Autism & Neurodivergence: Rethinking Access and Specialist Response

A comprehensive breakdown of presentation, clinical activity, and learning at Harmless CIC.

Caroline Harroe - CEO

HARMLESS

The Harmless Approach

Exceeding traditional mental health services through clinical depth and specialist understanding of neurodivergent needs.

Harmless is the centre of excellence for self harm and suicide prevention.
With lived experience at it's foundation, the service provides support, information, training and consultancy.
Delivers suicide crisis and bereavement services under 'The Tomorrow Project' and trauma services through 'Fearless'.

UNVEILING THE UNDERSERVED

47%

OF SERVICE USERS

A Significant Majority

Nearly half of all clients presenting in self-harm and suicide prevention services disclose neurodivergent traits or diagnoses. This highlights the critical need for neuro-specific service design that moves beyond standard "monolithic" care pathways.

54% of these individuals disclose Autistic traits, yet formal diagnosis remains elusive for most adults.

73% of presentations to crisis

ADAPTIVE SAFETY PROTOCOLS

Step 01: Training

Staff Empowerment

Harmless ensures that 100% of staff are comprehensively trained in autism-adapted safety planning, ensuring specialist response readiness.

Step 02: Screening

Universal AQ10

Every service user undergoes screening via the AQ10 tool to identify neurodivergent traits early in the clinical pathway.

Step 03: Adaptation

Specialist Response

Individuals screening positively are transitioned from traditional models to bespoke, autism-adapted safety planning.

AASP: THE CLINICAL INNOVATION

Autism-Adapted Safety Planning

CHOIR research led to the development of the AASP, which replaces neurotypical distractions with ND-congruent strategies:

- **Sensory Regulation:** Prioritizing "stimming," weighted blankets, or cold-water therapy.
- **Social Withdrawal:** Recognizing that solitude is often safer than "talking to a friend" during ND burnout.
- **Logic-Based Grounding:** Using factual interests to anchor the individual during crisis.

Why this exceeds other services:

"Most safety plans are dangerous for Autistic people because they suggest activities that increase sensory load. Harmless plans are built for the ND brain."

ADHD: MISDIAGNOSIS & OVERLAP

A qualitative study

Diagnostic Confusion

Traits such as impulsivity and emotional dysregulation frequently mimic presentations of BPD/EUPD and PTSD. This overlap contributes significantly to clinical confusion and delays in accurate support.

Gendered Barriers

Misleading "naughty boy" stereotypes hinder the recognition of ADHD in women and high-achieving individuals, who often experience internalised distress and exhaustion rather than external hyperactivity.

Research Learning: Diagnosis often brings a complex mix of relief/validation and deep grief for the "missed" younger self.

LIVED EXPERIENCE INSIGHT

> *"I look back at little me, and it breaks my heart because she struggled. All of that pain, that heartbreak, everything could have been avoided if someone... had actually listened to her."*

