Intersecting Needs: Neurodivergence, Gender, and Sexual Violence in Local Support Systems

A study of the local context of support for autistic young women and girls, and those with ADHD, who have experienced sexual violence and exploitation

Allnock, D. & Soares, C.

VRU | MAYOR OF LONDON VIOLENCE REDUCTION UNIT
advance
THE ROYAL BOROUGH OF KINGSTON UPON THAMES
University of Bedfordshire
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London's Violence Reduction Unit (VRU) has provided investment in local authorities to carry out research into local issues linked to violence. The funding has supported grassroots research, enhanced data analysis and enabled evaluations of innovative projects. The work provides a vital resource to local authorities to better understand local need, test potential solutions, share best practice, and makes an important contribution to the London evidence base. The VRU provides support to projects but does not have oversight of all research activities and outputs. Views or recommendations expressed in the reports should therefore be understood as the position of the researchers.

Acknowledgements

This research would not have been possible without the generous contributions of many individuals and organisations. We are deeply grateful to the seven young women and girls who shared their experiences with honesty and courage—your voices are at the heart of this work.

Special thanks to our partners at Kingston Council and Advance, national women's charity, for their collaboration, expertise, and commitment to improving outcomes for young women and girls affected by abuse and exploitation.

Advance approached us with a clear vision: to shine a light on the invisible needs of young women and girls (YWG), having identified a significant data gap in how this cohort is represented nationally. Together with Kingston Council, they recognised the silence surrounding neurodivergent YWG and the opportunity to explore and elevate the innovative practice already taking place in Kingston.

We would like to thank Achieving for Children (AfC) who were an integral part of the project from bid development through the journey of the project. Achieving for Children is a not-for-profit organisation that is focussed on supporting children and young people and provide children's services for Kingston Council.

We also want to thank all the professionals across education, health, social care, policing, and the voluntary sector in the Royal Borough of Kingston Upon Thames who gave their time and insights to this study through interviews or by completing our survey. Your reflections have been invaluable in shaping our understanding of the challenges and opportunities in supporting neurodivergent young women and girls.

Finally, we acknowledge the support of the London Violence Reduction Unit for funding this research and enabling a focus on this critical and often overlooked area.

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Executive Summary

This report presents the findings of a multi-method research study exploring how autistic young women and girls, and those with attention deficit hyperactivity disorder (ADHD), in the Royal Borough of Kingston Upon Thames can be better supported and protected from sexual violence and exploitation. Funded by the London Violence Reduction Unit (VRU), the study was undertaken via a partnership between Kingston Council, the Safer Young Lives Research Centre (SYLRC) at the University of Bedfordshire and the women's charity Advance.

Background and Purpose

Neurodivergent young women and girls - particularly those with autism and ADHD - face heightened risks of sexual exploitation and abuse, yet their experiences are often misunderstood, misdiagnosed, or overlooked. This study sought to understand the local context of support in Kingston, identify gaps and strengths in service provision, and offer evidence-informed recommendations for improving outcomes. Importantly, this report does not constitute an evaluation of practice. Rather, it presents practice insights based on professionals' experiences and perspectives which may reflect perceived rather than actual service delivery. These are valuable insights nonetheless which will enable leaders at Kingston Council to consider where improvements can be made.

Methodology

The research employed a multi-strand approach, including:

- Interviews with seven neurodivergent young women and girls with lived experience of sexual exploitation
- Interviews with 15 professionals across statutory and voluntary sectors
- A survey of 14 local services
- A case file analysis of five safeguarding cases
- Local data analysis

While the study initially took a broader view on both forms of neurodivergence that might be relevant and in its focus on sexual exploitation and domestic abuse, in reality, the interviews with professionals focussed closely on autism and ADHD as most relevant to their experiences supporting young women and girls; and the young women and girls who took part, and those represented in the case files, all were either autistic, or had ADHD, and had experienced sexual exploitation. Domestic abuse formed limited parts of the interviews with professionals.

This was a small, localised study of perceptions and experiences of practice, limiting the generalisability of the study (1) across other locales, (2) in relation to forms of neurodivergence other than ADHD and autism, and (3) in relation to forms of harm other than sexual violence and exploitation. However, the findings are likely to resonate across services and authorities in the UK and it is hoped that this report provides assistance to leaders and practitioners to examine their own practices and approaches.

Key messages

1. Lived experience of young women and girls in the research

These key messages derive from Chapters 4 and 5 of the report, emerging from recorded evidence in case files and from lived experiences recounted by young women and girls in interviews.

- **Neurodivergence shaped support experiences** - Sensory sensitivities, communication differences, and emotional regulation challenges influenced how young women and girls engaged with services.
- **Delayed recognition and fragmented support** - Neurodivergence was often identified late or not at all, leading to missed opportunities for early intervention.
- **Trust and emotional safety were critical** - Positive experiences were rooted in consistent, empathetic relationships where professionals adapted their approach.
- **Education settings were often harmful** - Bullying, exclusion, and misunderstanding were common. Specialist units were sometimes helpful but could feel isolating.
- **Police and mental health services re-traumatised** - CAMHS and police interactions were frequently described as distressing and disempowering.
- **Positive practice existed but was inconsistent** - Neurodivergence-aware and trauma-informed approaches underpinned some of the approaches by professionals who had contact with the young women and girls but were not systematically evident in their accounts of their experiences.
- **Identity and isolation were recurring themes** - Misunderstanding and stigma around neurodivergence contributed to emotional and social isolation.
- **Systemic gaps persisted** - Service thresholds, short-term models, and poor transitions left needs unmet and increased vulnerability.

2. Service provision & professional practice

Drawing on Chapters 3, 6–8, the study identifies key themes in professional and service-level responses that emerged from data and interviews from services and professionals we engaged with in Kingston Upon-Thames:

- **Early and holistic recognition of neurodivergence is essential** - Professionals need training to adopt a dual-lens approach integrating trauma and neurodiversity.
- **Relational continuity matters** - Frequent staff changes and short-term models undermine trust; new resources are needed to offset these limitations.
- **Practice must be personalised** - One-size-fits-all approaches fail neurodivergent young people. Communication, session structure, and environments must be tailored.
- **Trauma-informed care must be embedded** - Emotional safety, grounding techniques, and adapted therapeutic models are vital.
- **Support identity and belonging** - Validate experiences, avoid pathologising behaviours, and create safe spaces for peer connection and self-expression.
- **Promote advocacy and empowerment** - Professionals should act as intermediaries, support transitions, and co-design support plans with young people.
- **Engage families with cultural humility** - Address stigma, provide accessible resources, and support post-diagnostic journeys.
- **Intersectionality must be better accounted for** - Gender, race, and culture shape experiences and must be considered in support planning.
- **Social connection is protective** - Facilitate peer engagement through creative and informal spaces, while being mindful of sensory and emotional needs.

3. Strategic recommendations

The following represent strategic recommendations for Kingston Council to consider in improvements to provision for autistic young women and girls, and those with ADHD, who have experienced sexual violence and exploitation. Further practice- and service-focussed recommendations can be read in the report. Equally, these recommendations may be applicable to other councils and organisations more widely.

(1) Practice and Workforce Development

- Embed trauma-informed, neurodivergence-aware practice across services.
- Invest in intersectional training, especially for girls and culturally diverse populations.
- Provide practical, intervention-focused training tailored to short-term models.

(2) Service Design and Delivery

- Prioritise long-term, relationship-based models of care.
- Ensure referral pathways are inclusive and not diagnosis dependent.
- Offer structured pre- and post-diagnostic support.

(3) Systemic Reform

- Address diagnostic delays and fragmented transitions.
- Shift from diagnosis-led to needs-led models of support.
- Improve data collection and analysis on neurodivergent service users.

(4) Youth and Family Engagement

- Co-design services with neurodivergent young women and girls.
- Support families with culturally sensitive resources and guidance.
- Create inclusive, youth-led spaces for identity development and peer connection.

(5) Cross-Sector Collaboration

- Strengthen multi-agency partnerships and strategic panels.
- Share learning across sectors and integrate neurodivergence into safeguarding planning.

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1. Introduction and context

1.1 Introduction to chapter

Neurodivergent young women and girls face unique and often overlooked vulnerabilities that heighten their risk of experiencing domestic abuse and sexual exploitation (Brown-Lavoie et al. 2014; Franklin et al. 2024). In London's Royal Borough of Kingston Upon Thames (RBK), local data has revealed a disproportionate representation of neurodivergent females among victims of domestic and sexual violence, particularly those under the age of 25.

Despite growing awareness of neurodiversity, there remains a significant gap in understanding how the traits of neurodivergent conditions intersect with experiences of harm, and the effectiveness of support systems in relation to this. This study sought to attend to these identified gaps and build an understanding of the support needs and provision for neurodivergent young women and girls who have experienced domestic abuse and/or sexual exploitation in the RBK. This multi-method study involved local data analysis, interviews with a small sample of neurodivergent young females, interviews with a range of professionals who encounter and support young females with experiences of domestic abuse and/or sexual exploitation, a case file review, and a short survey of local services. Learning from these different elements of the study has built a picture of how support is delivered in the borough, the suitability of current approaches, and where there are opportunities for more inclusive, evidence-based support. A small scoping review of the literature was also undertaken and the findings from this research are placed within the context of this.

This chapter sets out the aims, objectives, set up and scope of the work, along with definitions of key terms relevant to the project. A summary of learning from the literature is also provided.

1.2 Research aims and objectives

The overarching aim of the research was to influence and improve the support provided to neurodivergent young women and girls who have experienced domestic abuse and/or sexual exploitation in the Royal Borough of Kingston Upon Thames.

The objectives were:

1. To examine what is already known about the experiences and support needs of neurodivergent young women and girls who have experienced domestic abuse and/or exploitation
2. To build a local profile of neurodivergent young women and girls in the borough who have experienced domestic abuse and/or exploitation

3. To explore the perspectives of neurodivergent young women and girls about their support needs and service experiences

4. To explore the experiences and perspectives of a range of professionals who strategically plan or directly deliver support to neurodivergent young women and girls and identify good practice

5. To understand the extent to which local services providing support to this cohort of young women and girls adapt their interventions and approaches to meet their specific needs

6. To map the journey through services of a small group of neurodivergent young women and girls

The research questions which guided this research were:

a. How can neurodivergent young women and girls be better supported and protected from domestic abuse and/or sexual exploitation?

b. How does neurodivergence intersect with experiences, risks, and support needs related to domestic abuse and/or exploitation for young women and girls in the borough?

c. Are the interventions and tools used with neurodivergent young women and girls who have experienced domestic abuse and/or exploitation evidenced in academic research as effective?

1.3 Funding and partnership

This research was funded by the London Violence Reduction Unit. It was undertaken by Kingston Council in partnership with the Safer Young Lives Research Centre (SYLRC)[1] at the University of Bedfordshire and Advance[2]. This partnership brought together the Council's expertise and knowledge of the local area, SYLRC's expertise on qualitative research and sexual abuse and Advance's expertise in support for women and girls affected by domestic abuse and other VAWG.

1.4 Definitions and scope

This section outlines the key terms and definitions used throughout this report.

Young women and girls

This project focuses on the experiences of young women and girls, defined here as individuals aged 14 to 25. Throughout the report, we use the term young women and girls to refer to this broad age group. When referring specifically to those under 18, we use the term girls.

