-1.pdf (uservoice.org)*

for improved training for staff, consistent assessments or screening mechanisms for neurodivergence, and more flexible support for neurodivergent individuals that meet their needs. User Voice also requested that courts should fully take into consideration an individual's neurodivergent needs when sentencing.

3.8 Panels should be mindful of the limitations of support for neurodivergent people in prisons when reviewing cases where there is possible neurodivergence.

Neurodiversity Support Managers

3.9 The Neurodiversity Support Manager (NSM) role has now been successfully rolled out across the prison service in England and Wales. NSMs may have significant experience working with people who are neurodivergent; however, many are not qualified to offer specialist advice on a prisoner's clinical condition. Many have been recruited from an education setting, including from the community or prisons. **NSMs support prisons in implementing a whole-prison approach to neurodiversity, including improving processes to identify and support prisoners with neurodivergent needs, and ensuring neurodivergent prisoners can access education, skills, and work opportunities within prison.**

3.10 NSMs have five key priority areas, which are to:

- Facilitate the sharing of information on neurodiversity and the identification of needs across the Prison Service.
- Provide training and support for prison staff to equip them to better understand and support those with neurodivergent needs within a custodial environment.
- Ensure that reasonable adjustments are made throughout the prison to help develop a more 'neurodiversity supportive' environment.
- Ensure that specialist or targeted support is available where appropriate, practical, and reasonable – both in education and the prison more widely.

3.11 Incorporate consideration for additional requirements of neurodivergent prisoners when preparing for release. This might include support finding employment, promoting awareness, and signposting or linking up with local services and support to access additional support available in the community for neurodivergent prisoners.

3.12 NSMs are developing one-page individual profiles or "passports" outlining the neurodivergent needs of the prisoners they support, so that staff across the prison are aware of how best to support them to access purposeful activity and how existing reasonable adjustments within the custodial estate can be improved. This might include documenting things they find difficult, the ways in which they would like others to work with

them and prompts for dealing with trigger situations. They may also set out how reasonable adjustments can be implemented to increase the prisoner’s ability to engage fairly with their parole hearing. **Panels should be mindful that these profiles are not diagnoses or assessments of risk. However, if panels would find this information helpful, they can request that relevant information from the profiles be provided in writing via the POM.**

3.13 Many NSMs are also delivering group work with prisoners with neurodivergent needs to help them to understand their needs and give them strategies that they can use to manage these both in prison and in preparation for release. To facilitate this, prisons are purchasing simple resources such as ear defenders, concentration aids (fidget tools), and overlays, to help support neurodivergent prisoners to manage their own needs.

How Could NSMs Contribute to the Parole Process?

3.14 As discussed above, while it is a specialist role which requires prior experience working with neurodivergent people and/or relevant knowledge and qualifications, NSMs are often *not* qualified neurodevelopmental or brain injury practitioners and are therefore unable to offer psychological advice on a prisoner’s clinical conditions and what treatments or interventions may help.

3.15 **Panels should note that NSMs are not trained to write reports for parole reviews. They are not risk assessors and should not be asked for a professional opinion or any other risk related aspect. As such, NSMs should not be directed to attend oral hearings as a witness to provide evidence and should only attend where the panel chair has approved an observer application for them to attend in a supportive capacity. Should panels require an update on NSM involvement, this can be provided in writing via the POM.**

3.16 NSMs take a *needs-led approach* to supporting neurodivergent prisoners. This means that rather than focus on the prisoner’s condition or diagnoses, they will be focused on what individual *needs* the prisoner may have. For example, where a prisoner has a communication need or a literacy need, the NSM establishes what support or adjustments can be put in place to ensure that they can access and understand requirements and opportunities around the prison and in preparation for their release.

3.17 Prisoners are screened by education providers on entry to prison to help identify any additional needs that may impact their ability to engage with the regime or opportunities in the prison. NSMs use this information, and where possible other information from prison staff, healthcare providers, other HMPPS databases and conversations with the prisoner to increase awareness of the prisoner’s needs and suggest adjustments that could support the prisoner or staff in the prison. For example, adjustments could include providing noise cancelling headphones or ensuring information is

available in an easy-read format. It could also include moving the prisoner to a more sensory-friendly environment, establishing consistent routines, or using clear, straightforward language. Further potential adjustments are outlined in Annex A.

3.18 There is only one NSM per prison site, so depending on the size of the prison, NSMs may not have worked with every neurodivergent prisoner.

Summary of NSMs Remit in Relation to Panels

3.19 NSMs cannot:

- Offer clinical advice on whether someone has specific conditions
- Offer advice on risk
- Advise on appropriate psychological interventions prisoners may need

3.20 NSMs can:

- Provide advice via the POM on what needs the prisoner has and how these might be best supported so that they can access the parole hearing
- Advise on what support (if any) the prisoner has received in prison and the impact of that in supporting engagement
- Work with the team around the prisoner (e.g., COMs and POMs) to ensure that they are aware of the prisoner's needs and required adjustments.

4. Neurodivergent Diagnoses

Diagnosis vs Need

4.1 The majority of neurodivergent individuals who engage with the CJS will not have a diagnosis.

4.2 The extraordinary rise in demand for autism and ADHD assessments in recent years has overtaken the NHS's capacity to meet it, resulting in wait times that vary from 12 weeks to over 10 years in some cases[12].

4.3 **Given the limitations around obtaining diagnoses in this area, it is important that panels focus on the prisoner's individual needs, rather than whether they have a diagnosis.** This is important whether reviewing a case on the papers, or during (and ahead of) an oral hearing.

4.4 The lack of evidenced diagnoses means that most of the neurodiversity information held on prisoners is a result of self-declaration or screening by prison staff at induction, or where concerns are raised later on. This,

[12] *ADHD UK'S Report into NHS ADHD Assessment Waiting Lists, October 2023*.

alongside the fact that some neurodivergent people also "mask" their difficulties, makes it difficult to ensure that every prisoner receives adequate support for any additional difficulties they face whilst living in a custodial environment.

