Deacon, Lesley, Colley, Louise, Bell, Natalie, Robson, Andrew, Yoxall, Anna, Salked, Lindsey, Mortimer, Lucy, Aspray, Kate, Rankin, Colette and Rodwell, Chantahl (2025) “It’s about adapting to the person not the label”: Exploring social care practitioners’ understanding of neurodiversity. Project Report. University of Sunderland. (Unpublished) sure@sunderland.ac.uk.

Facilitated Practice-based Research (© University of Sunderland) Report

“*It’s about adapting to the person not the label*”: Exploring social care practitioners’ understanding of neurodiversity

Practice Research Project Team consisting of Social Care Research Ambassadors, educators and researchers (in alphabetical order):
Kate Aspray, Natalie Bell, Louise Colley, Lesley Deacon, Lucy Mortimer, Colette Rankin, Andrew Robson, Chantahl Rodwell, Lindsey Salkeld and Anna Yoxall

MAY 2025

EXECUTIVE SUMMARY: The purpose of the report is to share findings from a small-scale exploratory qualitative research study conducted by a group of Social Care Research Ambassadors who participated in a Facilitated Practice-based Research project. The aim of the inductive exploratory study is to understand social care workers' current knowledge and practice experiences concerning neurodiversity. The title for the study emerged through a group of social care workers (including social workers and occupational therapists) participating in the 2024/5 Facilitated Practice-based Research cohort which is funded by the Regional Research Delivery Network NENC.

Conclusion: The analysis reveals inconsistencies in practitioners' understanding of neurodiversity terminology, with confusion between terms like 'neurodiverse' and 'neurodivergent'. Despite this, there is a positive perception of neurodiversity as an identity. Practitioners observe various forms of neurodivergence and note challenges in accessing services due to misdiagnosis and long waiting lists. Strategies for supporting neurodivergent individuals include tailored communication and more time for processing information. However, there are concerns about time constraints and a significant gap in formal training. Addressing these issues is crucial for improving support in social care settings. Further research and training initiatives are recommended.

Recommendations: Based on the findings from the report on neurodiversity in social care, the following recommendations are aimed at enhancing the support for neurodivergent individuals:

Training and education

1. Develop comprehensive training programmes: Organisations should look to implement mandatory training programmes for social care practitioners that cover the fundamentals of neurodiversity, including the differences between the concept of neurodiversity and labels such as ASD, ADHD etc. This training should be regularly updated to reflect the latest research and best practices.
2. Involve neurodivergent individuals in training: Organisations should ensure that training programmes include input from neurodivergent individuals to provide authentic insights and practical advice on how to support neurodivergent service users effectively.
3. Specialised training for managers: Offer specific workshops for managers to help them understand and support neurodivergent employees and service users better.

Practice adaptations

1. Personalised support plans: Organisations should encourage practitioners to develop individualised support plans that cater to the unique needs of each neurodivergent person. This includes allowing more time for processing information and tailoring communication styles.

2. Flexible appointment scheduling: Organisations should implement flexible scheduling options, such as longer or shorter appointments based on each individual's needs, to ensure they can receive adequate support.
3. Focus on strengths and interests: Practitioners should take the time to understand neurodivergent individuals, as this can help build rapport and provide more effective support.

Organisational changes

1. Reduce time constraints: It is important that policy makers consider how to address the pressures of time constraints in social care work by advocating for policies that allow practitioners more time to work with neurodivergent individuals.
2. Promote a positive view of neurodiversity: Organisations and policy makers should shift the culture to view neurodiversity as a positive and affirming concept rather than a deficit. This can help reduce stigma and improve the overall support provided to neurodivergent individuals.
3. Improve access to services: Policy makers should work towards reducing the barriers to accessing services for neurodivergent individuals, such as long waiting lists and the need for formal diagnoses.

Further research

1. Conduct ongoing research: Continue to conduct research on neurodiversity in social care to identify emerging needs and effective practices. This research should involve neurodivergent individuals and be used to inform training and practice.
2. Evaluate training programmes: Regularly evaluate the effectiveness of training programmes and make necessary adjustments based on feedback from practitioners and neurodivergent individuals.