In instances where participants - typically professionals - spoke more broadly about young people, but did not specify gender or gender identity, we use the term young people.

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[1] Safer Young Lives Research Centre | University of Bedfordshire
[2] Home - Advance Charity

Neurodiversity and neurodivergence

Neurodiversity can be defined as the neurological or neurocognitive variation naturally found in the brains of the human population. The concept of neurodiversity recognises cognitive differences as part of the broader spectrum of human diversity, rather than as deficits or disorders (Legault et al. 2021).

While often used interchangeably with neurodiversity, the term neurodivergence can more specifically be understood as a normative concept used to refer to someone whose neurological development and functioning (i.e. the way they learn, process, behave) diverges from what is considered ‘typical’ (Legault et al. 2021). Instead of suggesting a disorder, the term emphasises how society defines what is 'normal,' placing neurodivergent individuals outside those socially constructed standards.

There are several conditions that are categorised as neurodiverse such as: attention deficit hyperactivity disorder (ADHD), Autism Spectrum Condition (ASD), Dyslexia, Dyspraxia, and Dyscalculia. However, neurodiversity is complex. It encompasses a wide range of neurological and cognitive variations. What comes under the umbrella of ‘neurodivergence’ is contested and there are debates about whether mental health conditions should be considered neurodivergence at all. The term ‘conditions’ is itself challenged by some. There are also questions about whether a distinction should be made between congenital neurodivergence (those which are present from birth and includes conditions like, ASD, ADHD, or dyslexia) and those which are described as acquired neurodivergence - which relate to changes in brain function or cognitive processing that develops after birth, typically because of life experiences, trauma, illness, injury or other environmental factors (Black et al. 2024). Neurodivergent conditions can also very often co-occur, and many symptoms overlap. For example, research has found that between 20 and 65% of neurodivergent people are both autistic and have ADHD (Leitner, 2014; Chellappa, 2025).

The definitions provided below focus on the most relevant terms for this project, as they were the ones mentioned specifically by participants. These definitions are grounded in a social model of neurodiversity, which emphasises inclusion, acceptance, and the value of different ways of thinking and experiencing the world—rather than viewing these differences through a medical or deficit-based lens.

Autism Spectrum Disorder (ASD): A socially mediated neurodevelopmental condition characterised by differences in communication, sensory processing, and social interaction, which become disabling primarily due to social norms, expectations, and barriers (based on Legault et al. 2021).

Attention-Deficit Hyperactivity Disorder (ADHD): A condition characterised by differences in attention regulation, impulse control, and activity levels, which may become disabling when societal structures, expectations, and environments fail to accommodate diverse cognitive styles (Timimi, 2018).

Obsessive-Compulsive Disorder (OCD): A mental health condition characterised by intrusive thoughts (obsessions) and repetitive behaviours (compulsions), which are significantly influenced by learned behaviours, social modelling, cultural expectations, and interpersonal dynamics. Social learning theory suggests that individuals may develop OCD symptoms through observation of others' anxious behaviours, especially within family or cultural contexts that emphasise control, cleanliness, or perfectionism.

Pathological Demand Avoidance (PDA): A behavioural profile characterised by an extreme avoidance of everyday demands and expectations, often driven by high levels of anxiety. While not officially recognised as a standalone diagnosis in major diagnostic manuals like the DSM-5, it is widely discussed in the context of ASD conditions (PDA Society, N.D.).

Dyslexia: A form of neurodiversity characterised by difficulties with reading and writing which can be compounded by societal barriers, such as rigid educational systems, lack of accommodations, stigma and misunderstanding.

Sexual exploitation

We use the Department for Education (DfE) definition as expressed in its 2017 (p. 5) guidance:

"Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."

Domestic violence

We use the statutory definition of domestic abuse in the UK as it is set out in the Domestic Abuse Act 2021:

"Behaviour of a person ('A') towards another person ('B') is 'domestic abuse' if—
(a) A and B are each aged 16 or over and are personally connected to each other, and
(b) the behaviour is abusive."

Behaviour is considered abusive if it consists of any of the following:

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

It is also specified that it does not matter whether the behaviour consists of a single incident or a course of conduct. The Act also recognises children as victims if they see, hear, or experience the effects of the abuse.

1.5. Context and learning from existing literature

Estimated prevalence of neurodivergence

The estimated prevalence of ‘neurodivergence’ is 15% to 20% of the global population (Vo & Webb, 2024). In terms of some of the specific conditions, it is estimated that the global prevalence of ADHD in children is around 5% - although some studies in the United States suggest a prevalence rate of 8 -10% (Polanczyk et al. 2007). International studies also estimate 7% to 10% of children may have dyslexia (Wagner, et al. 2020).

In the United Kingdom, the estimated prevalence of ADHD is 5% (Polanczyk et al. 2007) and it is estimated that 10% of the UK population has dyslexia (British Dyslexia Association, 2024). Statistics suggest that around 3% of children aged 10-14 are thought to be autistic (O’Nions, et al. 2023), with Dyspraxia (a Developmental Coordination Disorder) estimated to affect 2% to 6% of children and Dyscalculia (a learning disability affecting a person’s ability to understand and work with numbers and mathematics) affecting an estimated 6% of primary school students.

These estimates provide a helpful indication of the prevalence of neurodivergence. Yet it is important to acknowledge that it is hard to accurately estimate this, given variations in the way neurodivergence is defined and understood. Further, there are demographic disparities which will also affect these estimates. Specifically, it is known that boys are more likely to be diagnosed with a neurodivergent condition than girls, who are at a greater risk of going undiagnosed (Young et al. 2020; Bargiela et al. 2016). Children from lower-income and minority ethnic backgrounds are also more likely to be undiagnosed or misdiagnosed (Vo & Webb, 2024).

Overview of the literature and limitations of the evidence base

At the outset of the study, we conducted a brief scoping review of the literature to map the evidence base on the ways in which neurodivergence intersects with and may heighten risks for sexual exploitation and/or domestic abuse - as well as the support needs of females with these experiences.

In terms of literature pertaining to neurodiversity and experiences of harm, there is a body of work relating to the relationship between adverse childhood experiences and neurodivergent status. A small number of papers were identified that discussed neurodiverse females or explored neurodiversity through a gendered lens. Likewise, some papers explored associations between neurodiversity and experiences of sexual abuse, domestic or interpersonal violence specifically. They provide useful learning and context to the current study; however, we found a paucity of literature specifically focused on neurodivergent females affected by domestic abuse and/or sexual exploitation and associated risks, experiences, and needs.

Limitations of the current evidence base are also acknowledged in the existing literature itself. For example, a systematic review of the literature on psychosexual orientation, behaviours and experiences in individuals with ASD or ADHD notes that methodological variability and issues between and within studies as well as retrospective reporting has hindered our full understanding of the psychosexual behaviours and experiences of those with these conditions (Young and Cocallis, 2023). Another scoping review looking at ‘cognitive impairments’ as a factor that may increase an individual’s vulnerability to exploitation also notes there are gaps in the literature regarding specific types of conditions and their relationship to exploitation, and to other demographic characteristics (Lambert et al. 2024).

The literature also acknowledges that there are few studies that offer comparisons between the neurodiverse and ‘neurotypical’ population, making it difficult to determine experiences that are distinct to neurodivergent individuals (Smusz et al. 2024; Young and Cocallis, 2023). Another significant gap in the evidence base is qualitative studies with neurodivergent young people themselves (Smusz et al. 2024).

Neurodiversity, violence and abuse

While limited, existing research does point to neurodivergent children and young people being at increased risk of sexual (and criminal) exploitation. A recent study exploring the trafficking and exploitation of children and young people within the UK with special educational needs (including Autism and ADHD) highlights this, and that more needs to be done to better identify and support children and young people with these needs and keep them safe from exploitation (Franklin et al. 2024). Other studies also suggest that neurodivergent females, are at greater risk of being a victim of severe violence during adolescence and young adulthood (Ghirardi et al. 2023) or at risk of sexual exploitation (Young et al. 2020).

Given the difficulties estimating neurodivergence (especially among females) and the fact that experiences of sexual and domestic abuse also often go unreported, it is difficult to accurately estimate the prevalence of neurodivergence among those affected by these specific experiences. However, a range of UK support services for children and young people experiencing exploitation have noted high proportions of neurodivergence amongst those they support (Ivison Trust, 2023).

Several studies (internationally) also help to build a picture of this. A population-based prospective twin study in Sweden exploring childhood neurodevelopmental disorders and risk of coercive sexual victimisation in childhood and adolescence, found that having a neurodevelopmental disorder (in general) was a vulnerability factor for coercive sexual victimisation and being actively targeted by perpetrators (Gotby et al. 2018). A study with youth aged 13-24 in the United States (n=269) who had experienced commercial sexual exploitation prior to age 18 found that the overwhelming majority (82%) had been diagnosed with a neurodevelopmental disorder or neurological impairment, or other mental illness or disorder and that 73% had more than one of these diagnoses (Rothman et al. 2024). Brown- Lavioe (2014) found that autistic individuals were 2-3 times more likely to experience unwanted sexual contact, coercion and rape compared to non-autistic adults. This is supported by Yau et al. (2023) who suggest autistic women experience increased vulnerabilities to sexual exploitation.

Deliberate targeting

In the UK, a survey of Police officers and health and social care professionals (n=717) exploring the attitudes and practices of key personnel towards domestic abuse experienced by women with intellectual disabilities, found that amongst both groups, there was a belief that this cohort of women were deliberately targeted by the abusers (McCarthy, et al. 2019). The belief that neurodivergent people are deliberately targeted by perpetrators is also echoed by Douglas and Sedgewick (2024).

Mechanisms for higher rates of violence amongst neurodivergent individuals

Researchers have tried to understand the mechanisms for the observed higher rates of victimisation among neurodivergent individuals. In their literature review, Young and Cocallis (2024) found that for those with ASD, social communication deficits such as the ability to understand and interpret social norms, cues and emotions, are thought to affect ability to successfully initiate sexual interactions, leading to what they term ‘socially inappropriate sexual behaviour’ (Young and Cocallis, 2023).

In the survey of police officers and health and social care professionals, those who felt women with intellectual disabilities were more vulnerable to abuse cited reasons such as ease of manipulation, limited support networks, social isolation, communication difficulties, a possible lack of awareness of what constitutes an abusive relationship, and poor ability to assess risk and harmful behaviour (McCarthy, et al. 2019). Brown-Lavoie et al. (2014) also identifies lower levels of sexual knowledge as a risk factor.

Discussing ASD symptoms, such as social and communication difficulties, Ghirardi et al. (2023) suggest that this may have opposite effects in males and females in terms of vulnerability to victimisation. They suggest, for example, that young women might become the target of violence because of their interpersonal difficulties, whereas for young men, having fewer interactions with others or even being socially isolated may protect them from contexts where violence may occur.

In one of the few studies that explores firsthand accounts of (adult) autistic people (n=24) about intimate partner violence and sexual assault, participants identified several themes in relation the mechanisms of this. These included a diagnosis of autism being used to target and manipulate them, and poor family structures that did not support them to recognise abusive behaviours. This study notes that while autistic people experience many of the same patterns of abuse as non-autistic people do, there are unique autism-related vulnerabilities and outcomes (Douglas and Sedgewick, 2024).