Protected Characteristics

4.5 It is possible that an individual's neurodivergence or neurodivergent traits (if undiagnosed) could be classed as a disability.

4.6 Section 6(1) of the Equality Act 2010 states that a person has a disability if:
- That person has a physical or mental impairment, **and**
- The impairment has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

4.7 This means that a diagnosis is not explicitly required for an individual to be protected from discrimination under the protected characteristic of disability. The Government Equalities Office has published guidance on what needs to be considered when determining whether someone meets the criteria for the protected characteristic of disability under the Equality Act 2010[13].

4.8 Panels are expected to ensure any reasonable adjustments are considered and then implemented when hearing the cases of individuals who meet the criteria for disability. Further information on this can be found in the Protected Characteristics Guidance.

When There is a Diagnosis

4.9 Established diagnoses, vulnerabilities and/or diversity needs should be recorded towards the start of COM reports. Panels may also find prisoners' diagnoses evidenced (or referred to) in Psychologist, Psychiatrist, healthcare, or OASys reports.

When There is Not a Diagnosis

4.10 Undiagnosed neurodivergent individuals may still be protected from discrimination under The Equality Act 2010 (as 4.6 above).

4.11 In general, it is good practice for panels to not assume that an individual is neurotypical. Panels should do what they can to ensure individual needs are understood and considered in relation to assessing risk, custodial behaviour, and the practicalities of parole hearings, regardless of diagnosis status. Appropriate adjustments should be put into place wherever there is a need for them.

[13] Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability (HTML) - GOV.UK (www.gov.uk)

4.12 Due to neurodivergent individuals being overrepresented within the criminal justice system, simple adjustments should be made in anticipation of need to create an environment more supportive of neurodivergence. This may include:

- making changes to the physical environment – for example, removing visual clutter from walls or reducing noise and lighting in anticipation of individuals sensory needs; and
- embedding supportive practices – for example, ensuring reading material is accessible, providing reminders of social expectations, using words and images to communicate, and providing questions or instructions one-at-a-time with processing time after.

4.13 Implementing these adjustments as standard will help create a more inclusive environment, supporting individuals regardless of neurodivergent condition and enabling better opportunities for those with needs arising from neurodivergence to engage.

4.14 Any involvement with NSMs should be recorded in the dossier. If panels are unclear whether there has been NSM involvement, they can make a direction for clarification.

Directing a Formal Diagnostic Assessment

4.15 **It is not necessary for panels to direct a formal diagnostic assessment, with a view to obtain a diagnosis, in every case where neurodivergence may be a factor.** However, there may be occasions where a formal assessment may assist the panel with their risk assessment and therefore be a determinative factor in considering whether the proposed risk management plan includes the essential elements, and the release test has been met. See 4.17 below which details when an assessment may be helpful.

4.16 Directing a formal assessment needs to be weighed up with due consideration of the delay it will likely add to progressing an individual's parole review. Panels will need to be sure that the case cannot reasonably proceed without a formal assessment, and suitable measures cannot be put in place by taking a needs-based approach (please see section below).

4.17 In addition, panels should be mindful that formal diagnostic assessments in prison are not always possible due to the limited availability of information from the community. These formal assessments require a developmental history which may require obtaining collateral information about the persons childhood experiences, life span functioning and medical history, from family members or other professionals. Where an individual is in prison, obtaining this information may not be possible.

4.18 On average, it takes around three to five years in the community to get a diagnosis, though some are opting into the "right to choose" option,

which gives individuals the option to pick their NHS provider (which may have shorter wait times than their local provider). In principle, this option applies to people in prison, but in practice, this is not always possible due to funding constraints and practical logistics.

4.19 Directing a formal assessment could be helpful to panels in the following situations:

a. Where there have been barriers to engagement with agencies required to manage an individual's risk in the community. It is sometimes the case that formal diagnoses are required for services to accept referrals
b. Where there are barriers to effective communication that cannot be resolved by following existing guidance
c. Where neurodivergent traits are hypothesised to be related to risk, but the formulation is impaired by the lack of diagnosis
d. Where an individual is likely to need an enhanced Risk Management Plan (RMP)
e. Where a prisoner's case is complex or 'stuck' as treatment needs are not well understood
f. Where there have been repeated recalls or issues with responsivity, and neurodivergence could be a significant factor.

4.20 **Panels should consider how helpful having a diagnosis would be in understanding an individual's relationship to risk, but be mindful not to get involved in sentence planning. A diagnosis should not be required to enable a fair hearing, especially where panels take a needs-based approach.**

4.21 Should the panel need specialist advice on whether to direct a formal diagnostic assessment, they can discuss the case with a specialist member advisor – the list of members can be found here.

4.22 For more information about specialist reports, please see the guidance.

Differential Diagnoses

4.23 Whilst there are many cases of individuals waiting for a diagnosis, or being unaware that they are neurodivergent, panels should be mindful that there is the possibility of a differential diagnosis.

4.24 A differential diagnosis is where symptoms could be caused by a range of different conditions, and steps need to be taken to distinguish one particular condition from others that present with similar clinical features. For example, deficient social communication symptoms may look like autism, but could also be explained by generalised anxiety disorder; or restricted, repetitive patterns of behaviour could instead be obsessive compulsive disorder.

4.25 The diagnostic criteria for a number of neurodivergent conditions, including autism and ADHD, are based on white, male children and Western norms[14]. It is well acknowledged that the autism and ADHD traits relevant to white, male children can be very different for adults, women, people of colour, and transgender individuals[15][16]. This could influence potential misdiagnoses for autism and ADHD.

4.26 **Whilst it is not for panels to diagnose prisoners, if panels are considering directing a formal diagnostic assessment, they should be mindful of the potential for a differential diagnosis.** Panels may find it helpful to consider resources[17] that give further information on conditions that can be misdiagnosed as autism or ADHD, especially if there is an absence of a full range of likely neurodivergent symptoms.