Introduction: This research project emerged through a group of Social Care Research Ambassadors (SCRA) engaging in a Facilitated Practice-based Research (FPR) (©University of Sunderland) programme with academic educators and researchers from the University of Sunderland. The aim of the SCRA scheme is to support social care practitioners in the North East and North Cumbria to develop experience and skills in research methods, processes and governance. It is a collaboration between the Regional Research Delivery Network (North-East and Cumbria) (RRDN NENC) and the University of Sunderland. The purpose of FPR is to support practitioners to reframe their practice skills as research skills, and to complete their own practice-based research (Deacon, 2022; 2023). During the programme, the cohort worked together to co-construct, design, implement and analyse a piece of practice research relevant to their shared organisations.

Research aim: The topic for the study emerged through a group of social care workers (including social workers and occupational therapists) participating in the 2024/5 cohort. The aim was to explore the how social care practitioners made sense of neurodiversity.

Research question: What do people who work in social care understand about the concept of Neurodiversity?

- How confident do practitioners feel in their knowledge of neurodiversity?
- What examples of neurodivergence do practitioners observe in their practice?
- How do practitioners adapt their practice to ensure the involvement of neurodivergent service users?
- What training and/or further research might be beneficial to improve knowledge and practice relating to neurodiversity.

Overview of current literature: Neurodiversity is a social justice concept that emerged through interactions within the autistic community in the 1990s (Botha et al., 2024), and this term was then used within the academic community by Judi Singer (1998). Over twenty years later a new critical paradigm of Neurodiversity Studies has begun to emerge (Rosqvist et al., 2020). *Neurodiversity* refers to the population, i.e. the population is neurodiverse, with the current largest group within this being referred to as *neurotypical*, and those who have 'perceived variations' from the majority in cognitive, sensory and emotional areas as *neurodivergent* (Rosqvist et al., 2020, p.1). Examples of neurodivergence are autism, ADHD, dyslexia, dyspraxia and sensory processing disorder (to name a few). Stenning and Rosqvist (2021) highlight that medical diagnosis of neurodivergence is just the starting point, and neurodiversity as a concept challenges the notion that being neurodivergent is inherently negative.

This pervading negative perception of neurodivergence, however, is problematic in practice environments, as workers within these spaces tend to take a deficit and risk view of neurodivergence. For example, in family law, Pickar (2022) highlighted that neurodivergent families are viewed as lacking capacity in some way, with their neurodivergence perceived as a risk. Also, Brown et al. (2023) found that autistic adults are likely to have more negative health outcomes than neurotypical adults and can struggle to access services. Torres et al.

(2020) explored how small involuntary movements increase with age for autistic people more so than for neurotypical people in similar age demographics, emphasising the need for a more nuanced and dynamic way of understanding the intersectionality of autism and ageing.

Benson (2023) highlights, however, that social care operates from a 'neuro-normative' lens whereby autistic traits, for example, are regarded suspiciously. The example was given concerning a girl, 'Lilly', and her desire to wear a 'onesie' all the time alongside her development of severe agoraphobia. For her mother the priority was supporting her daughter to leave the house, but because of the outfit she was perceived by others as not providing appropriate care for her child. When considering how assessment frameworks operate within social care, it can be observed that these perceptions are made through this neuro-normative lens (Benson, 2023). For example, using the *Framework for the Assessment of Children in Need and their Families* (DoH, 2000), when assessing parent/s' capacity, concepts such as 'emotional warmth' when seen through a neuro-normative lens could mean expectations of eye contact, hugs, physical affection, etc. However, children who are autistic or who have sensory processing difficulties may find these things unpleasant, and autistic parents may demonstrate emotional warmth differently. Social care workers might believe this parenting differently to be 'wrong', rather than appreciating what is necessary and 'normal' within a neurodivergent family. Milton (2012) referred to examples such as this as the 'double empathy problem', i.e. that their understanding of each other is missed. However, in social care environments this can become more problematic and more severe, seeing neurodivergent parents as a risk (Benson, 2023) rather than seeing neurodivergent people as having unique characteristics rather than deficits (Khan et al., 2022). There are additional benefits to taking a more positive view of neurodivergence, not least because it minimises discrimination against neurodivergent people, but also because, as Scavarda and Cascio (2025) highlight, embedding a neurodiverse-affirming approach within practice environments can have a positive impact on mental health and wellbeing.