Identification and support

The existing literature offers little guidance on how to best support neurodivergent children who have experienced interpersonal trauma (Kalisch et al.2025) but there is a general perspective that better understanding of neurodiverse conditions particularly in females can support earlier identification, diagnosis and positive outcomes.

There are specific barriers that seem to hinder the recognition of neurodivergence in females. For example, Young et al. (2020) note there is increasing recognition that females with ADHD present a different set of behaviours to their ADHD male counterparts and that these are currently less well understood and identified. They suggest barriers to identification include symptomatic differences, gender biases due to stereotypical expectations, comorbidities and compensatory functions, which mask or overshadow the effects of ADHD symptoms. They call for a better understanding of ADHD in girls and women to improve their longer-term wellbeing and outcomes.

The need for more training for professionals is noted in several papers. Specifically, there is a need to better understand how trauma including sexual or domestic violence is experienced and affects disabled and neurodivergent females (Rothman et al. 2024; McCarthy, M et al. 2019). Literature highlights the need for a greater understanding of neurodiversity so that neurodiverse individuals can be better identified and supported (Douglas and Sedgewick, 2024; Franklin et al. 2024). There is also a call for more training that enables a strength and skills-based approach to support and interventions. Young et al. (2020) suggest that to effectively identify, assess, and support girls and women with ADHD, it is important to move away from the narrative of ADHD as a behavioural disorder and attend to the more subtle and/or internalised presentation that is common in females. They also advocate for a 'lifespan, multi-agency model of care to support females, noting that periods of transition can be a particularly difficult time for them.

In a study with 102 autistic adults examining the impact of interpersonal violence from their own perspective, and what helps or hinders their recovery, findings highlight the importance of considering the relationship between stigma and victimisation, and the relationship between trauma, masking, and burnout in autistic people. Reducing barriers to support and recovery are contingent on reducing structural inequality and again, providing better training about autistic people to frontline professionals (Pearson et al. 2023).

Educational services

One of the key support needs evident in the literature is around education. Franklin et al. (2024) assert that children and young people being able to engage in education services and have their needs met is one of the most significant factors in keeping children with special educational needs safe from exploitation. Research also indicates that autistic individuals receive less sexuality education than their 'typically developing' peers (Smusz et al. 2024) and that interventions aimed at increasing knowledge may be an important preventative tool for individuals with ASD (Brown-Lavoie et al. 2014). There is evidence of an appetite amongst neurodivergent young people themselves for more support/education around developing healthy relationships (Douglas and Sedgewick, 2024). Some victims and survivors said that they particularly valued support and information that would help them to recognise that they were subjected to abuse.

From this basis they could then consider what types of support they most needed (Domestic Abuse Commissioner, 2023).

Better support for parents of neurodivergent children is also a need identified in the literature. This includes support with their own mental health, managing their own emotions, and support to respond to their children's emotions and needs (D'Arcy et al. 2024; Kalisch et al.2025).

1.6 Structure of the report

This report is structured to provide an understanding of how neurodivergent young women and girls—particularly those with autism and ADHD—experience and navigate support systems following sexual exploitation or domestic abuse in the Royal Borough of Kingston Upon Thames. The report structure is as follows:

(1) Chapter 1 has introduced the research context, aims, and definitions, alongside an overview of the shape of the existing evidence base.

(2) Chapter 2 outlines the multi-methodological approach.

(3) Chapter 3 explores the profile of neurodivergence among girls who have experienced domestic abuse and sexual exploitation using Kingston data.

(4) Chapter 4 focusses on the journey through services of five neurodivergent girls who experienced sexual exploitation, analysing their case files to explore this journey.

(5) Chapter 5 centres the voices and lived experiences of seven girls, who are autistic or have ADHD, and who have experienced sexual exploitation to understand their experiences of services.

(6) Chapters 6 and 7 turn to the perspectives and experiences of professionals working with this cohort of young women and girls to understand the challenges in practice and promising practice described.

(7) Chapter 8 assesses internal service readiness, including workforce training and capacity.

(8) Chapter 9 consolidates structural and systemic barriers to effective support.

(9) Finally, Chapter 10 concludes with key findings and strategic recommendations for improving outcomes for neurodivergent young women and girls.

2. Methodology

2.1 Introduction to the chapter

This research employed a multi-strand methodology to explore the experiences and service provision for neurodivergent young women and girls affected by domestic abuse and/or sexual exploitation. The study was conducted through a partnership between Kingston Council, the Safer Young Lives Research Centre (SYLRC), and Advance. A brief scoping review was undertaken, alongside five distinct research strands, each informing the research questions through qualitative and quantitative methods. This chapter provides a more detailed overview of these methods along with some context around neurodiversity and harm as it pertains to the final dataset of the project. Ethical approval was sought and approved for all key stages of research from the University of Bedfordshire's Institute for Applied Social Research Institute Ethics Panel.

2.2 Understanding the scope of neurodivergence and experiences of harm in this research

Neurodivergence encompasses a broad spectrum of traits and experiences. Our initial approach was deliberately inclusive of this diversity, aiming to reflect the wide range of neurodivergent characteristics that services may encounter when supporting young women and girls affected by domestic abuse and/or sexual exploitation.

However, in practice, the data informing this research primarily relates to autistic young women and girls, and those with ADHD. For instance, all seven young women and girls in our sample were assessed as having traits associated with autism or ADHD. Similarly, the professionals interviewed predominantly reflected on their experiences supporting autistic girls and young women, or those exhibiting ADHD-related traits—patterns also echoed in the survey responses from local services.

Although there were occasional references to other forms of neurodivergence—such as dyslexia, obsessive-compulsive disorder (OCD), or pathological demand avoidance (PDA)—these were not consistently mentioned across the interviews or surveys or discussed in any depth. This may suggest that professionals either have limited experience supporting young women and girls with these conditions, or they may be less confident in identifying and addressing them. Other possible explanations include diagnostic overshadowing (focusing on more prominent or better-understood conditions) (Kanne, 2018), gendered differences in presentation, stigma or misconceptions surrounding certain diagnoses, systemic constraints such as time or resource limitations, and gaps in training or research that underrepresent these profiles in females.

In this report, when individuals referred to specific neurodivergent traits, such as autism or ADHD, we have used the name of the trait as expressed. Where references were more general and could not be clearly linked to a particular trait or condition, we have used the broader term neurodivergence.

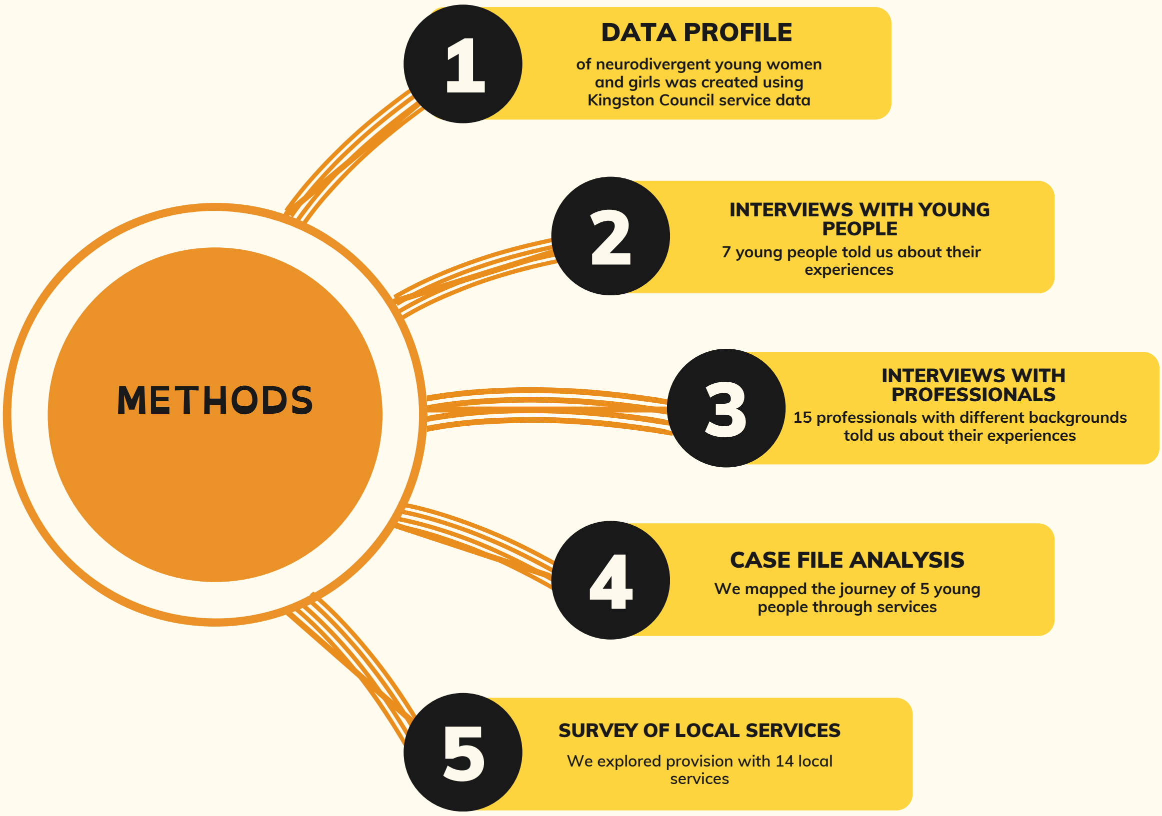
Finally, where general differences in cognitive processing were discussed, we use the term *neurodiversity.*

In a similar vein, both the young women and girls and professionals who participated in interviews primarily discussed experiences related to sexual exploitation rather than domestic abuse. As a result, the report predominantly reflects those experiences. Where relevant, references to domestic abuse have also been included.

2.3 Methodological overview

Figure 2a provides a visual representation of the methods used in this research, and a brief description of each stage follows. A full description of the methods can be read in Appendix A.

Figure 2a: Visual diagram of methodology



Strand 1: Local data analysis

Led by Kingston Council in collaboration with SYLRC, this strand aimed to build a local picture of neurodivergent young women and girls supported for experiences of domestic abuse and/or sexual exploitation using Children's Services contact data. Data from the Multi-Agency Risk Assessment Conference (MARAC) and the Vulnerable Adolescents Supported into Adulthood (VASA) Panel, based on small samples, was also analysed for insights.

Strand 2: Interviews with neurodivergent young women and girls

Seven autistic young women and girls, or young women and girls with ADHD all with experiences of sexual exploitation, participated in interviews. Recruitment was led by Kingston Council, with additional participants sourced by SYLRC, taking a flexible approach to promote participation. A risk and needs assessment approach enabled safe recruitment. The interviews were carried out by Kingston Council staff or by young people's support workers. The interviews explored the young women and girls' experiences of services and professionals. Ethical approval was obtained, and interviews were conducted using a flexible, needs-sensitive approach. Framework analysis was used to interpret the data, with participant voices featured in Chapter 5.

Strand 3: Interviews with professionals

The SYLRC researchers carried out online interviews with fifteen professionals from statutory and non-statutory services located in the Royal Borough of Kingston Upon Thames. Participants included social workers, health practitioners, police, educators, and voluntary sector professionals. Interviews explored their understanding of neurodivergence, support strategies, and challenges faced. Thematic coding and framework analysis were applied to the data.