5. A Needs-Based Approach

5.1 Whilst it is primarily for the Secretary of State for Justice and other witnesses to ensure that needs are identified and addressed, it is important that panels remain alert to individual needs, bearing in mind that needs can take many forms and sometimes may not be obvious.

5.2 It is possible that other individuals involved in the parole process may be neurodivergent. As such, it is good practice to make adjustments as standard to create a more inclusive environment. Examples of different needs and potential adjustments are outlined below.

Communication Need

5.3 A communication need may become apparent in an oral hearing where an individual has difficulty processing certain information, especially where information comes in multiple parts, where multiple people are speaking (in person or remote), or where someone has spoken quickly. More information on specific communication needs is included in Annex A.

5.4 A communication need may present as:

- Not answering questions or following instructions
- Not answering questions properly, such as providing seemingly irrelevant or unusual information, or having an unexpected openness
- Not giving eye contact, seeming distracted or unable to concentrate
- Appearing to be rude, rigid, cold or unemotional, or seeming to have no concern for others
- Difficulty with time concepts and sequencing of events

[14] *Autistic women and girls (autism.org.uk)*
[15] *Neurodiversity: What is it and what does it look like across races? | OpenLearn - Open University*
[16] *Autism and gender identity*
[17] *Professionals - Compass Psychology | Psychology Experts | Specialists in ADHD & Autism*

- Getting stuck on a topic or ruminating about something
- Avoidance or trying to leave the situation

5.5 Things that may help support communication:

- Checking that they are paying attention, observing body language and asking questions to test engagement – don't assume just because someone is not looking at you that they are not paying attention
- Giving simple instructions
- Waiting for a response
- Checking understanding by asking open questions such as “how did that happen?” rather than “did that happen?”; or asking them to repeat what was asked/said in their own words
- Keeping a calm, steady voice
- Reminding the individual of expectations
- Providing accessible documents – keep written material short, use simple language, large font size & images, or have ‘Easy Read’ options available.
- Avoiding using words or phrases that may be taken literally and be misleading, such as “I will be two seconds” or “between a rock and a hard place”.
- Ensuring the environment or format of the parole hearing is appropriate, depending on individual needs, such as ensuring the hearing starts on time or considering whether to hold a hearing remotely.

5.6 Adopting best practice from the Questioning Vulnerable Prisoners (QVP) member training and making adaptations may support the prisoner to engage in their parole review without the need for a more formal communication needs assessment.

5.7 If there appears to be exceptional communication needs which could result in the prisoner not being able to engage fairly in their parole review, please see the Intermediaries Guidance for further information.

Emotional Dysregulation

5.8 Emotional regulation is the ability to self-regulate one’s emotions. This includes being able to recognise feeling overwhelmed or a sense of losing control, and then taking steps to regain emotional control to be able to function in a more manageable state. Emotional dysregulation is the inability to do this.

5.9 Emotional regulation can be a particularly significant challenge for neurodivergent people. Social challenges, difficulty with change and sensory sensitivities as well as the additional anxiety may all lead to heightened stress and frustration. The inability to manage this can mean that small incidents or issues can escalate quickly.

5.10 Due to the sense of pressure and importance associated with parole hearings in particular, some prisoners (even those who are neurotypical) may show emotional dysregulation to varying degrees during their oral hearing.

5.11 Please see paragraphs 5.15-5.20 below for signs of, and ways to support, emotional dysregulation.

Sensory Overload

5.12 Sensory overload is when someone's senses take in more information than their brain can process. The body enters a heightened state of stress, which can trigger an individual's fight, flight, freeze, or fawn response[18].

5.13 Neurodivergent individuals are particularly prone to sensory overload, and can become easily overwhelmed by busy environments, bright lights, unfamiliar places, or sounds coming from multiple areas.

5.14 Panels should be mindful that the environment of a parole hearing could trigger sensory overload. This is relevant whether the hearing is in-person or remote; even over video stream, the prisoner could still be located in a potentially overwhelming environment.

Identifying and Supporting Emotional Dysregulation and Sensory Overload

5.15 There are a lot of similarities between signs of emotional dysregulation and sensory overload which can include:
- Irritability
- Restlessness, fidgeting and showing discomfort
- Getting overly excited or "wound up"
- Appearing distracted and showing difficulty when responding to questions

5.16 Further signs of emotional dysregulation can include:
- Tearfulness and crying
- Aggressive movements or raising their voice/shouting
- Impulsive responding, such as answering before the question is finished, or talking over others whilst they are speaking
- Questioning the point of their hearing or what they or others have to say
- Refusal or inability to engage with those in the hearing, or not trying
- Standing up and attempting to or leaving the room
- Increase in repetitive self-soothing behaviours

5.17 Additional signs of sensory overload can include:
- 'Stimming' - repetitive or unusual body movement or noises

[18] *Fight, Flight, Freeze, or Fawn: How We Respond to Threats (simplypsychology.org)*

- A persons urge to cover their ears or shield their eyes from sensory input
- Being hypervigilant of surroundings, including overreacting to loud noises, being jumpy or disproportionately defensive
- Higher levels than usual of sensitivity to sensory input, e.g., textures, fabrics, clothing tags, or other things that may rub against skin

5.18 What can help when someone is showing signs of emotional dysregulation or sensory overload:

- Awareness of the sensory environment
- Removing or reducing potential triggers
- Resources to help the prisoner manage their sensory input, e.g., ear defenders, or concentration aids (commonly known as fidget toys)
- Knowing self-regulation strategies
- Support from others to help the person de-escalate, such as encouraging the attendance of supportive relative at an oral hearing
- If necessary, requesting a short break for the prisoner to take time out, or talk in a space with low sensory input to support them to manage their sensory overload

5.19 What can make it worse:

- Other participants/attendees raising their voice in frustration
- Physically touching or restraining the prisoner
- Interrupting
- Mirroring any of the prisoner’s behaviours
- Showing frustration, annoyance, or impatience, etc
- Not taking a break or verbally addressing the situation when it is evident that a certain point of emotional dysregulation or sensory overload has been reached.