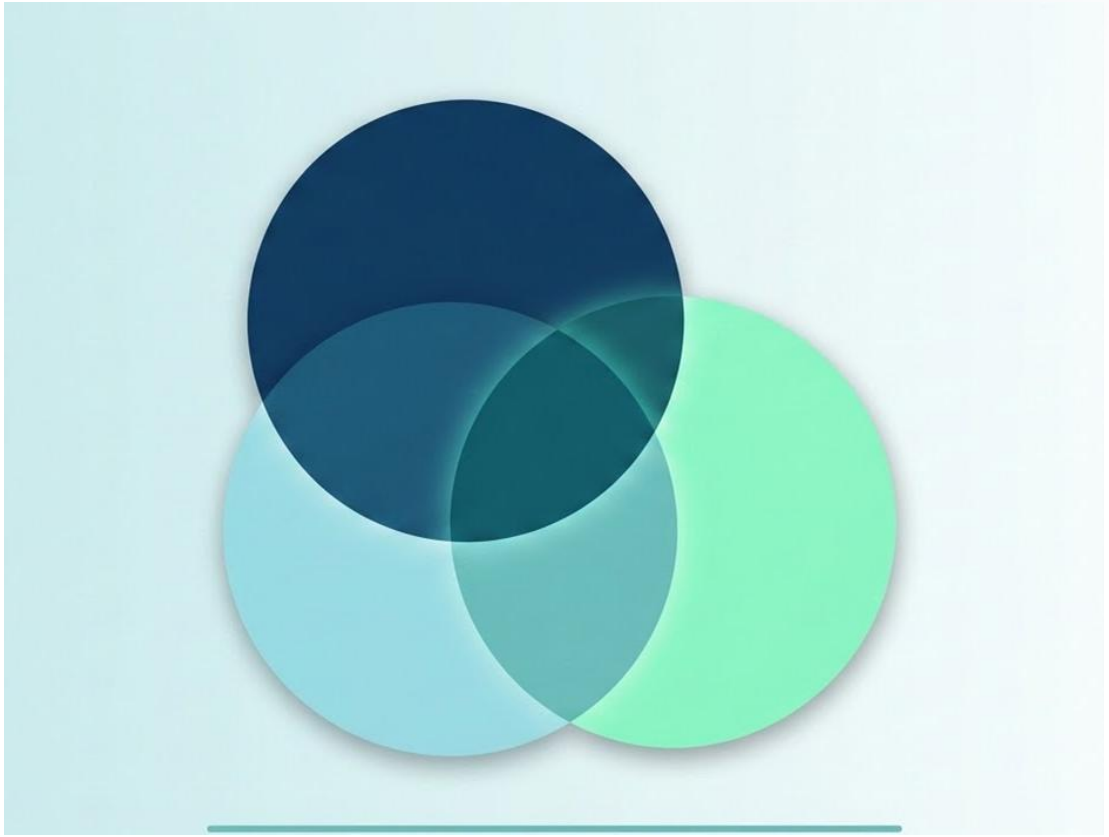
— Qualitative Participant on Late ADHD Diagnosis

THE AUTISM–BPD MISDIAGNOSIS GAP

A qualitative study

- **Critical Overlap:** 12.2% of autistic clients were previously diagnosed with BPD/EUPD, often obscuring neurodevelopmental needs.
- **Masking Hypothesis:** Autism is significantly underdiagnosed in cis-women and LGBTQIA+ individuals who may use "masking" to camouflage traits.
- **Gender Vulnerability:** 75.4% of BPD diagnoses in the study were cis-women, while cis-males represented only 7.1%.
- **Diagnostic Stigma:** BPD labels often lead clinicians to overlook sensory overload, interpreting it as "interpersonal instability."

> Only 22.8% of clients with a BPD label have a formal autism diagnosis.



THE COMORBID MENTAL HEALTH DIAGNOSTIC EXPERIENCE

- Depression & Anxiety (30.9%)
- None (24.5%)
- BPD / EUPD (12.2%)
- PTSD (9.4%)
- Depression (8.2%)
- Other (14.8%)

Systemic Impact: 38.6% of BPD-diagnosed individuals are unemployed. 35.6% experience unplanned discharge from services, often labeled as "unsuitable."

STRATEGIC SHIFTS IN SERVICE DELIVERY

Clinical Screening

Implement gender-informed screening for autism/ADHD in patients with severe emotional dysregulation, particularly for women and LGBTQIA+ clients.

Refined Criteria

Distinguish between BPD "outbursts" and autistic "meltdowns" caused by sensory overwhelm or burnout. Move beyond standard DBT for neurodiverse types.

Service Accessibility

Address high discharge rates by adapting clinical environments to reduce sensory overload and offering remote or home-based support options.

Holistic Integration

Integrate physical health support for co-occurring conditions (PCOS, chronic pain) which are disproportionately high in the BPD/Autism intersection.