Strand 4: Case file analysis/ Journey mapping

The SYLRC researchers developed a short survey for local services, distributed by Kingston Council to 17 local services; 14 completed it (82% response rate). The survey explored service characteristics, staff readiness, direct support practices, and challenges in supporting neurodivergent young women and girls and included both closed- and open-ended questions. Quantitative and qualitative analyses were conducted, and findings were integrated with other strands.

Strand 5: Survey of local support services

The SYLRC researchers developed a short survey for local services, distributed by Kingston Council to 17 local services; 14 completed it (82% response rate). The survey explored service characteristics, staff readiness, direct support practices, and challenges in supporting neurodivergent young women and girls and included both closed and open-ended questions. Quantitative and qualitative analyses were conducted, and findings were integrated with other strands.

3. Neurodiversity, experiences and risk in Kingston Upon Thames

3.1 Introduction to chapter

This chapter presents an analysis of contact and safeguarding data concerning girls and young women aged 13–25, in Kingston, with a particular focus on neurodiversity. The chapter explores:

(1) Descriptive analysis of Kingston Council children's services contact data for levels of neurodivergence present for young women and girls, aged 13-25 who have experienced domestic abuse and/or exploitation

and

(2) Insights from Kingston Council's Multi-Agency Risk Assessment Conferences (MARAC) and Vulnerable Adolescents Supported into Adulthood (VASA) Panel representing data on 17–25-year-old young women and girls in terms of patterns of engagement, risk, and support needs.

The data presented below was prepared by Kingston Council analysts for the purposes of this report. The datasets are brief snapshots, based on different, and short, date ranges, and both the MARAC and VASA Panel datasets are based on small sample sizes. Across all datasets, as there is likely under-recording of neurodivergence, the data should be interpreted with caution.

3.1 Kingston Council contact data; patterns among young women and girls aged 13 to 25

This data covers contacts recorded between 01/04/2025 to 09/07/2025. "Contact" data refers to records of interactions or engagements between young people (in this case, girls and young women aged 13–25) and Children's Services or other safeguarding teams.

Contact reasons were selected based on a comprehensive list developed through internal consultation in Kingston Council, including additions such as Domestic Abuse and Sexual Abuse. Appendix A (detailed methodology) includes the full range of contact reasons that formed the basis of the analysis. The wide range of contact reasons included was intended to capture the full spectrum of abuse experiences and avoid under-reporting of this cohort.

These contacts are logged in Kingston Council's Liquidlogic Children's System (LCS) and typically include:

- Initial referrals or reports (e.g. concerns raised by schools, police, health professionals, or family)

  - Follow-up visits or assessments
  - Safeguarding interventions
  - Welfare checks
  - Support planning or case management activities

Data notes (see more in Appendix A):

Young women and girls with autism spectrum disorder (ASD) were identified through analysis of structured disability fields in the LCS system and/or where they were recorded as having an Education, Health, and Care Plan (EHCP) or Special Educational Needs and Disabilities (SEND) involvement

ASD and Behavioural and Emotional Health needs (BEH) (which include ADHD, ADD or other behavioural and emotional needs) were grouped with corresponding EHCP needs (ASD and Social, Emotional, and Mental Health -SEMH-needs respectively) to better capture neurodivergent profiles.

Due to known under-recording in structured fields, EHCP data was included to improve identification accuracy.

Reasons for under-recording may be related to whether children's services staff have the full picture when initial contacts are made and/or are unlikely to record disabilities if they have not had sight of a written confirmation of diagnosis by a medical professional. The analyst producing this work noted that even if disability has not been recorded in the structured fields, it may be recorded in written comprehensive case summaries; however, this would require a significant amount of work to manually check case summaries for this information.

Table 3a shows that in the period between April 1, 2025, and July 9, 2025, there were 1,069 contacts involving 492 girls. This means there were 1,069 recorded instances where these young women were engaged by services for safeguarding or support reasons during the specified period.

Table 3a: The presence of recorded neurodivergence in Kingston children's services data

Neurodiversity identified via disability or EHCP	No (%) of young women and girls	No (%) of contacts in period
Recorded Autism Spectrum Disorder (ASD)	32 (7%)	85 (8%)
Recorded behavioural condition, including ADHD, ADD or other behavioural or emotional regulation traits	20 (4%)	89 (8%)
Other types of Disability (but no ECHP)	31 (6%)	87 (8%)
No recorded disability or EHCP	409 (83%)	808 (76%)
Total	**492 (100%)**	**1069 (100%)**

The table shows that most girls (83%) had no recorded disability or Education, Health and Care Plan (EHCP), accounting for 76% of contacts.

Young women and girls recorded as being Autistic (ASD), having behavioural conditions or traits including ADHD, ADD or other behavioural or emotional regulation needs, or having other types of disability had disproportionately higher contact rates relative to their population size.

Summary insights from the contact data:

Between April 1 and July 9, 2025, Kingston Council recorded 1,069 safeguarding or support contacts involving 492 girls and young women aged 13–25. Most of these individuals (83%) had no recorded disability or Education, Health and Care Plan (EHCP), yet they accounted for 76% of all contacts.

However, the data also revealed that young women and girls who were recorded as:

- Autistic (ASD),
- Having behavioural or emotional regulation conditions (e.g. ADHD, ADD), or
- Having other types of disability

were disproportionately represented in the contact data relative to their population size. These groups had higher contact rates, suggesting that neurodivergent young women may be more likely to encounter safeguarding services, or that their needs may be more complex or visible to professionals.

Despite this, the analysis also acknowledged significant under-recording of neurodivergence. This is likely due to:

- Incomplete information at the point of contact,
- A lack of formal diagnosis,
- Professionals not recording disabilities without written confirmation, and
- The presence of relevant information in unstructured case notes rather than structured data fields.

3.2 Multi-Agency Risk Assessment Conference (MARAC) data insights

The Multi-Agency Risk Assessment Conference is a regular meeting where representatives from various agencies (such as police, health, social care, housing, and domestic abuse services) come together to share information about high-risk domestic abuse cases. The goal is to:

- Assess the level of risk to the victim (and any children involved)
- Coordinate a safety plan
- Ensure appropriate support and intervention from all relevant services

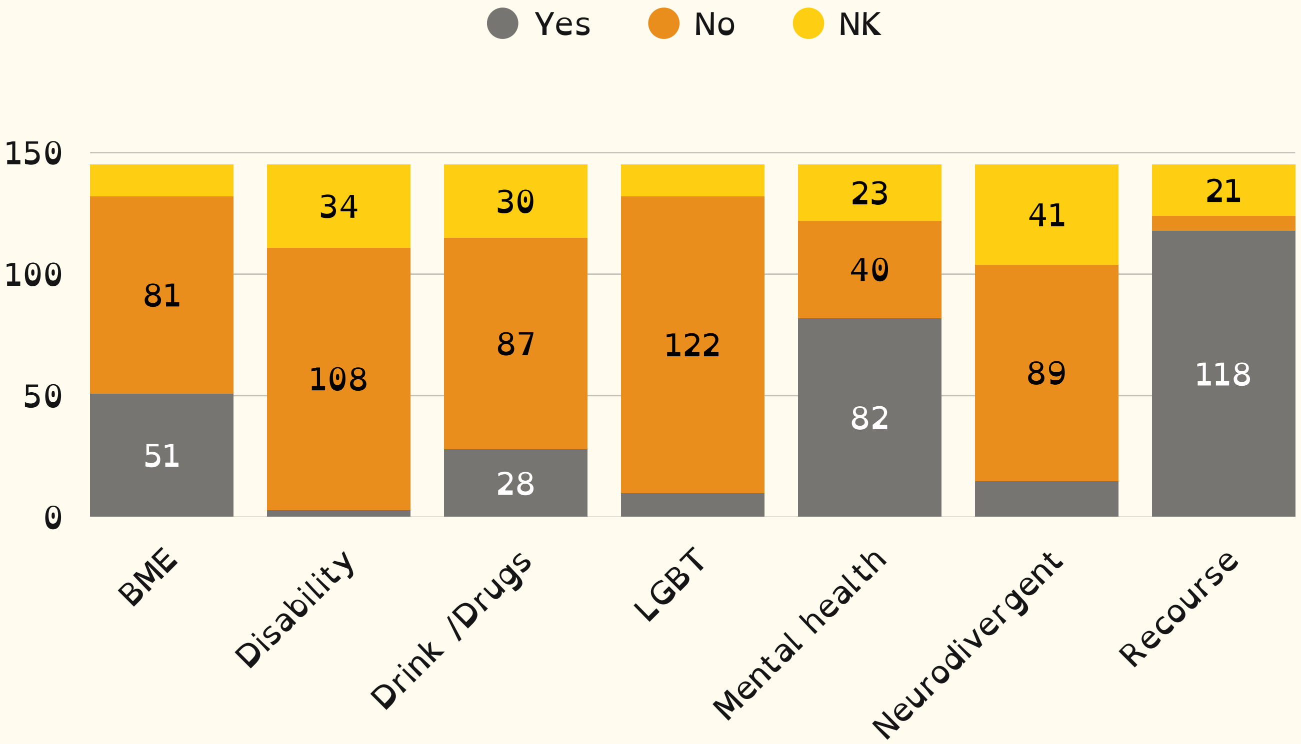
The MARAC data presented below relates to young women aged 18–25 who are considered at high risk of harm, often due to domestic abuse, and may also have complex needs such as neurodivergence, mental health issues, or substance use. The data was drawn from a shared MARAC referral form used across the whole of the South West Basic Command Units (BCU) with the analyst noting that it is not specific in terms of questions relating to neurodivergence and does not provide users with guidance about what to include/ what constitutes neurodivergence. The data covers January 2022 to December 2024.

There were 145 unique cases during the two-year period analysed:

- 41 (28%) cases where neurodiversity status has not been recorded
- 89 (61%) cases recorded as not having any form of neurodiversity
- 15 (11%) cases recorded as being neurodivergent

Figure 3a shows there were low levels of agency identification of neurodivergence in this cohort. Levels of 'unknown' neurodivergence status are twice as high as 'unknown' recourse to public funds status.