5.20 Please see Annex A for more information on potential adjustments.

Common Behaviours and Presentations

5.21 Panels should consider to what extent the factors that are commonly associated with neurodivergence (below) apply in individual cases, and whether the RMP has suitably identified proportionate support. Every individual is different, and so panels should bear in mind that factors which apply to one neurodivergent person may not apply to another, and a neurodivergent individual may experience or have experienced all or none of the below.

5.22 **Emotional dysregulation**: as outlined above, this is common in neurodivergent individuals. Panels may wish to explore to what extent an individual is able to self-regulate.

5.23 **Sensory overload**: as outlined above, the overwhelm associated with sensory overload can be particularly difficult for neurodivergent

individuals. Panels may want to assure themselves of the individual's internal controls, and that they have sufficient support in the community.

5.24 **Complex needs and trauma**: there is often a complex history of comorbid psychiatric conditions and past traumatic experiences. Rates of trauma are higher in neurodivergent populations, and this can exacerbate poor mental health[19], which could impact levels of risk. Panels may wish to explore this theme further and ensure the RMP has sufficient support in place. Please guidance on Trauma Informed Practice for more information.

5.25 **Vulnerability to exploitation**: some neurodivergent individuals will be more susceptible to manipulation or exploitation[20]. Panels may want to know what their support system looks like in the community, and how any risk of vulnerability to exploitation will be managed.

5.26 **Reward-seeking**: some neurodivergent individuals have deficiencies in their brain's reward system[21], which can result in reward-seeking behaviours, hyperactivity, and impulsivity.

5.27 **Obsessive**: this can present in neurodivergent individuals as persistent and recurring thoughts or images that are experienced as intrusive and distressing. Whilst it is not a defining characteristic of neurodivergence, panels may wish to explore if this is present, and if so, what controls are in place to support the individual.

5.28 **Rigid thinking**: this is a core feature of many neurodivergent conditions. Neurodivergent individuals can be particularly averse to change, complexity and challenge, and may struggle with compromise[22]. Panels may want to see if this is addressed in the RMP.

5.29 **Masking**: to minimise the negative impact of discrimination or social exclusion, neurodivergent people often use the strategy of masking. Masking is where a person makes a deliberate effort disguise their neurodivergent traits whilst simultaneously taking on traits deemed more acceptable to neurotypicals[23]. It can be conscious or unconscious, and the continued effort of masking for extended periods can be detrimental to mental health[24]. Panels may notice individuals appearing to respond to questions posed but the answers do not seem to make sense or are not relevant to the question asked. It is important for panels to consider that this may be a possible indicator of masking communication/language difficulties, rather than them being obtuse or evasive. Panels will want to

---

[19] *Association of Autistic Traits With Depression From Childhood to Age 18 Years | Depressive Disorders | JAMA Psychiatry | JAMA Network*
[20] *Autism spectrum conditions - Preventing Exploitation Toolkit*
[21] *Attention-deficit-hyperactivity disorder and reward deficiency syndrome - PMC (nih.gov)*
[22] *What does it take to be rigid? Reflections on the notion of rigidity in autism - PMC (nih.gov)*
[23] *Reconsidering autistic 'camouflaging' as transactional impression management: Trends in Cognitive Sciences (cell.com)*
[24] *"Don't treat autistic people like they're a problem, because we're not!": An exploration of what underpins the relationship between masking and mental health for autistic teenagers - UCL Discovery*

be mindful of this when reviewing cases, regardless of whether there is a diagnosis, as the use of predetermined social scripts in interactions could reflect what the individual thinks the panel wants to hear[25].

5.30 **Confabulation:** Confabulation is a type of memory error in which gaps in a person's memory are unconsciously filled with fabricated, misinterpreted, or distorted information. When someone confabulates, they are confusing things they have imagined with real memories and have a lack of awareness that a memory is false or distorted. They are not attempting or intending to deceive or lie. Confabulation can happen when a person is prompted to recall past events. As with all cases, panels should not solely rely on the prisoner's account of events without further exploration and substantiation of other evidence.

Neurodivergence in Women and Girls

5.31 Women and girls are disproportionately affected by misdiagnosis and late diagnosis[26]. The lack of screening and diagnostic tools that have been validated for use with women and girls, as well as the lack of prevalence data in women and girls, have likely contributed to late diagnosis and the scarcity of interventions for women and girls who are neurodivergent[27]. Panels should keep this in mind when scrutinising post-programme reports.

5.32 Research shows that neurodivergent traits can present differently in women and girls compared to men and boys, making diagnosis and understanding more challenging. There are many pressures on women and girls to behave a certain way to fit in socially. Some neurodivergent women and girls learn scripts to use in social situations and may develop a passive way of behaving with others that focuses on making the other person feel comfortable.

5.33 For example, autistic characteristics in women and girls may differ from those of other autistic people. They might seem to have fewer social difficulties than autistic men and boys, but this could be because they are more likely to 'mask' their autistic traits (though the stress of doing so can result emotional instability, anxiety and overwhelm). Some of the core characteristics of autism are having repetitive behaviours and highly focused interests. Stereotyped examples of these include rocking backwards and forwards, and a fascination with trains. However, in autistic women and girls these behaviours and interests may be similar to those of non-autistic women and girls, such as twirling hair and reading books, and as such may go unnoticed despite the greater intensity or focus that is typical for autistic people[28].

---

[25] *Camouflaging Intent, First Impressions, and Age of ASC Diagnosis in Autistic Men and Women | Journal of Autism and Developmental Disorders (springer.com)*
[26] *Journey to diagnosis for women with autism | Emerald Insight*
[27] *Neurodiversity in the criminal justice system: a review of evidence (justiceinspectorates.gov.uk)*
[28] *Autistic women and girls (autism.org.uk)*

5.34 ADHD can also present differently in different people. Sex and hormones may influence which symptoms are dominant, and gender norms (social norms for different genders) may force women and girls to mask and hide symptoms[29]. In both sexes, changes in hormone levels can influence ADHD symptoms.