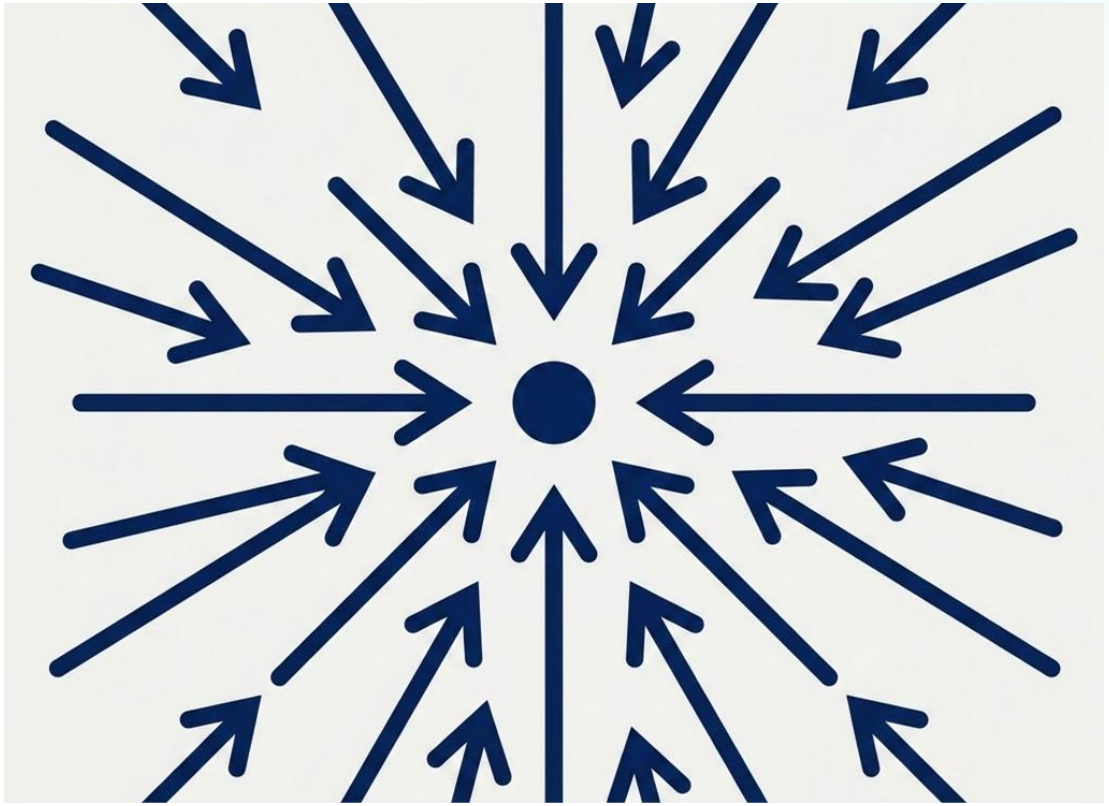
THE "NEUROQUEER" EXPERIENCE

A qualitative study

Intersectional Identity

LGBTQIA+ individuals are significantly more likely to be neurodivergent. This community experiences "Minority Stress" from multiple sources, exacerbated by daily ND-related challenges.

- Cumulative effect of discrimination.
- Self-discovery as a protective factor.
- Crucial role of community engagement.



IDENTIFIED BARRIERS IN STATUTORY CARE

The Sensory Barrier

Waiting rooms with fluorescent lights, ticking clocks, and loud voices can trigger "meltdown" before an appointment even begins.

The Communication Barrier

Therapies relying on abstract metaphors or "mindfulness" can be inaccessible for those with literal processing styles or aphantasia.

The Gatekeeping Barrier

ND individuals are often labeled as "too complex" for IAPT/Talking Therapies but "not ill enough" for Secondary Care.

The "Non-Engagement" Myth

Missed appointments are often due to executive dysfunction or phone-call anxiety, yet results in discharge from NHS services.

DRIVERS OF SUICIDE CRISIS

Isolation remains the **top reported driver** to distress, particularly within neurodivergent cohorts who often feel disconnected from meaningful support systems.