Methodology and methods: Emancipatory Practice Development underpins the research focus of the FPR programme (Deacon, 2022; 2023). It emphasises the need for improving practice to be supported by a person-centred approach to access the voice of the person using the service (Deacon, 2022). The term 'service user' is used to refer to anyone who is accessing a service, so in the case of this project *social care workers* were the *service users.* A pragmatic approach was taken (Muurinen and Satka, 2020) to access their voice through the use of a qualitative approach in the first instance (Macdonald and Deacon, 2019). This enables the voice of the *service user* to come through more clearly, and can be followed up by wider surveys that take a statistical focus to test findings on a larger scale, to inform service provision. As the group of practitioners are diverse but all work within social care environments, and the funder covers the North-East, Yorkshire and Cumbria, these were the parameters that underpinned the decisions regarding focus and reach of the research.

Through a process of exploration the cohort chose focus group and interview as the preferred method for data collection. When exploring the most appropriate method for the participant group, cohort members were mindful of the potential for neurodivergence among the population. A conscious neuro-affirming/neuro-inclusive approach was taken to offer both in-person/online interviews or focus groups depending on participant preferences. Prior to data collection taking place, interview questions were shared with all participants to allow for preparation. The questions emerged from a review of current literature alongside both practice and personal reflections.

1. What do you understand by the terms ‘neurodiversity’, ‘neurodivergence’ and ‘neurotypical’? (This is not a test, we are just trying to determine your knowledge and/or experience of it.)
2. What training have you received in neurodiversity, e.g. in education and in practice?
3. Do you see examples of neurodivergent people in your practice? If so, what does this look like?
4. How do you adapt your practice differently to meet the needs of neurodivergent people? Can you give examples?
5. How do you involve neurodivergent people in decision making? How much power do think neurodivergent people have in this? Does this feel authentic? Please give examples of what this looks like.
6. How confident do you feel in your knowledge and practice concerning neurodiversity?
7. What services are you aware of for neurodivergent people? Do you know neurodivergent people who have been able to access them?
8. Is there anything else you would like to tell us?

Ethics: Ethical approval was sought and received from the University of Sunderland Research Ethics Committee (application: 030169, 11 December 2024), as the academic host of the research.

Approach to analysis: A three-phrase qualitative thematic analysis was conducted using Braun and Clarke’s (2006; and Clarke and Braun, 2013) six-stage framework in each phase: familiarisation, coding, search for themes, reviewing themes, defining and naming themes, and writing up themes. The three-phase approach was necessary as a quality control measure to enable each member of the project team to engage in thematic analysis, to gain research experience and to share out the work of the project.

In Phase 1 each member of the practice research team analysed the transcript for the focus group they moderated or interviews they led. Each followed the six-stage framework for coding and submitted their findings, showing how they had come to decisions regarding identification of themes. In Phase 2 an experienced researcher in the project team conducted a quality assurance check, comparing each team member’s findings to the original data and combined the summaries together. Following this, in Phase 3 the same researcher conducted an overall six-stage framework analysis to code the themes in answer to the research questions.

Participants: Those who work in social care across the North-East, Yorkshire and Cumbria regions were invited to participate. There were a total of fifteen (n=15) who participated in the study. Two focus groups took place (n=7) and eight individual interviews (n=8). Participants’ professions included social work, social care, occupational therapy, mental health and youth offending. Eight identified as neurodivergent (n=8) with two declining to answer.