Figure 3a: Identification of needs among young women aged 18-25 from MARAC data

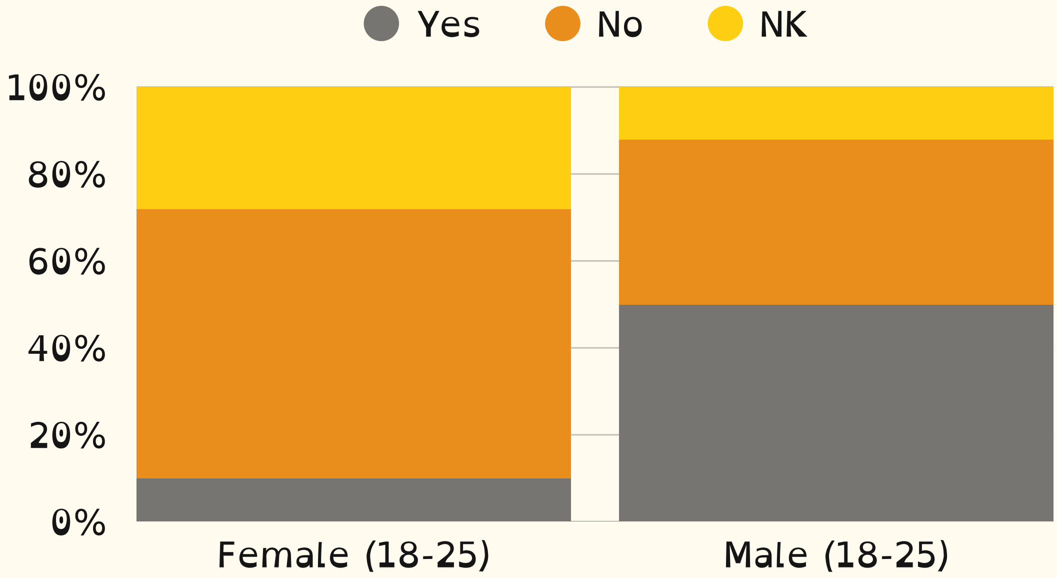


Where neurodivergence status was recorded, 15 (11%) of young women aged 18-25 were recorded as having a form of neurodivergence. All of those recorded as neurodivergent were Autistic (n=15, 100%). Eight of these cases (53%) also had an ADHD diagnosis. All 15 of the young women with neurodivergence recorded on the referral form were White British. In contrast, 40% of the young women with 'no' recorded for neurodivergence were from minoritised ethnic backgrounds (primarily South Asian). For those where neurodivergence was 'unknown' (n=24), 15 were from minoritised ethnic backgrounds, while the remainder did not record ethnicity. This finding particularly draws attention to potential under-recording, given that wider research identifies that Black girls are underdiagnosed and under-supported (UK Parliament, 2024).

A dip sample of 10 cases where neurodivergence was recorded as 'No' revealed that in 4 of the 10 cases, agency updates at the MARAC meeting had further identified that the young women were already diagnosed with ASD or were on a pathway to diagnosis, but this had not been updated within the data measures. This suggest there is likely to be formal under-recording of neurodivergence within MARAC cohorts.

Figure 3b indicates that neurodivergence status is more commonly identified in males than females (unknown in 12% of males compared to 28% of females). Levels of neurodivergence were also significantly higher in the small proportion of male victims in the dataset (50% versus 10% of females).

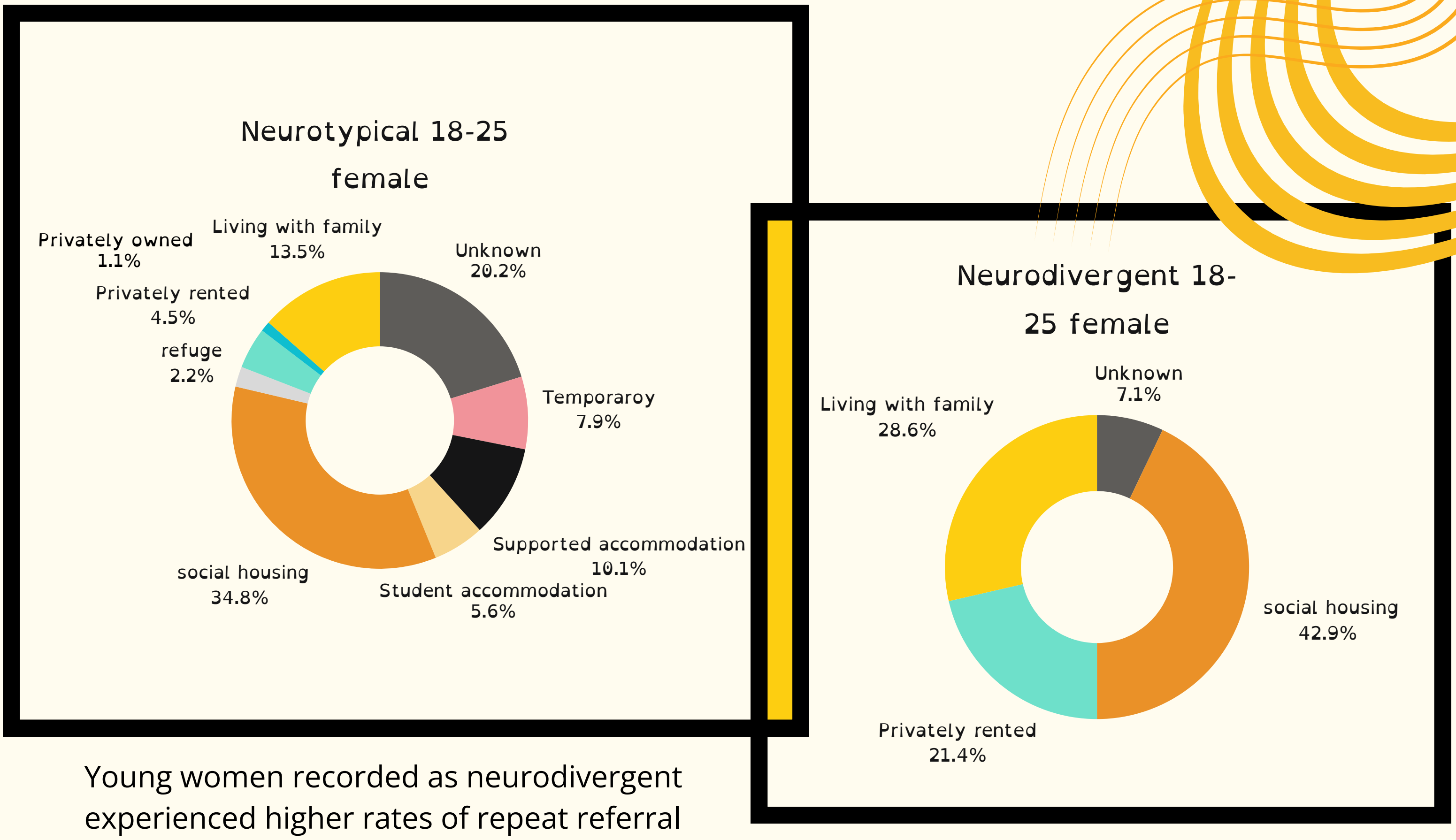
Figure 3b: Comparative analysis of neurodivergence among males and females at MARAC



The perpetrators of abuse for neurodivergent young women were commonly intimate partners (there were only 2 cases where the perpetrator was a family member), in contrast to young women and girls with no neurodivergence recorded. In these cases, rates of familial domestic abuse were 4 times higher than those for young women with a recorded neurodivergence.

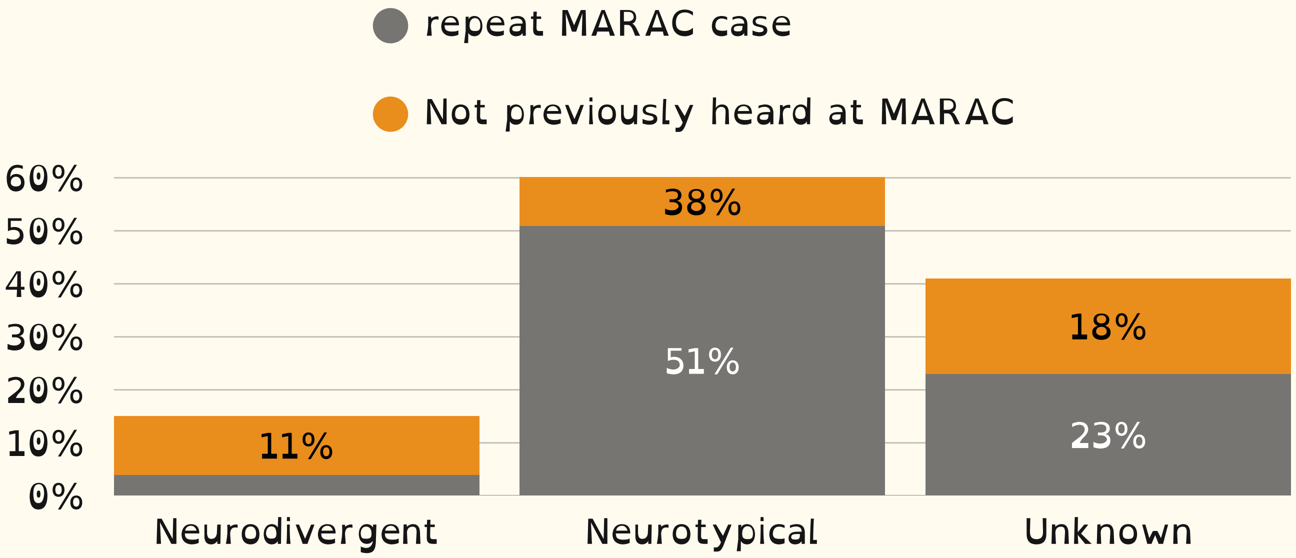
Figure 3c indicates that a greater proportion of neurodivergent young female victims were still living at home with family.

Figure 3c: Status of living arrangements of young women seen at MARAC



Young women recorded as neurodivergent experienced higher rates of repeat referral into MARAC, as Figure 3d below shows.

Figure 3d: Repeat referrals to MARAC



Whilst there seemed to be little difference in the levels of young women that have children, rates of current pregnancy were higher in the known neurodivergent cohort (33% vs 11%).

Almost all (93%) of the young women recorded as being neurodivergent had a mental health need, compared to 60% of those not recorded as being neurodivergent. Six (40%) of the neurodivergent young women were recorded as having a drug / alcohol need, compared to 21% of the cohort with 'no' recorded for neurodivergence.

Of all the 145 young women seen at MARAC during this period, 10 were recorded as being LGBTQ+. Four (40%) of those that identified as LGBTQ+ were recorded as being neurodivergent.

Most of the cases involving intimate partner abuse featured a perpetrator who was a similar age to the victim/survivor. However, in 3 of the 4 cases where the (male) perpetrator was 10+ years older, the victim was recorded as being neurodivergent. The 2 largest age groups (19 yrs and 20 yrs) featured neurodivergent victims / survivors.

Three of the 15 young MARAC victims were also known to the VASA (Vulnerable Adolescents Supported into Adulthood) panel. All referred into VASA after being heard at MARAC (within 6-12 months of being heard at MARAC due to DA) due to wider exploitation concerns.

Summary insights from the MARAC data:

The data showed that more young women referred to MARAC were recorded as not neurodivergent (61%) than those recorded as neurodivergent (11%), with nearly one-third having unknown neurodiversity status. All who were recorded as neurodivergent were autistic, with just over half also having ADHD co-occurring.

The young women recorded as having autism and/or ADHD showed higher rates of intimate partner abuse than those recorded not having a neurodivergence; had higher rates of repeat referrals into MARAC; and a greater likelihood of mental health and/or drug and alcohol needs, were currently pregnant, and identified as LGBTQ+.In cases with significant age differences between the perpetrator and the young woman (10+ years), the young women were often neurodivergent.
However, this data must be interpreted with caution as these patterns may not hold if there is under-recording.

3.3 The Vulnerable Adolescents Supported into Adulthood (VASA) data insights

This section presents descriptive data about nine females referred to the VASA panel between 20 September 2022 and 20 May 2025. The overarching VASA cohort from which these 9 were taken comprises 33 individuals, including 24 males and 9 females, with females representing 37.5% of the Kingston cases.
The VASA (Vulnerable Adolescents Supported into Adulthood) panel is a multi-agency panel that supports young adults aged 18-25 who are at risk of exploitation and high harm. It was developed to bridge a gap in services for adolescents transitioning into adulthood who have complex needs related to exploitation or harm. The panel, made up of a range of representatives from partner agencies within Kingston and Richmond.