PROJECT SPOTLIGHT: THE CHOIR

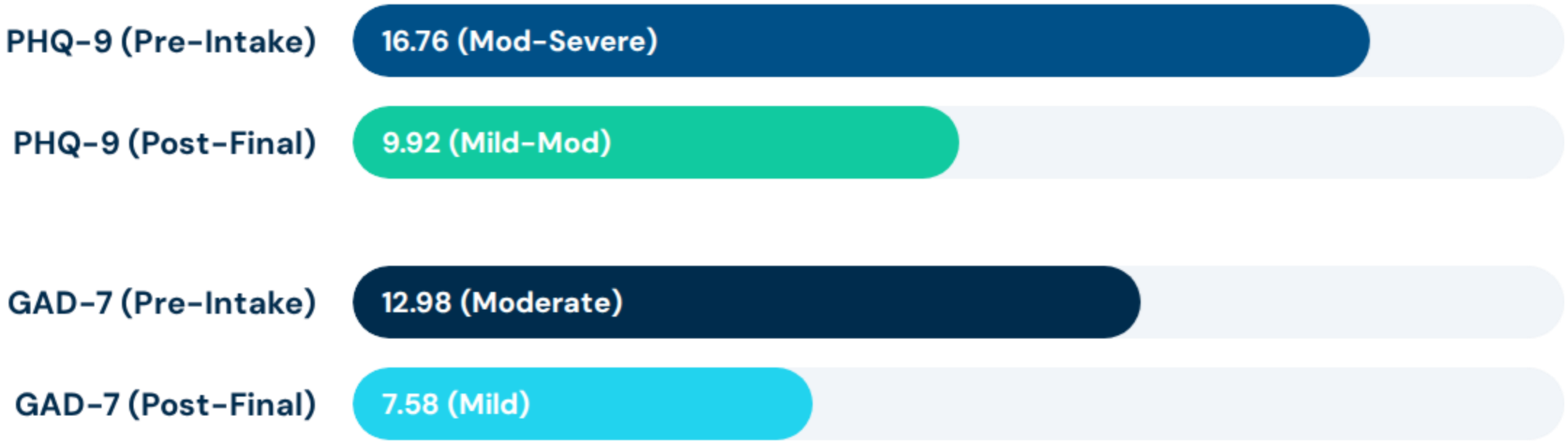
A community-based, sensory-aware intervention facilitating therapeutic return through connection and expression.

Stabilizes ND clients effectively via a **low-sensory, inclusive environment**, providing a disproportionately **high therapeutic return**.

Tackles Health Inequalities: This community-based modality directly addresses disparities in support for the ND demographic.

'Gold Standard' Approach: A specialist model demonstrating significant engagement where traditional services may fail, built for the ND brain.

CHOIR: Depression & Anxiety Impact



Clients experience a **41% reduction** in depression and a **42% reduction** in anxiety scores.

Statistical Evidence of Efficacy

Significance

Both metrics yield

$p < .001$

We reject the null hypothesis; distress reduction is highly significant.

Large Effect Size

Cohen's d: 1.03 (Depression) and 0.95 (Anxiety).

This indicates a full standard deviation of improvement.

Confidence

99.9% Confidence Level.

Strongest possible statistical evidence for service efficacy.

Comparative Recovery Velocity

58%

NET IMPROVEMENT (ND)

Eliminating the Recovery Gap

While the Neurotypical baseline shows a 39% improvement, Harmless's specialist model achieves **58%** for Neurodivergent clients.

The ND cohort enters with higher complexity (Mean 17.80) but exits with *lower* distress scores (Mean 7.50) than the general population.

THE HORIZON OF HARMLESS ND RESEARCH

Screening

Evaluation of AQ-10 for accurate autism screening in crisis.

Safety Plans

Implementation of Autism-Adapted Safety Plans (AASP).

Therapy RCT

Mentalisation-based therapy assessing efficacy for ND self-harm.

Physical Health

Investigating co-morbid physical health in neurodivergent users.

Specialist Excellence

Leading the way in neuro-specialist mental health response.

Visit: harmless.org.uk | Contact: caroline@harmless.org.uk

Partnered with Fearless Trauma Services CIC