Code	Neurodivergent	Adult/Child social care	FG/I
P1	No	Adults	FG1
P2	Yes	Children	FG1
P3	Yes	Adults	FG1
P4	Yes	Adults	FG1
P5	Yes	Adults	FG1
P6	No	Children	FG2
P7	No	Both	FG2
P8	No	Both	I
P9	Yes	Children	I
P10	Yes	Adults	I
P11	Did not answer	Did not answer	I
P12	Yes	Adults	I
P13	No	Adults	I
P14	Yes	Adults	I
P15	Did not answer	Did not answer	I

Table 1. Participants' information based on consent form

Descriptive findings

The findings section is set out to answer each of the research questions.

Question 1. How confident do practitioners feel in their knowledge of neurodiversity?

The data analysis reveals inconsistencies in practitioners' knowledge of neurodiversity terminology, with terms like 'neurodiverse' and 'neurodivergent' often used interchangeably. When asked what neurodivergent meant, many practitioners were unclear. For example,

> *Neurodivergent, I must admit I am blanking on…* (P7)

> *I'm not actually sure…* (P6)

This was not just restricted to those who were not neurodivergent. For example, P11 is neurodivergent but identified themselves as neurodiverse:

> *I would classify myself as neurodiverse… I would classify neurodivergent and neurodiversity as anything that strays away from neurotypical* (P11)

Based on this data and other observations across social media and society, 'neurodiverse' appears to be becoming a commonly used term in place of 'neurodivergent'. As stated earlier, 'neurodiverse' refers to the whole population, i.e. everyone, with the current largest group being referred to as 'neurotypical' and those who have variations as being 'neurodivergent' (Rosqvist et al., 2020). This would not be problematic *per se,* except there is a need to use specific terms in specific contexts to explain meaning. For example, in

Universal Design using the specific term *neurodiverse* is meaningful, as the intention is to cater to *all* neurotypes, not just those who diverge from the 'norm', therefore it is aimed at being fully inclusive to the neurodiversity of the whole population (Milton et al., 2017).

When considering the underlying concept of neurodiversity, i.e. a social justice concept that celebrates human diversity in cognitive, sensory and emotional domains (Rosqvist et al., 2020), practitioners tended to demonstrate understanding of this. In general, they viewed neurodiversity positively, seeing it as an identity rather than a label, aimed at promoting acceptance and inclusion.

> *It's around difference, you know about appreciating the difference…* (P12)

> *Neurodiversity tries to increase acceptance and inclusion of people while at the same time, embracing differences* (P2)

There was broad agreement that it was the particular diagnostic term that was the label (i.e. with negative perceptions), and not neurodiversity in general. Neurodiversity, as a concept, was seen positively by the participants because it was perceived to be *enabling*. They suggested diagnoses were labels (such as Autistic Spectrum Disorder or ADHD), rather than neurodiversity, which was, for them, seen as a positive and affirming concept. Whilst participants acknowledged that there appeared to have been a shift in recent years, and that new knowledge was emerging around neurodivergence, they identified how this was still not embedded within their organisations (explored later). When considering how their knowledge of neurodiversity developed, they reported that this largely stemmed from personal, self-directed research or tacit knowledge, rather than from formal training. For example, participants gave examples of learning about their own diagnosis, or from their own interest.

> *I feel like if I wasn't told that I was probably neurodivergent, I wouldn't have looked into it. But yes, it's all my own research*. (P9)

> *I suppose for me, because I have an interest and because I work, you know, with people who are [neurodivergent] that I tend to maybe take my own research that way* (P12)

> *I think a lot of my learning has come through personal experience, but also, I guess, self-identified learning* (P2)

As well as personal research, practitioners referred to tacit knowledge concerning the development of their neurodiversity knowledge, for example, that expertise filters through from other professionals, e.g.