A comparison of young women with a neurodivergence status and without

Of the 9 females, 4 (44%) had confirmed or suspected neurodiversity needs. Diagnoses stated on the referral forms reflected:

- Autism
- ADHD and complex developmental trauma,
- ADHD and ASD:

Table 3b: Characteristics of young women and girls with recorded neurodivergence compared with those without a recorded neurodivergence

Category	With a recorded neurodivergence (n=4)	Without a recorded neurodivergence (n=5)
% of Female Cases	44%	56%
Age Range	17–19	18–22
Exploitation Types	- 2 sexual exploitation - 1 both sexual & criminal exploitation - 1 domestic abuse	- 4 domestic abuse - 1 sexual exploitation
NEET (Not in Education, Employment or Training)	3	3
Substance Use	2	2
Mental Health Concerns	4	4
Previous CP/CIN Plans	4	2
Previously Looked After Children	3	2
Current Care Leavers	2	1
Duration Open to VASA	7 months to 2 years 4 months	2 to 5 months (plus 1 new referral)

The following observations are based on a very small sample and should be interpreted with considerable caution. Given the known under-recording of neurodivergence (as identified within the MARAC data above), these patterns may not be representative or statistically meaningful.

Preliminary observations show that among the four females in the cohort with confirmed or suspected neurodivergence (representing 44% of the sample), there appeared to be a higher prevalence of sexual exploitation compared to those without recorded neurodivergence.

Additionally, one case of criminal exploitation was identified within this group, whereas no such cases were recorded among those without a recorded neurodivergence.

Young women with recorded neurodivergence also tended to have more complex care histories and longer durations of engagement with the VASA panel—ranging from seven months to over two years. More young women with recorded neurodivergence had been previously looked after, were current care leavers, and had had prior involvement with child protection or children in need plans than young women without a recorded neurodivergence. All four had documented mental health concerns, and most were not in education, employment, or training (NEET).

In contrast, the five females without recorded neurodivergence were more likely to have experienced domestic abuse as their primary form of exploitation. While they also presented with significant vulnerabilities—including substance use, mental health needs, and NEET status—their engagement with the VASA panel was generally shorter, typically lasting less than six months.

3.4 Chapter summary and implications

The findings presented in this chapter highlight concerns about the quality and completeness of data relating to neurodivergence among young women and girls in safeguarding contexts. Across all datasets—whether from Children's Services contact records, MARAC, or the VASA panel—there is evidence of under-recording, which has important implications for both practice and policy.

One of the most pressing issues is the under-identification of neurodivergence in structured data fields. Many young women who may be neurodivergent are not formally diagnosed or their diagnoses are not shared with social care professionals. As a result, their needs are often not captured in the systems used to inform decision-making. This is particularly problematic in safeguarding contexts, where accurate identification of vulnerabilities is essential for effective intervention.

The data also reveals inconsistencies in how neurodivergence is recorded across different services and datasets. For example, a significant proportion of MARAC cases had no recorded neurodivergence status, and dip-sampling revealed that some young women initially recorded as not neurodivergent were later found to have a diagnosis or be on a diagnostic pathway. These inconsistencies undermine the reliability of the data and make it difficult to draw meaningful conclusions about the prevalence and impact of neurodivergence.

Another structural limitation lies in the design of the MARAC referral form itself, with likely implications for other referral forms such as for the VASA panel. The form does not include specific prompts or guidance regarding neurodivergence. This absence likely contributes to the high proportion of cases with 'unknown' neurodivergence status and may discourage or prevent professionals from recording relevant information.

Without clear fields or definitions, practitioners may be uncertain about what constitutes neurodivergence or whether informal observations are appropriate to include. This design flaw further undermines the reliability of the data and highlights the need for more intentional data collection tools.

Another challenge lies in the structure of the data itself. While structured fields are useful for quantitative analysis, they often fail to capture the complexity of young people's experiences. Important information may be documented in narrative case notes or referral forms, but these are not routinely analysed due to the time and resource demands of manual review. A recent study by Day (2025) also found, via a case file analysis, that traits of neurodivergence were noted informally or observed by professionals but not formally recorded or acted upon until crisis points. This hidden data creates a systemic blind spot, where valuable insights remain concealed in unstructured text.

The limitations of the datasets—particularly their small sample sizes and short timeframes—further constrain the ability to generalise findings. While some patterns appear to emerge, such as higher rates of repeat referrals or mental health needs among neurodivergent young women, these must be interpreted with caution. The risk is that these patterns may reflect recording practices rather than actual differences in experience or need.

Gender bias also appears to play a role in under-recording. Neurodivergence was more frequently identified in males than females in the MARAC data, suggesting that the traits of neurodivergent girls and young women may be less recognised or understood by professionals. This aligns with broader research indicating that neurodivergence in females often presents differently and is more likely to be missed.

Implications for service delivery

Ultimately, the under-recording of neurodivergence has clear implications for service delivery. When neurodivergent needs are not recognised, young women may not receive the tailored support they require, and safeguarding responses may be less effective. Moreover, under-recording means that it is difficult to interpret patterns that may appear in the data. For example, with the significant percentage of 'unknowns' (as in the VASA data), it is not possible to know whether any emerging patterns are real. Addressing these data quality issues is therefore not just a technical challenge—it is a matter of equity.

Some potential approaches to improve data capture

(1) **Apply natural language processing (NLP) to case notes**
  - Use AI tools to scan unstructured text for mentions of neurodivergence, traits, or diagnostic pathways.
  - This can surface hidden indicators not captured in structured fields.

(2) **Integrate Cross-Agency Data**

- Link education (EHCP/SEND), health (CAMHS, diagnostic services), and social care records to build a more complete picture of neurodivergence.
- Establish data-sharing protocols and governance frameworks to support this.

(3) Incorporate self- and family-reported information

- Include questions about neurodivergence in assessment conversations with young people and families.
- Ensure these are framed sensitively and inclusively.

(4) Enhance staff training

- Provide training on recognising neurodivergent traits, especially in girls and young women who may present differently.
- Emphasise the importance of accurate and consistent recording.

(5) Revise referral and assessment forms

- Update multi-agency referral forms (e.g. MARAC) to include structured fields and guidance for recording neurodivergence.
- Provide clear definitions and examples to support consistent and confident recording by practitioners.
- Ensure forms prompt for both diagnosed and suspected neurodivergence, including space for practitioner observations or self-reported traits.

(6) Use screening tools in assessments

- Introduce brief, validated screening tools (e.g. AQ-10, SDQ) to support early identification of neurodivergent traits (Allison et al. 2012; Goodman, 1997).
- Use these tools as part of a broader assessment process, not for diagnosis.

(7) Establish data quality audits

- Regularly audit datasets for completeness and accuracy of neurodivergence recording.
- Use findings to inform continuous improvement in data practices.

4. neurodivergence, trauma, and systemic response in safeguarding contexts

4.1 Introduction to chapter

This chapter presents a cross-case narrative analysis of five complex safeguarding cases involving girls with varied diagnoses or suspected diagnoses, with some files evidencing co-occurring neurodivergent traits. It explores the intersections between neurodevelopmental conditions, trauma histories, and systemic responses, shedding light on how these factors shape the lived experiences of girls facing multiple vulnerabilities. Through a thematic synthesis of casework across ten key stages—from pre-referral to case closure—the chapter identifies recurring patterns, systemic challenges, and opportunities for more responsive, inclusive practice.

The five girls who were subject of the case files were adolescent females aged 14 to 17, from diverse ethnic backgrounds including White British, Polish, and Mixed heritage. Each presented with complex and overlapping vulnerabilities. All had suspected or diagnosed neurodevelopmental conditions—most commonly ADHD, autism spectrum traits, or learning difficulties—though assessments were frequently delayed, incomplete, or contested.

The case files were purposefully selected for relevance to safeguarding in the context of sexual exploitation, variations in recognition and assessment of neurodivergence, and recency of cases to reflect contemporary practice relevance. Caution is required in interpreting the findings. The small, purposeful sample means findings cannot be generalised to all similar case files. Furthermore, the quality of the data extracted from case files is only as accurate and complete as the case files themselves, therefore where data is missing from case files, this may present a less complete picture of service experience and provision. However, the findings offer insights for professionals and policymakers seeking to improve outcomes for neurodivergent young women and girls in safeguarding contexts.

The files and the data derived from them have been anonymised. In the findings below, ‘CF’ refers to a case file, followed by a number (1–5) indicating which of the five case files included in the analysis is being referenced.

4.2 Thematic casework across ten safeguarding domains

This analysis is structured around ten domains of casework that could be observed within the case files. Each stage reveals systemic patterns, professional challenges, and opportunities for improved practice.

1. Pre-referral

Across all five cases, early indicators of neurodivergence and vulnerability were present but inconsistently recognised. In some instances (e.g. CF1 and CF2), parents or schools identified concerns and initiated informal support. In others (CF4 and CF5), signs such as aggression, social withdrawal, or risky online behaviour were evident for years before formal recognition. Notably, in CF4, early signs of ADHD were documented as early as age four, but assessments were delayed due to non-engagement and systemic barriers.

2. Early Help

The provision and uptake of early help varied. CF1 demonstrated proactive parental involvement, including private assessments and education, health and care plans (EHCP) applications. In contrast, CF4 and CF5 revealed missed opportunities, where early help was either not offered or not sustained due to parental challenges or service disengagement. In CF3, early help was largely reactive, triggered by safeguarding concerns rather than developmental needs.

3. Referral

Referrals were typically made in response to escalating risk, particularly around CSE, missing episodes, or emotional distress. In CF1 and CF3, referrals were initiated by education or health professionals following parental concerns. CF4 and CF5 highlight how referrals occurred only after significant harm or risk had already materialised, suggesting a need for earlier intervention pathways that are sensitive to neurodivergent-related vulnerabilities.

4. Engagement & relationship building

Effective engagement was closely linked to professionals' ability to adapt their approaches. In CF1 and CF3, it was evident that workers used creative tools (e.g. drawing, writing, "All About Me" worksheets) to build trust and support communication and engagement around these approaches was evident. CF2 highlighted the importance of respecting autonomy and communication preferences, particularly in the context of PDA. However, CF4 and CF5 showed that while relationships were built, the specific impact of neurodivergent engagement was not always explicitly acknowledged or addressed in the files.

5. Assessment & diagnosis

There was a wide spectrum of diagnostic clarity. CF1 had a comprehensive diagnostic profile (ADHD, ASC, dyslexia, dyscalculia), while CF2 had a confirmed autism diagnosis but limited follow-up. CF3 and CF5 illustrated the challenges of navigating assessments, with delays, rejections, and confusion over whether symptoms were trauma-related or neurodivergence. CF4 had a confirmed ADHD and ODD diagnosis, but autism remained unassessed. Across cases, assessments were sometimes delayed or deprioritised, especially when trauma was present.

6. Direct work

Direct work was most effective when tailored to the young person's needs and preferences. CF1 and CF3 included structured sessions on relationships, safety, and emotional regulation, with some adaptation for neurodivergence. CF2 and CF4 showed that while neurodivergence was acknowledged, it was not always integrated into the content or delivery of direct work. CF5 demonstrated how relational and reflective work (e.g. art therapy, identity exploration) could support engagement, even in the absence of a formal diagnosis.