5.35 **Panels should be mindful of the different presentations of neurodivergence in women and girls when considering behavioural reports.**

5.36 Neurodivergent women and girls are also disproportionately vulnerable to abuse when compared to neurotypicals[30]. Panels may wish to refer to the Trauma Informed Practice Guidance for more information.

Neurodivergence in Children

5.37 Children from lower socio-economic backgrounds (who make up a significant proportion of children in the CJS) are more likely to receive a diagnosis of social, emotional and mental health (SEMH) needs, rather than autism or speech, language and communication challenges. For many children, 'poor behaviour' has been seen as the diagnosis, without considering the underlying reasons[31].

5.38 Some children may experience challenges in a number of areas which interact and overlap, but the individual challenges may not be seen as severe enough to reach the diagnostic criteria. For example, a child may have difficulties with reading, attention and writing (challenges linked to three distinct neurodivergent conditions) but they may not receive a diagnosis of any specific condition. The reading challenges faced by the child may not be deemed 'bad enough' to gain a diagnosis of dyslexia, but they may still cause difficulties for the child when trying to read legal documentation. **Panels should assume that communication challenges could be universal and ensure that information is given in an accessible manner, remembering to check for understanding.**

5.39 Separate guidance has been produced on conducting parole reviews for children: Children's Guidance

[29] Understanding ADHD in Women (healthline.com)
[30] Hidden-Hurts-report-September-2020-Final.pdf (buckssafeguarding.org.uk)
[31] Neurodiversity – a whole-child approach for youth justice (justiceinspectorates.gov.uk)

6. Annex A[32]

Areas of Need: Cognition and Learning

Neurodivergent Condition	Description	In Practice
Dyslexia https://www.bdadyslexia.org.uk/ http://www.dyslexia-help.org/	Dyslexia is a learning difficulty that primarily affects the skills involved in accurate and fluent reading and spelling. Characteristic features of dyslexia are difficulties in: Phonological awareness – ability to recognise sounds within words (e.g. knowing which of these rhyme 'bake', 'bike', 'snake') Verbal memory – Remembering information that you have read or heard Verbal processing speed – Recalling information from your long-term memory in response to a verbal or written question It is important to note that Dyslexia occurs across the range of intellectual abilities. People can be born with Dyslexia, or it can be acquired as a result of traumatic brain injury, stroke or dementia.	**Reading:** • Confuses words that are visually similar such as cat and cot • Reads slowly • Re-reads information to understand it • Omits, repeats or adds extra words • Displays challenging behaviour when given a task involving reading (E.g. Following written instructions or reading safety information) **Writing:** • Spells the same word differently in one piece of work • Better answering verbally/talking than writing down information • Poor handwriting and/or writes very slowly • Difficultly with punctuation & grammar (e.g. Upper & Lower case) **Other:** • Avoid work that involves reading and/or writing • Find it hard to listen and maintain focus • Find it hard to concentrate if there are distractions • Doesn't know their left from right • Gets confused if given several instructions at once • Often forgets important information, conversations or dates • Regularly late • Find some tasks really easy but unexpectedly challenged by others
Potential Adjustments: • Use visuals alongside written information to help with understanding • Use bullet points and ensure text is spaced out well in documents and emails • Use font size 12+ in any documents or emails • Offer to print out any information on coloured paper • Give additional thinking or processing time, and break up information into small chunks • Check understanding regularly, and try not to overburden people with verbal distractions		

[32] *The information in this Annex has been collated using the Neurodiversity Staff Guide, produced by HMP Kirkham, amongst other resources that have been hyperlinked throughout.*

<table>
<tr><td colspan="3">• In written communication, prioritise important tasks first</td></tr>
<tr><td>Developmental Coordination Disorder / Dyspraxia

https://dyspraxiafoundation.org.uk/</td><td>Developmental Coordination Disorder (DCD), also known as dyspraxia, affects an individual's movement and co-ordination. It does not impact intelligence and can affect people of all intellectual abilities. People with dyspraxia may struggle with co-ordination in tasks such as playing sport, balancing or driving a car. Their fine motor skills may also be affected in tasks such as writing or using small objects. People with dyspraxia may also have ADHD, dyslexia, autism, difficulty with Maths, depression or anxiety.</td><td>Symptoms vary dependent on the individual and can change over time. Routine tasks may be difficult as dyspraxia can affect:
Co-ordination, balance and movement:
• Regularly trips and falls "Clumsy"
• Struggles to manage stairs quickly
• Difficulties keeping to own space, knocks into objects, knocks over items, walks into things/people
How the individual learns new skills, thinks, and remembers information:
• Takes speech literally
• Gets confused if given several instructions at once
• Difficulties sitting still and finds it hard to concentrate for periods of time
Daily living skills:
Difficulty dressing and undressing e.g. tying shoe laces, tie, buttons
Difficulty with measuring and pouring
Difficulty preparing meals
Fine motor skills:
• Handwriting is messy, poorly laid out and difficult to read
• Difficulty using specific equipment and tools that rely on motor skills, eg. Scissors, poor control of computer mouse
• Difficulties with sports and physical activities, eg. Ball skills.
• Difficulty stabilising materials with one hand whilst using equipment with the other, e.g. In woodwork, engineering, barbering
Functioning in social situations:
• Doesn't have many friends, difficulty working in a group, difficulty adapting to new situations, immature behaviour
• Dealing with emotions
• Time management, planning and personal organisation skills
• Lack of awareness of potential danger</td></tr>
<tr><td colspan="3">Potential Adjustments:
• Try to avoid overwhelming the person with information, and give them additional time to process what is being said
• Take regular breaks to support productivity and concentration
• Give simple, clear instructions and encourage the individual to write them down if helpful</td></tr>
</table>