> *Whenever we suspect we've got a young person who either does or doesn't have a diagnosis, but we suspect… then [the Speech and Language Therapist] works with you* (P2)

This was an example given of working alongside, for example, psychologists or speech and language therapists. Practitioners identified that working with other professionals who had more expertise enabled knowledge to filter through. However, practitioners did not feel confident in their knowledge of neurodiversity or how to address it with others. For example,

> *I'm a little sensitive when other people, you know, if they're going through that journey as well, just being a little bit sensitive about it, because they did not expect it would have that impact on me.* (P9)

They gave the example of when it was first mentioned to themselves,

> *I was like, how very dare you, you know, and the idea of someone who is a learning disabled person, that's because the common misconception. And I think I felt a fool. No, I think I fell foul to that as well, you know. And so I think the embarrassment comes that I might offend someone. I think that that's where the embarrassment is. I don't want to offend someone.* (P9)

What they connected here was how there still appears to be a conflation where autism is being perceived as 'learning disabled'. Therefore, when practitioners raise the question of the potential for neurodivergence with someone, they felt they were, in effect, referring to them as being learning disabled. In reality they felt this meant they were referring to someone as intellectually challenged in some way.

Question 2. What examples of neurodivergence do practitioners observe in their practice?

Practitioners identified that neurodivergent colleagues experienced particular challenges within the workplace, because of the attitudes of other colleagues towards them, regardless of whether or not they identified as neurodivergent or not. Both neurodivergent and non-neurodivergent practitioners identified this as problematic. One practitioner in particular emphasised that they see examples of neurodivergence in their colleagues just as much as they see it in the service users, for example.

> *We see it in the family network. We see it in colleagues. I see it in myself.* (P2)

Practitioners also reported seeing how other colleagues talked about neurodivergent service users and how this made them feel uncomfortable about themselves. The below quote refers to how people with ADHD are perceived.

> *When my colleagues are talking about, oh, you know, the house is an absolute mess, and you know they're not remembering to take their meds, it's sometimes, it upsets me because I'm like, well, my house is a mess, and I sometimes forget to take my meds, you know?* (P9)

When considering examples of neurodivergence within their practice, practitioners identified concerns in how particular groups of neurodivergent people were being treated within different services. For example, those working with children and young people highlighted,

> *…a lot of these young people may present to police because I think a lot of the time they're misdiagnosed with offending behaviour when sometimes it's stress behaviours* (P2)

Relating to working within mental health services practitioners mentioned seeing an increase in misdiagnosis in the past:

> *For people who between ages 30-60, we're finding a lot of women often being diagnosed in the past with personality disorders or stuff like that, when actually we're on the [autistic] spectrum.* (P5)
>
> *I work in adult mental health and we see a lot of people, male and female, that come through that are of the older generation who are very typical, typically autistic, and has been have been missed, have paranoid schizophrenia labelled attached to them.* (P3)

Whilst these were specific examples, several practitioners talked of how challenging they were finding the issue as they were seeing an increase in people presenting neurodivergent needs but without a diagnosis.

> *The services in the area are diagnosis led. So you can't access anything without a diagnosis and the wait lists are so long.* (P4)

Practitioners also identified how in working with adults they had cases being referred to them for physical support needs, but then found they also had needs as neurodivergent people which also needed consideration.

> *I would say that I have been allocated around half a dozen in the last year where I have been allocated a case and have worked through the documents and the primary support needs are physical, but you can see there is a diagnosis for autism.* (P12)

Question 3. How do practitioners adapt their practice to ensure the involvement of neurodivergent service users?

When considering how to adapt practice, practitioners reflected on a range of different approaches they had taken which they felt were helpful for neurodivergent people. Time, in particular, was a key issue. However, this could look differently depending on the individual/s they were working with. For example, more time may be needed to process information they received.

> *It's probably going to take more than normal. It's probably going to take several appointments, and you've just got to invest that time.* (P1)

P1 identified 'longer appointment' times might be needed, whereas P11 suggested shorter visits with 'spurts of interventions' depending on how long the person could tolerate. The most important aspect practitioners identified was to focus on the individual before them – as P11 suggested, ‘going at the individual’s… pace’.

Something practitioners said they found helpful in taking steps to understanding the individual was to

> *find out the hobbies and interests… one lad I went to, I think it was the second appointment when I realised that he played the guitar… and then that opened up a world of everything* (P1)

Tone and words were also considered, for example P1 suggested,

> *Sometimes I use terms like ‘petal’ and ‘love’ and it just rolls off my tongue and I have to make sure that I don’t when I go to see them because I just know for a fact that they just won’t like it* (P1)

They also suggested it can be helpful to ‘use short sentences and wait for the reply and listen carefully’ (P1) or to ‘lower [your] tone…’ (P3).