7. Multi-agency coordination

Multi-agency working was evident in all cases but varied in effectiveness. CF1 showed strong coordination between Child and Adolescent Mental Health Services (CAMHS), education, and social care. CF3 and CF5 involved Multi Agency Risk & Vulnerability to Exploitation (MARVE) Panel, Phoenix Project, and safeguarding teams, but coordination around neurodevelopmental assessments was inconsistent. CF4 highlighted the risk of siloed working, where neurodivergence and safeguarding concerns were addressed separately. In several cases, changes in professionals disrupted continuity and hindered collaborative planning.

8. Planning & review

Planning and review processes seemed most effective in cases with clear safeguarding frameworks (e.g. Child Protection or Child in Need plans). CF1 and CF2 had structured reviews and transitions between plans. CF4 and CF5 showed that while plans were in place, they focused on risk management rather than developmental needs. In CF3, planning was reactive and lacked a long-term view, particularly regarding neurodevelopmental support.

9. Transition planning

Transition planning was inconsistently addressed in the case files. CF1 included discussions about specialist school placements. CF4 and CF5 began to explore transitions to college and independent living, but without formalised plans. CF2 and CF3 lacked clear transition strategies, despite the girls approaching adulthood. This gap poses risks for continuity of care and support, particularly for those with complex needs.

10. Case ending

Case endings appeared to be driven by service thresholds rather than readiness. CF1 transitioned from Child Protection to Child in Need with ongoing support. CF5 was closed despite unresolved neurodevelopmental assessments, raising concerns about unmet educational needs. CF4 remained open due to ongoing care needs. In several cases, closure occurred without clear transition or contingency planning, potentially leaving the girls vulnerable.

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Diagram 4a captures these findings and stages below.

Figure 4a

JOURNEY MAPPING THROUGH SERVICES:

NEURODIVERGENT CHILDREN AND YOUNG PEOPLE WHO EXPERIENCED SEXUAL EXPLOITATION

1 **Pre-referral**

Family history of trauma, domestic abuse or social care involvement were evident. There were often missed opportunities for early intervention.

2 **Early help**

Early signs of neurodivergence or behavioural indicators indicative of neurodivergence were noted in school or home settings, but not acted upon until crisis.

3 **Initial referral to children's services for event which underpinned case file review**

Initial referrals triggered by safeguarding concerns. Neurodivergent traits often not central to the referral. Concerns about parental capacity and home environment were more prominent.

4 **Engagement & relationship building**

There was evidence of good engagement and relationship building by children's services staff, with use of creative methods described (such as drawing, writing and sensory accommodations).

5 **Assessment & diagnosis**

Delay in assessments for ADHD and autism were notable with referrals often rejected or deferred. Debates around trauma versus neurodivergence often complicated diagnosis and support. EHCPs and CAMHs involvement were inconsistent.

6 **Direct work**

There was often a focus on emotional regulation, relationships, and safety. Limited neurodivergence-specific adaptations recorded in the files, apart from creative engagement approaches. .

7 **Multi-agency coordination**

Multi-agency working was evident but inconsistent particularly in relation to coordination around neurodevelopmental assessments.

8 **Planning & review**

In this stage, Child in Need, Child Protection, or Risk Outside the Home Plans were used to coordinate support. Multi-agency risk meetings were used for risk management. Safety planning and goal setting occurred with families.

9 **Transition planning**

Transition planning was inconsistently addressed. It was sometimes there but without formalised plans.

10 **Case ending**

Case endings were often driven by service thresholds rather than readiness. with some unresolved issues evident and at times without clear contingency planning.

4.3 Key themes relating to neurodivergence: recognition, delay and fragmentation

Across all five cases, neurodivergence—including ADHD, ASD, dyslexia, dyscalculia, and PDA—was a central yet inconsistently addressed factor. Early signs were sometimes recognised by caregivers or professionals, but formal assessments were delayed or obstructed by systemic barriers such as:

- CAMHS gatekeeping (CF3 & 5), where trauma was prioritised over neurodivergence, leading to missed or delayed diagnoses.
- Inconsistent documentation (CF1), where EHCPs and case notes failed to reflect the full neurodivergent profile.
- Cultural and familial dynamics (CF2 & 3), where perceptions of mental health and neurodivergence influenced engagement with services.

Despite these challenges, some professionals demonstrated adaptive practices—such as using visual tools or indirect communication (CF3)—highlighting the potential of neurodivergence-informed approaches when implemented.

Trauma and emotional dysregulation

All five girls experienced significant trauma, including:

- CSE (CF1, 2, 3 & 5), facilitated by online grooming and exacerbated by missed social cues linked to neurodivergent traits.
- Domestic abuse in the home and neglect (CF4 & 5), contributing to emotional dysregulation, self-harm, and suicidal ideation.
- Housing instability and parental mental health issues (CF3 & 4), compounding emotional and behavioural challenges.

Emotional dysregulation—manifesting as panic attacks, impulsivity, and self-harm—was a common thread, sometimes misunderstood as purely behavioural rather than trauma- or neurodivergence-related. This misinterpretation led to punitive responses in educational settings (C1) and disengagement from therapeutic services (CF2).

Education: exclusion, EHCP gaps, and adaptive potential

Educational environments frequently failed to accommodate neurodivergent needs. Mainstream schools could exacerbate distress through rigid disciplinary measures (CF1) or failed to engage altogether (CF2 & 4). Key issues included:

- Delayed or absent EHCPs (CF3, 4 & 5), despite clear indicators of need.
- Lack of neurodivergence-specific adaptations, such as sensory accommodations or executive functioning support.
- Positive re-engagement in later stages (CF4 & 5), where college settings offered more flexible, person-centred approaches.

These findings underscore the importance of trauma-informed, neurodivergence-aware educational planning from an early stage.

Safeguarding and risk: neurodivergence and vulnerability

Neurodivergence potentially increased vulnerability to exploitation and risk-taking behaviours. Traits such as impulsivity, missed or misinterpreted social cues, and emotional dysregulation intersected with:

Family engagement varied widely, from highly proactive (CF1) to disengaged or overwhelmed (CF4 & 5). Protective factors included:

- Parental advocacy (CF1), which facilitated early assessments and specialist placements.
- Creative and therapeutic outlets (CF2 & 5), such as art, music, and vocational interests, supporting emotional expression and identity development.
- Stable placements and relational consistency (CF4), enabling recovery and re-engagement with education and services.

However, systemic inflexibility could limit the impact of these protective factors, particularly when services failed to adapt to neurodivergent-related needs.

4.4 Summary

This cross-case analysis highlights the complex interplay between neurodivergence, trauma, and systemic safeguarding responses. The findings reveal how delays in recognition, fragmented assessments, and rigid service thresholds can compound vulnerability for neurodivergent young women and girls. However, when professionals adopt flexible, trauma-informed, and neurodiversity-aware approaches, meaningful engagement and improved outcomes become possible.

5. Neurodivergent young women and girls' experiences of services and professionals following sexual exploitation

5.1 Introduction to chapter

This chapter foregrounds the voices of the seven young women and girls who participated in this research, focusing on their experiences with services and professionals. Although the sample size is small, their accounts offer rich and insightful learning for practice. Some of their insights are not exclusive to neurodivergent young women and girls and align with broader research on post-abuse support. However, others highlight specific challenges and needs related to neurodivergence, illustrating how differences in cognitive and sensory processing can intensify certain needs.

At times, the young women and girls did not clearly articulate how the support they received related to their neurodivergent identities. In other instances, they made these connections explicitly and insightfully. Some young people may lack the vocabulary to link their experiences to diagnostic labels, may not perceive themselves as different, or may not recognise how their experiences diverge from those of others. Inconsistent responses from adults can also make it more difficult for young people to identify patterns between their needs and the support provided. Additionally, differences in cognitive and sensory processing may affect their ability to generalise or connect their experiences to neurodivergence. Regardless of the reason, all these young women and girls were speaking from their lived experiences as autistic individuals or individuals with ADHD. The participants described interactions with a range of professionals following their experiences, offering both positive and negative reflections—often revealing a complex and mixed picture. This chapter examines in depth the young women and girls' experiences with:

1. Educational settings and professionals
2. Health settings and professionals
3. Police and court settings and professionals
4. Social care settings and professionals
5. Other professionals

At the end of the chapter, common cross-cutting themes will be shared in a graphic, creating a bridge to Chapter 5.

5.2 The young women and girls who took part in the research

While the overall project had an initial focus on experiences of domestic abuse and sexual exploitation, the young women and girls who were interviewed all experienced sexual exploitation. All seven are autistic young women and girls, or young women and girls with ADHD, some with co-occurring traits, and all had awareness of these identities. Some had been formally diagnosed, while others were awaiting assessment. Table 5a provides an overview of the young women and girls' ages at the time of interview, ethnicity, form of neurodivergence, and assessment / diagnostic status. None had any other physical or learning disability.

Table 5a: Characteristics of the young people who took part in interviews

	Age	Ethnicity	Neurodiversity	Assessment status
YP1	14	White British	ADHD, ODD, possibly ASD	On waiting list
YP2	16	White British	Autism and strong traits of having PDA	Formally assessed for Autism
YP3	15	Mixed Heritage - Black African and Asian	ADHD	On waiting list
YP4	22	White	ASD	On waiting list
YP5	19	Any other Asian background	Autism, ADHD and EUPD	Formally diagnosed
YP6	16	White British	ADHD	Formally assessed
YP7	18	White British	ADHD	On waiting list

5.3 The young women and girls' experiences in education

All seven young women and girls had diverse and often challenging educational journeys, which are not unusual for young people who have experienced sexual exploitation (Lloyd, 2025). Their experiences spanned mainstream education, Pupil Referral Units (PRUs), and specialist educational settings, including those delivering specialist mental health provisions. The young women and girls' accounts included experiences of bullying, exclusion, and inconsistent support. While positive encounters were rare, they offered valuable insights into what effective and compassionate practice can look like. In contrast, negative and neutral experiences were more prevalent, often highlighting systemic gaps in understanding and support.

Four young women and girls mentioned teachers, with two describing notably positive interactions. One young person with ADHD recalled a teacher who used creative, flexible and activity-based methods—such as walks and drawing—to provide comfort and support:

> **“PEOPLE DOING THINGS WITH ME, LIKE MY TEACHER... SHE TOOK ME FOR A WALK OR LET ME DRAW THINGS”-YP3**

Another autistic young person described a nurturing environment in a school-based mental health unit, where teaching assistants trained in mental health created a safe and informal space. The unit manager stood out for her warmth and emotional support:

> **“SHE WAS REALLY NICE. IF YOU NEEDED A BREAK OR WHATEVER. YOU KNOW, SHE WEREN’T SHY ABOUT HUGS. SHE WOULD HUG YOU IF YOU WANTED THAT OR NEEDED THAT...WE NEEDED STRENGTH”-YP4**

The unit manager was particularly valued because she recognised that many of the young people in the unit were returning to difficult home environments after school, so would offer hugs and comfort.

Two girls shared negative experiences with teachers. One felt persistently misunderstood and unfairly labelled due to their neurodivergence:

> **“I WAS JUST KINDA MADE OUT TO BE THE NAUGHTY KID ALL THE TIME AND THAT WAS LIKE THE ONLY WAY I WAS SEEN”-YP1**

Another, also diagnosed with ADHD, expressed frustration that repeated reports of bullying, associated to their neurodivergence, were ignored:

> **“THEY WOULDN’T DO ANYTHING”-YP6**

Although it is difficult to determine why the teachers acted as described, broader research indicates that neurodivergent students are more likely to report negative school experiences compared to their neurotypical peers (Milner et al. 2025). This may stem from a perception that professionals, including teachers, often misunderstand neurodivergence and the behaviours associated with it (Pearson et al. 2024).