<table>
<tr><td colspan="3">• Be aware that light, sound, smell and the feel of certain materials can cause dysregulation
• Encourage the individual to identify preferences and engage in helpful sensory techniques</td></tr>
<tr><td>Dyscalculia

http://www.dyscalculiaassociation.uk/

https://www.bdadyslexia.org.uk/</td><td>Dyscalculia is a learning difficulty defined as a specific and persistent difficulty in understanding numbers and specifically difficulties with number sense, e.g:

• Subitising – looking at a group of objects and recognising how many there are without counting them
• Symbolic magnitude comparison – looking at two numbers and knowing which is larger
• Non-symbolic magnitude comparison – looking at two groups of items and knowing which is larger without counting
• Ordering – placing numbers in ascending or descending order

People can be born with it or it can be acquired as a result of traumatic brain injury, stroke or dementia.</td><td>• Frequently late
• Difficulty doing mental maths
• Trouble handling money and keeping track of finances
• Difficulties telling time on an analogue clock
• Poor memory for anything number related – dates, phone numbers, facts
• Easily loses things
• Finds it difficult to remember names
• Gets anxious at the thought of doing maths
• Regularly runs out of time when doing a task
• Uses fingers to count
• Unable to remember math rules or times tables
• Struggles using/understanding dates – following use by dates</td></tr>
<tr><td colspan="3">Potential Adjustments:
• Check understanding at regular intervals, and allow extra time for responses</td></tr>
<tr><td>Learning Disability

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

A Learning Disability can be mild, moderate (MLD), severe or profound. It can be difficult to identify a mild learning</td><td>• Not talking about their history chronologically
• Confusion about times of appointments
• Difficulties in understanding and following instructions
• Difficulties in processing information quickly
• Poor planning and sequencing
• Repetition of phrases in conversation without expanding on content
• Not able to cope with more than one task at a time
• Difficulties in understanding information
• Problems with maths, reading or writing
• Learning new skills at a slower pace
• Problems with communication, such as speaking slowly or having a small vocabulary or mixing up or</td></tr>
</table>

	disability as the individual will often mix well with others and will be able to cope with most everyday tasks. Whereas people with a severe learning disability or profound and multiple learning disability (PMLD), will need significant care and support with areas such as mobility, personal care and communication. A Learning Disability can be caused due to difficulties before or during birth when the brain is still developing, or after birth due to early childhood illnesses, accidents or seizures.	consistently mispronouncing or misusing words
Potential Adjustments: • Give information using minimal words and short sentences • Use pictures and objects of reference when appropriate • Give the individual time to process information		

Areas of Need: Communication and Interaction

Neurodivergent Condition	Description	In Practice
Autism Spectrum Condition https://www.autism.org.uk/	Autism Spectrum Condition also known as Autism Spectrum Disorder and autism. Individuals with lower support needs have previously been called high functioning, though it should be noted that what looks like high functioning, is often just high masking. High masking individuals have previously been labelled as having Aspergers Syndrome (though this label is no longer used). Autistic savants are those with remarkable talents; Savant Syndrome occurs more often in	**Social Difficulties:** • Have little or no interest in other people, which can result in not having any real friends. • Not understanding people's emotions. For example, not understanding why anyone has been cross with them. • Seem not to realise the consequences of what they may have done. • Get anxious and upset about familiar situations and social events. **Communication & Interaction Difficulties:** • May need more time to process information. • Find it hard to understand how other people think or feel. • Take longer to understand information. • Do or think the same thing over and over. • Not being able to express themselves well. • Sometimes using many words when one would do. • Making up their own words. • Show unusual or no eye contact. • Flat affect or facial expression that does not match their internal state.

<table>
<tr>
<td></td>
<td>autism than other conditions.
Autism is a lifelong condition which affects how people communicate and interact with the world.
Autism is a spectrum and therefore individuals will have different areas of strength and difficulty the main consistent areas of need are:
• Social communication & Social interaction
• Repetitive & restrictive behaviour
• Over or under sensitivity to light, sound, taste or touch
• Highly focused interests or hobbies
• Extreme anxiety
• Meltdowns and shutdowns

The term “allistic” refers to someone who is not autistic. This is regardless of whether they are neurodivergent in other ways.

“AuDHD” is a term sometimes used to refer to someone who has both ASC and ADHD.</td>
<td>• Find it difficult to talk to others.
• Speak honestly, to the point of bluntness and rudeness.
• Seem anxious, agitated or even scared of you.
• Not being able to understand gestures and facial expressions or tone of voice.
• Saying odd things. For example, repeating your words back to you, time and time again.
• Using odd phrases and odd choice of words.
• Take words and phrases literally, so have difficulty understanding idioms.
• Behaviours sometimes occur as a way of communicating.
Behaviours:
• Odd mannerisms such has hand flapping or other unusual behaviours.
• Anger, aggression or frustration if routines are changed or where rules are not followed as previously set out. This may be relevant when faced with delays in processes.
• Actions may be repeated over and over again, such as rocking backwards and forwards.
• Special interests may develop at any age. They can be about unusual, specific, or ordinary things. It is the intensity of the interest, rather than the subject matter, which makes something a special interest. It is possible that special interests may develop that are adjacent to risk behaviours, but are not necessarily risky themselves.
• Show sensitivity to sound, light or touch.
Emotional Regulation Difficulties:
• Many people with autism will show signs of distress before having a meltdown.
• May exhibit signs of anxiety such as pacing, seek reassurance through repetitive questioning or show physical signs such as rocking.</td>
</tr>
<tr>
<td colspan="3">Potential Adjustments:
• Be mindful of strategies the person may be using to prevent meltdown, such as stimming, deep breathing, counting, etc.
• Where possible, remove potential meltdown triggers, and be aware that light, smells, sounds and materials may cause dysregulation
• If a meltdown does occur, give the person time to recover, calmly ask if they are okay and give them plenty of time to respond
• Don’t interpret no response as a failure to cooperate; increasing the amount of force in a demand could potentially escalate the situation
• Clearly explain the situation and what is expected of them</td>
</tr>
</table>