Practitioners reflected, however, on how it can be challenging in the context of busy practice and social care practitioners’ expectations:

> *I find some social workers, they get quite stressed because it's not progressing as quick as what they want.* (P5)

This presented a conflict for practitioners to balance the additional time needed for neurodivergent people with the restricted timescales placed on them to complete assessments. However, there was broad agreement from practitioners that there seemed to be more knowledge in children’s services than there was in adult services. One participant, for example, said:

> *we've done the Oliver Gowen McGowan training, but only the first stage. We haven't done the face to face yet.* (P5)

Practitioners also acknowledged that because they were struggling with their own perceptions of neurodiversity, as mentioned earlier, around the conflation with learning disability, they then struggled to adapt their own practice. Adaptations that were identified were to adapt to the person and not the label because there is a danger that labels ‘pigeonhole’ people (P3):

> *It's about adapting to that person and not going, first off that label, I was guilty in that instance of thinking she's not going to engage with me. This diagnosis label is different, because every person is different. This is the person and see what I get.* (P3)

The role of social care practitioners in planning and supporting therefore sits well alongside curiosity around people’s unique strengths and needs. For one practitioner,

> *you're constantly assessing, coming up with an assessment or hypothesis about something, but equally, I need to remind myself every now and again that I need to not assume. I need to ask what's best for them. This includes, for example, critiquing training or guidance that focus on one specific neurodivergent aspect.* (P2)

This was highlighted that

> *you're still pigeonholing that person and thinking, okay, so they're autistic, I've got to go alongside them, and I've got to change the way I'm doing things. I've got to make it easy to read when actually that might not be what they need. So these misconceptions around what actually is helpful for somebody who is, say, for example, autistic, or who has ADHD was not coming through that therefore the guidance is telling practitioners to adapt in one way, rather than actually acknowledging the individuality of the person.* (P3)

It was emphasised that, in effect, more time is what is necessary in order to actually be able to adapt practice to those individuals.

Question 4. What training or further research might be beneficial to improve knowledge and practice relating to neurodiversity?

Most of the practitioners acknowledged that training and knowledge were limited. They emphasised that it was important to actually involve neurodivergent people in service design and adaptation to ensure it was fit for purpose. For example, participants said the views of neurodivergent people in shaping services was 'a massive area for development' *(*P2). Largely, practitioners referred to there being no training. They referred to the previous training that they received within, for example, Social Work qualifications:

> *So being at universities, there was none whatsoever. So nothing in nothing as in nothing formal, nothing that you'd need.* (P9)
>
> *I took my training as a social work social work degree, like many, many years ago, and I don't remember ever being a thing then I qualified a very long time ago, about 23 years ago, we didn't touch on neurodiversity at all. We knew learning disability, we knew autism. We were still talking about Aspergers at that time, but there wasn't a huge amount that was spent on that. So I think a lot of my learning has come through personal experience, but I also guess, I guess self identified learning.* (P8)

Practitioners also suggested that when training was offered, it was not enough,

> *definitely not enough out there that was, and I'm someone that's researched it a lot for my own purpose.* (P9)

or that it was optional rather than being mandatory (P12). They identified that learning had to be self-directed or self-initiated (as shown in the discussion of Question 1), that they felt they were not given supportive knowledge from the top down. There was no standardised training, and therefore personal experience was dependent on how they adapted their own practice and how they understood neurodiversity.

> *I don't mind, because I'm interested in it but the onus does feel like I'm doing it on my own, rather than it being openly available to people within our council.* (P8)

However, those who were based in health-related social care fields such as occupational therapy, did identify that there was more training available.

> *When I was in education, I had a lot of training around autism, ADHD and lots of others, like dyslexia, dyspraxia, all sorts of things, lots of training, including an NVQ Level Three in autism. Since becoming an occupational therapist, I'm working with adults. We've done the council's mandatory autism training, but really that's that for all the training.* (P1)

So although practitioners had received training within professional development since qualifying, they did not have any in higher education. Participants suggested that the teaching in HE was largely on disability (learning disability, physical disability and mental health) rather than on neurodiversity, and they referred to having the Oliver McGowan training around autism but reported that they had not received the second part:

> *We've done the Oliver McGowen, but only that first stage, you know the one where you do the online stuff, we haven't done the face to face and all yet. There's a second stage and a third stage. Isn't that where you've got to be trained by an autistic person in the room face to face? We haven't done that.* (P3)

Specific training was seen as being needed, rather than broad training. For example, 'specific training around how to break things down into manageable steps' (P3), and training for managers: 'Our organisation has put on a neurodiversity workshop for managers' (P2).

Discussion and conclusion

The analysis has revealed inconsistencies in practitioners' understanding of neurodiversity terminology. Many participants struggled to differentiate between terms like 'neurodiverse' and 'neurodivergent', often using them interchangeably. Despite this confusion, there was a general positive perception of neurodiversity as an identity rather than a label. Practitioners reported observing various forms of neurodivergence among their service users, including misdiagnosis of other conditions such as personality disorders and schizophrenia. They noted that neurodivergent individuals often face challenges in accessing services due to a lack of diagnosis and long waiting lists. Social care practitioners identified several strategies for adapting their practices to support neurodivergent individuals. These included allowing more time for processing information and tailoring communication styles to meet individual needs. However, practitioners expressed concerns about the pressures of time constraints in their work. They further highlighted a significant gap in formal training related to neurodiversity and a lingering conflation of autism with learning disability, which presented challenges in supporting neurodivergent people. Many felt that training should involve neurodivergent individuals to ensure that services are designed to meet their needs more effectively.

Whilst there appears to be a growing awareness of neurodiversity among social care practitioners, significant gaps in knowledge, training and practice adaptations still remain. Addressing these issues is crucial for improving the support provided to neurodivergent individuals in social care settings. Further research and training initiatives are recommended to bridge these gaps and foster a more inclusive approach to service delivery.

Recommendations

Based on the findings from the report on neurodiversity in social care, the following recommendations are aimed at enhancing the support for neurodivergent individuals:

Training and education

1. Develop comprehensive training programmes: Organisations should look to implement mandatory training programmes for social care practitioners that cover the fundamentals of neurodiversity, including the differences between the concept of neurodiversity and labels such as ASD, ADHD etc. This training should be regularly updated to reflect the latest research and best practices.
2. Involve neurodivergent individuals in training: Organisations should ensure that training programmes include input from neurodivergent individuals to provide authentic insights and practical advice on how to support neurodivergent service users effectively.
3. Specialised training for managers: Offer specific workshops for managers to help them understand and support neurodivergent employees and service users better.

Practice adaptations

1. Personalised Support Plans: Organisations should encourage practitioners to develop individualised support plans that cater to the unique needs of each neurodivergent person. This includes allowing more time for processing information and tailoring communication styles.
2. Flexible appointment scheduling: Organisations should implement flexible scheduling options, such as longer or shorter appointments based on the individual’s needs, to ensure they receive adequate support.
3. Focus on strengths and interests: Practitioners should take the time to understand neurodivergent individuals, as this can help build rapport and provide more effective support.

Organisational changes

1. Reduce time constraints: It is important that policy makers consider how to address the pressures of time constraints in social care work by advocating for policies that allow practitioners more time to work with neurodivergent individuals.
2. Promote a positive view of neurodiversity: Organisations and policy makers should shift the culture to view neurodiversity as a positive and affirming concept rather than

a deficit. This can help reduce stigma and improve the overall support provided to neurodivergent individuals.

3. Improve access to services: Policy makers should work towards reducing the barriers to accessing services for neurodivergent individuals, such as long waiting lists and the need for formal diagnoses.