• Where possible, give prior warning if there are to be changes to pre-agreed situations • Keep language clear, concise and simple: use short sentences and direct step-by-step instructions, and allow extra time for the person to respond • Ensure questions are direct, clear & focused on one thing at a time. A person with autism may respond to your question without understanding the implication of what they are saying or may agree with you because they think this is what they are supposed to do • Avoid assuming that if they repeat what you say, they are being rude or insolent. A response like that could be echolalia (repetition of they question or phrase), so check they have understood the question • Be aware that your behaviour or language may be confusing to someone with autism, in the same way that some autistic behaviour may be unexpected to you • Avoid using sarcasm, figures of speech or irony. They may take things literally, causing misunderstandings • Don't interpret the person avoiding or giving excessive eye contact as rudeness or a cause for suspicion • Don't attempt to stop the person from flapping, rocking, or making other repetitive movements as these can be self-calming strategies. Some people who are neurodivergent, especially those who are late-diagnosed or self-diagnosed may not be aware that they have sensory needs or be able to articulate them. In these instances, trial and error may be needed		
Developmental Language Disorder https://radld.org/	Developmental Language Disorder (DLD), previously known as specific language impairment (SLI), means the individual has significant, ongoing difficulties understanding and/or using spoken language. There is no obvious reason for these difficulties, for example, there is no hearing problem, physical disability or known condition (e.g. Autism) that explains them.	**What it looks like:** • Finds it difficult to come up with the word they want to say or feels like the word is 'on the tip of their tongue' • Substitutes related words when talking, even if they don't mean the same things (eg. Says "table" instead of "chair" or "beef" instead of "Chicken") • Switches sounds within words without noticing • Forgets words or says them out of order • Doesn't understand jokes; takes everything very literally • Finds it difficult to focus on what someone is saying, particularly if there is background noise • Finds it difficult to answer questions about what was just said or answer direct questions • Finds it difficult to keep up with conversations • Unable to follow multi-step verbal instructions • Acts impulsively & doesn't seem to think through the consequences of their actions **What it feels like?** It is different for everyone, but people describe it as: • It's like when you are half asleep & you can hear what someone says, but your brain feels too sleepy to do anything with the stuff you heard and then it leaves your head • You have ideas and know what you want to do and how, but you can't seem to explain yourself. You get muddled. Or you think

		that you've explained it and the other person is muddled. It's hard to get ideas to make sense to both of you • I can't remember jokes or explain the plot in films • Getting people's names right is a nightmare – especially ones with similar sounds like Sarah and Sharon • For me, I get my thoughts mixed up if I have two thoughts in my head. I once said that I'd put the butter in the car because I was answering a question 'where's the butter?' but thinking about the car • Well, I just couldn't say what I wanted and then I got bullied – so I just used my fists – it was easier • I always have to write myself a note to help me remember

Potential Adjustments:

- Get the person's attention by sitting at their level (or get eye contact), saying their name & getting them to look
- Offer regular breaks to give the person the best opportunity to remain engaged
- Reduce your language by using simple, concise sentences, as longer or more complicated sentences can be hard to follow
- Where possible or relevant, try to say things in the order that they will happen, or describe events in chronological order. For example, instead of "before being released from prison, you will need to complete XYZ" you can say "you will need to complete XYZ before being released from prison".
- Slow your speech down to give the person a chance to think or process what is being said
- Check the person has understood what you have said. Do not ask "have you understood?" as the person may just agree to avoid embarrassment. Instead, you could ask them to repeat back to you in their own words
- People with DLD often don't make links between words. Link new or harder words to simpler ones. For example, "in a search we discovered fermenting liquid – that's the prison term for hooch"
- If a sentence comes out in a muddle & there are grammatical errors, don't say they are wrong. Say it back for the person to hear with the errors corrected. This is called **recasting**. For example, if the person says "I went to see the Keyworker tomorrow", you could reply with "okay, you're going to see your Keyworker tomorrow"
- It can be hard for people with DLD to remember words. It's like they are stuck on the tip of their tongue. Here, you can offer choices, for example if the person is struggling to answer "who did you meet with?" you could offer "was it your Keyworker, or the POM?"

Areas of Need: Social, Emotional, Mental Health and Executive Functioning

Neurodivergent Condition	Description	In Practice
Attention Deficit Hyperactivity Disorder (ADHD)	Attention Deficit Hyperactivity Disorder is considered a mental disorder affecting children and adults. It can include inattention (not being able to keep focus),	Not everyone with ADHD will present with all these features, but they are an idea of some features we may see:

https://adhdfoundation.org.uk/	hyperactivity (excess movement that is not fitting with the setting) and impulsivity (hasty acts that occur in the moment without thought). **How are ADHD and ADD different?** Attention Deficit Disorder includes similar presentation as those with ADHD but without the hyperactivity aspect. Some consider ADHD as the disorder and ADD as a subset of this. **Treatment Options** <u>Pharmacological treatments (medication)</u> • Stimulants are believed to work by increasing dopamine levels in the brain. Dopamine is a neurotransmitter associated with motivation, pleasure, attention, and movement. For many people with ADHD, stimulant medications boost concentration and focus while reducing hyperactive and impulsive behaviours. <u>Non-pharmacological treatments – psychological, educational, occupational</u> • Psychoeducation: helping the person to understand their ADHD and how to manage it • Psychological: neurocognitive intervention that addresses offending behaviour, ADHD, and other behaviour related co-morbid deficits (e.g., difficulty time-keeping, organising, planning, and self-regulating emotions and behaviour). Short programmes (less than 4 months) are best, with small numbers (10-12), running once or twice a week. R&R2ADHD is a treatment programme based on CBT designed to build pro-social competence. Completed in 2 months, consisting of 15 treatment sessions deliverable up to 2x per week. Has been	• Hyper focus – when full engaged with something of interest, they are motivated and engage well. They do however become unaware of other things around them • The lack of focus in when they are expected to engage in tasks they are not interested in/not motivated to engage with – the mind can't focus, it lacks order **Inattentive:** • Often has trouble staying focused on a task • Doesn't pay close attention to details or makes careless mistakes • Has trouble organising tasks or activities (misses deadlines, regularly late) • Is easily distracted • Doesn't follow through on instructions or fails to complete work/activities • Often forgets routine chores (returning phone calls, appointments) • Avoids tasks that require long periods of mental focus • Regularly loses or misplaces things • Doesn't appear to be listening even when spoken to directly, and often seems to be daydreaming when spoken to • Often moves on and starts a new task before finishing old ones **Hyperactive / Impulsive:** • Often has trouble staying focused on a task • Doesn't pay close attention to details or makes careless mistakes • Has trouble organising tasks or activities (misses deadlines, regularly late) • Is easily distracted • Doesn't follow through on instructions or fails to complete work/activities