Further research

1. Conduct ongoing research: Continue to conduct research on neurodiversity in social care to identify emerging needs and effective practices. This research should involve neurodivergent individuals and be used to inform training and practice.
2. Evaluate training programmes: Regularly evaluate the effectiveness of training programmes and make necessary adjustments based on feedback from practitioners and neurodivergent individuals.

By implementing these recommendations, it is suggested that social care organisations can better support neurodivergent individuals and create a more inclusive and effective service environment.

References

Benson KJ (2023) ‘Perplexing Presentations: Compulsory Neuronormativity and Cognitive Marginalisation in Social Work Practice with Autistic Mothers of Autistic Children’, *The British Journal of Social Work*, 53(3): 1445–1464.

Botha, M, Chapman, R, Onaiwu, MG, Kapp, SK, Ashley, AS and Walker, N (2024) ‘The neurodiversity concept was developed collectively: An overdue correction on the origins of neurodiversity theory’, Autism, 28(6): https://doi.org/10.1177/13623613241237871.

Braun, V and Clarke, V (2006) ‘Using Thematic Analysis in Psychology’, *Qualitative Research in Psychology,* 3: 77–101.

Brown L, Aitken R, Berry K and Gowen E (2023) *Ageing Well with Autism*, Innovation in Aging, 7(Suppl 1): 41.

Clark, T, Foster, L, Sloan, L and Bryman, A (2021) *Bryman’s Social Research Methods.* Oxford: OUP.

Clarke, V and Braun, V (2013) ‘Teaching Thematic Analysis’, *The Psychologist,* 26: 120–123.

Deacon, L (2023) ‘Facilitated Practice-based Research: A model of Empowerment to Reduce Research Anxiety in Social Work Practitioners and Reframe Cultural Capital’, *European Journal of Social Work Research*, 1(1): 102–117.

Deacon, L (2022) ‘Emancipatory Practice Development in Social Welfare Service Evaluation – a worked example’, *International Practice Development Journal*, 12(1): https://doi.org/10.19043/ipdj.121.008.

DoH (2000) *Framework for the Assessment of Children in Need and their Familes*. London: HMSO.

Khan, MH, Grabarski, MK, Ali, M and Buckmaster, S (2023) ‘Insights into Creating and Managing an Inclusive Neurodiverse Workplace for Positive Outcomes: A Multistaged Theoretical Framework’, *Group & Organization Management*, 48(5): 1339–1386.

Macdonald, SJ and Deacon, L (2019) ‘Disability Theory and Social Work Practice’ in M Payne and ER Hall (eds), *Routledge Handbook on Social Work Theory.* Oxford: Routledge.

Milton, D, Martin, N and Melham, P (2017) ‘Beyond Reasonable Adjustment’ in D Milton and N Martin (eds), *Autism and Intellectual Disability in Adults, Volume 1*. Shoreham-by-Sea: Pavilion.

Milton DEM (2012) ‘On the ontological status of autism: The “double empathy problem”’, *Disability & Society*, 27(6): 883–887.

Muurinen, H and Satka, M (2020) ‘Pragmatic Knowledge Production in Practice Research’ in L Joubert and M Webber (eds), *The Routledge Handbook of Social Work Practice Research.* Oxford: Routledge.

Pickar, DB (2022) ‘Considerations regarding child and parent neurodiversity in family court’, *Family Court Review*, 60(3): 492–506.

Rosqvist, HB, Chown, N and Stenning, A (2020) *Neurodiversity Studies.* Oxford: Routledge.

Scavarda, A and Cascio, MA (2025) ‘“Children should be raised like this”: A history of the neurodiversity movement in Italy and its implications for children’s well-being’, *Children & Society*, 39(1): 128–145.

Singer, J (1998) *Disability Discourse*. Maidenhead: OUP.

Stenning, A and Rosqvist, HB (2021) ‘Neurodiversity studies: Mapping out possibilities of a new critical paradigm’, *Disability & Society*, 36(9): 1532–1537.

Torres, EB, Caballero, C and Mistry, S (2020) ‘Aging with Autism Departs Greatly from Typical Aging’, *Sensors*, 20(2): 572.