	piloted at HMP Feltham. Other approaches which may be helpful include DBT and cognitive remediation therapy (CRT). • There is research to support the benefits of CBT when combined with medication, with some improvement in co-morbid features such as anxiety, depression, anti-social behaviour and social functioning.	• Often forgets routine chores (returning phone calls, appointments) • Avoids tasks that require long periods of mental focus • Regularly loses or misplaces things • Doesn't appear to be listening even when spoken to directly, and often seems to be daydreaming when spoken to • Often moves on and starts a new task before finishing old ones
Potential Adjustments: • Minimise distractions where possible • Be clear on structure and timing • Offer regular breaks to give the person the best opportunity to remain engaged • Reduce your language by using simple, concise sentences, as longer or more complicated sentences can be hard to follow • Ask if it would be helpful to have questions written down as well as spoken		
Tic Disorder https://www.tourettes-action.org.uk/	Tics are irregular, uncontrollable, unwanted, and repetitive movements of muscles that can occur in any part of the body. Movements of the limbs and other body parts are known as motor tics. Involuntary repetitive sounds, such as grunting, sniffing, or throat clearing, are called vocal tics. Tics are often just the tip of the iceberg, and the individual may have many other underlying conditions, experiences and difficulties. The two main tics in adults are: **Tourette Syndrome:** • Complex neurological disorder and it is the most severe and least common tic disorder • Characterised by multiple tics, both motor and vocal **Persistent or Chronic Motor or Vocal Tic Disorder:** • Characterised by a person who displays either motor or vocal tics, but not both	**Motor Tics:** • Quick eye blinks or eye jerks • Tongue movements, including sticking out the tongue • Head twitches or head jerks • Squatting and hopping • Shoulder shrugs • Facial grimacing • Touching people or things • Obscene gesturing or gyrating movements **Vocal Tics:** • Facial grimacing • Touching people or things • Obscene gesturing or gyrating movements • Facial grimacing • Touching people or things • Obscene gesturing or gyrating movements • Facial grimacing • Touching people or things • Obscene gesturing or gyrating movements Symptoms of tic disorders may: • Facial grimacing • Touching people or things • Obscene gesturing or gyrating movements
Potential Adjustments: • Where possible, ignore the tics		

- Be aware that if the individual is tic-ing they are unlikely to be able to listen to and understand what you are saying
- Offer regular breaks to give the person the best opportunity to remain engaged
- Ask questions using simple, concise sentences

Areas of Need: Sensory and Physical

Neurodivergent Condition	Description	In Practice
Acquired Brain Injury www.headway.org.uk/effects-of-brain-injury	Each year, around 350,000 people are admitted to hospital in the UK with an acquired brain injury, with an estimated 1.3 million people living with a disability as a result (Centre for Mental Health, 2016). A brain injury, the effects of which can often be hidden and misunderstood, can include difficulty managing behaviour and controlling one's anger, as well as the ability to process and retain information or instruction. Acquired brain injury (ABI) refers to any brain injury sustained since birth. This includes strokes, infections, tumours, poisoning, oxygen deprivation and traumatic brain injury (TBI). The most common causes of TBI are violent assaults, domestic violence, road traffic collisions, falls, and accidents in the workplace. How many people in prison have a brain injury - Research indicates that more than half of people in prisons may have had a traumatic brain injury. Survivors of brain injury are vulnerable and may be easily led astray and exploited. Brain injury survivors will frequently experience difficulties with substance misuse and mental health issues, including	No two brain injuries are the same. The effects of brain injury are wide ranging and frequently hidden. Many survivors will lack insight and awareness into their difficulties making it hard to identify and provide appropriate support. Some of the effects of brain injury that may have an impact on a survivor's journey through the criminal justice system and life in prison include, but are not limited to: • Memory problems - Can lead to a survivor finding it difficult to follow a daily routine, remember rules, regulations and instructions; • Attention & concentration difficulties - Can affect a survivor's ability to follow and take in information; • Impulsivity and lack of self-control - May lead to displays of inappropriate behaviour and confrontation; • Anger & irritability - May result in explosive outbursts; • Information processing difficulties - May result in slower verbal and physical responses that could be misinterpreted as evasive or uncooperative behaviour; • Communication difficulties - Can make it difficult for a survivor to understand others or articulate their own needs or views; • Fatigue - One of the most commonly experienced & most debilitating effects of brain injury, can impact every aspect of a person's day-to-day functioning and may result in the survivor appearing lazy or disinterested; • Executive functioning deficits - Impacts a survivor's ability to

	anxiety and depression. They are also at increased risk of self-harm and suicide.	problem solve, plan, organise and think flexibly; • Epilepsy - May result in seizures and require medication.

Potential Adjustments:

- Where possible, in advance, reach out to those supporting the person (POM, healthcare, etc.) to gain a better understanding of how their functioning is affected by the brain injury
- Use this information to make reasonable adjustments. They will likely vary from person to person as brain injury affects people in different ways
- There may need to be specialist assessment to help the person and those supporting them to understand difficulties and what might help. This is the responsibility of the prison
- Consider whether an intermediary is required
- Offer regular breaks to give the person the best opportunity to remain engaged
- Ask questions using simple, concise sentences