Specialist educational provision was mentioned by a few of the young women and girls, in relation to their experiences in specialist units attached to mainstream schools. This refers to tailored educational support and services designed to meet the unique needs of children and young people with special educational needs and disabilities (SEND) (DfE, 2014). This type of provision goes beyond what is typically available in mainstream schools.

Another autistic young person described a specialist setting that she felt prioritised containment over inclusion. Even short sessions were difficult due to inflexible routines and there were limited opportunities for social interaction:

> **“I HAVEN’T HAD A CONVERSATION, A 10-MINUTE CONVERSATION WITH ANY OF THEM”-YP5**

Their experience with a virtual school further emphasised the isolating nature of some alternative educational models.

One young person shared a particularly distressing experience involving a safeguarding officer at her school. After disclosing abuse by a peer, they were pulled from class for a first-time meeting with the officer. Instead of offering support, the officer relayed a message from the perpetrator's mother, accusing the young person of causing harm. The officer sided with the perpetrator, saying:

> "HE SAID, 'HE'S BEEN THROUGH ENOUGH. YOU NEED TO LEAVE HIM ALONE NOW.'"-YP4

This left the young person feeling betrayed, silenced, and blamed. The young person left the meeting immediately and never returned to school.

Other educational roles—such as a school counsellor, a police school liaison officer, a house leader, and an educational psychologist involved in an Education, Health and Care Plan—were mentioned only briefly. These accounts were neutral and lacked reflection on the quality or impact of these individuals, suggesting they played no significant or memorable role in the young women and girls' experiences of support.

5.4 The young women and girls' experiences of health and mental health care

Discussions about health care were sporadic and varied in depth across the young women and girls' accounts. Mental health care was mentioned more frequently and in greater detail than physical health care. This is a trend we have seen in other research (Allnock et al. 2022). This tendency may reflect the ways in which mental health challenges are more deeply and immediately felt in the aftermath of exploitation. Psychological impacts can often permeate daily life, making them more salient in young people's narratives. In contrast, physical health issues - unless acute or ongoing - may be perceived as more transient or less directly attributable to the exploitation experience. For instance, three young women and girls mentioned visiting a hospital following experiences of exploitation, but they did not elaborate on the quality or impact of those visits. Similarly, one young person briefly referenced attending a sexual health clinic but provided no further detail.

Notably, none of the participants spoke about receiving specialist mental health or therapeutic support from voluntary sector organisations. While several described experiences with school-based specialist mental health units, more generally it seems that the girls had no contact with third-sector services or did not find them relevant to mention. This, in fact, is the opposite of what other research has identified, where young people speak in more detail about their experiences of voluntary sector support (Allnock et al. 2022).

Only one young person provided a detailed account of their experience with Child and Adolescent Mental Health Services (CAMHS), which was largely negative and distressing. Key themes from their account included:

- *Misunderstanding and misdiagnosis*: The young person felt CAMHS professionals prematurely labelled her as depressed without fully understanding the complexity of her emotions, leading to an oversimplified view of her mental health struggles.
- *Lack of empathy and communication*: She described feeling judged and observed rather than listened to and supported. Repeated questioning about distressing topics made her feel interrogated rather than helped.

  - *Discomfort with the environment*: The clinical setting and unfamiliar staff made her feel uneasy. Reasonable adjustments were not made, despite CAMHs being aware of her ADHD. She felt a lack of control, particularly when asked to remain in a room without the option to leave.
  - E*motional distress as a cry for help*: She viewed her behaviour—such as getting drunk and screaming at staff—as a desperate plea for help, but felt it was met with further questioning instead of meaningful support.
  - *Powerlessness and frustration*: Her account conveyed a strong sense of being dismissed and not taken seriously, leaving her feeling powerless and deeply frustrated by the lack of compassion in her care.

Although this is the experience of just one young person in the sample, her experiences reflect broader reviews and research into the experiences of both parents and young people with CAMHS which finds that care quality may be compromised for some young people. This is often due to a shortage of skilled practitioners and the significant pressures facing CAMHS, which can hinder the development of strong, supportive relationships with young people—relationships that are essential for effective and sustained care (CQC, 2017). Parents accessing CAMHs for their autistic children also report an absence of reasonable adjustments being made, or which are ineffective, impacting on their children's distress and behaviour while on the premises (Ashworth et al. 2025).

5.5 The young women and girls' experiences of social care

Five of the young women and girls indicated they had experience of social work support, though only three discussed them in detail. While all three described some positive interactions—highlighting what effective support looked and felt like—their stories also revealed inconsistencies. Two had multiple social workers, which led to their overall experiences being marked by a lack of continuity. The third experienced a discontinuation of support by the social worker, but she was never told why this happened: *"she just sort of stopped coming"*-YP7.

Positive experiences of social care were rooted in genuine care, time investment, and personal interest in the young person's life beyond their case file. The two young people who spoke in depth about their experiences emphasised the importance of being treated with dignity and respect. Trust developed when social workers were consistent, empathetic, and non-judgemental.

"SHE ASKED ME ABOUT MY STREAM, SCHOOL, PERSONAL LIFE... NOT ABOUT THE CASE. THAT MADE ME OPEN UP."-YP5

The third highlighted the importance of being allowed to fidget or move during conversations, something her social workers accepted as part of her

"THEY ACTUALLY LISTENED, SPOKE TO ME, LET ME FIDGET AND WANDER ABOUT WHEN I WAS TALKING, AND THINGS LIKE THAT, AND ACTUALLY RECOGNISED WHAT I NEEDED."-YP7

The young women and girls valued trauma-informed approaches that recognised their unique needs and histories. Bespoke support - such as extended visits and personalised care-was seen as more effective than standard statutory provisions.

“IT WAS VERY MUCH TRAUMA INFORMED. VERY MUCH BESPOKE TO MY OWN NEEDS.”-YP5

Effective social workers were described as strong advocates - willing to challenge systems or management to support the act in the young person’s best interests. Conversely, lack of advocacy or passive compliance with systemic issues led to feelings of abandonment or oppression.

One of the young people really valued that her social worker fought on her behalf, advocating for a new foster care placement to replace the one that was not working. She articulated how persistent and demanding the social workers were who advocated for her:

“THEY DIDN’T GIVE A FUCK. THEY WERE LIKE. ‘THIS IS WHAT [NAME] NEEDS AND THIS IS HOW THINGS ARE GOING TO BE.’”-YP5

However, advocacy was not experienced as consistent for this young person. The same young person who praised her social worker’s earlier efforts felt unsupported during the period where a Deprivation of Liberty safeguard was in place. These orders, often involving placement far from families and friends, can be distressing, isolating and damaging to a young person’s sense of autonomy and self-worth (Haydon, 2018).

“I THINK SHE COULD HAVE ADVOCATED MORE. MY DOLS…. I THINK THAT PROLONGED THE DISTRESS THAT I SUFFERED. YOU KNOW, SOMETIMES THEY DIDN’T HAVE MY BEST INTEREST IN MIND” – YP5

Most of the young women and girls did not speak in depth about educational interventions by social workers, aimed at increasing knowledge and empowering young people.Only one spoke about her social worker who specialised in drugs and alcohol. She acknowledged that this increased her knowledge on alcohol units and their impact, although it left her feeling overwhelmed and ‘*tired*’*-YP2.*

Frequent changes in social workers could disrupt young people’s sense of stability and trust. In contrast, positive experiences were associated with long-term relationships with a single, committed social worker.

“I’VE ONLY HAD TWO SOCIAL WORKERS IN MY LIFE. THEY GENUINELY CARED ABOUT ME.” -YP5

Initial interactions with social workers were sometimes marked by confusion about their roles and intentions. Clear, transparent communication about processes and decisions was seen as essential – but often lacking.

“YOU NEED TO EXPLAIN TO ME WHO YOU ARE.” – YP5

Several of the young people described feeling disempowered by the system, especially when decisions were made without their input or understanding. Frequent relocations, lack of consistent mental health support, and inappropriate placements were common grievances.

“I’VE ASKED FOR COUNSELLING FOR YEARS. I’VE NEVER HAD IT CONSISTENTLY BECAUSE SOCIAL WORKERS MOVED ME. I’VE NEVER BEEN THERE TO ACTUALLY BE ABLE TO RECEIVE IT” – YP6

One participant highlighted the negative impact of cultural insensitivity, where a social worker's personal beliefs interfered with professional responsibilities. A social worker of the same South Asian heritage appeared to downplay the young person's experience of exploitation, seemingly influenced by personal beliefs. The young person did not find it helpful, feeling that the social worker accepted that 'this sort of stuff [exploitation] happens'. The young person felt strongly that:

> **"YOU CAN'T BRING YOUR OWN PERSONAL BELIEFS AND BIASES INTO YOUR WORK. I WOULDN'T DO THAT IN MY WORKPLACE. I DON'T KNOW WHY SHE DID" – YP5**

5.6 The young women and girls' experiences of the police and court

All seven young women and girls had contact with the police for varied reasons, sometimes for multiple issues or incidents:

- Four had police contact due to acute mental health episodes including suicidal ideation or attempts, self-harm and going missing
- Three were in contact with the police following reports of sexual abuse or exploitation, or domestic abuse or violence
- Two had police contact following domestic incidents at the home involving parents and siblings
- Two were arrested or threatened with arrest

Only one of them spoke about their experience in court.

All shared negative accounts of police contact; a few shared positive accounts of certain police officers, both in contact with the police due to acute mental health episodes. Their accounts offer a powerful and painful insight into how interactions with police can profoundly affect young people's trust in authority, mental health, and sense of agency.

While many of the themes described are not exclusive to neurodivergent young people, the impact of police contact was often intensified by their neurodivergent needs. Although a few positive encounters were acknowledged, the dominant themes were mistrust, confusion, emotional harm, and a clear need for empathy and effective communication.

Mistrust and negative perceptions

Several of the young women and girls expressed deep mistrust and negative feelings toward the police. This was often rooted in:

- Perceived unfair treatment (e.g. being arrested while the aggressor was not).
- Feeling unheard or disbelieved, especially when reporting abuse.
- Exclusion from important discussions, such as police speaking only to or through parents.
- Being treated with suspicion or hostility, particularly when there was a history of going missing or mental health challenges.

> **"THEY DON'T HELP NO ONE, THEY DON'T THINK ABOUT NO ONE." — YP1**

The young person with police contact following family conflict had initially a good experience with the officer, although this became marred when her mother told her the police officer contradicted what they told the young person, which resulted in confusion and hurt.

This recollection was shared within a context of family strain, and it is not possible to know whether the officer did contradict her, or whether her mother misinterpreted what the officer said. While this ambiguity makes interpretation difficult, this experience nevertheless left the young person feeling hurt and increasing their mistrust in the police.

Poor communication

A recurring issue was the absence of clear communication. This is particularly salient for individuals with ADHD or who are autistic. Memory limitations can make it difficult for young people with ADHD to hold and manipulate information, forget instructions, or misunderstand tasks and vague or implied instructions can be confusing. Autistic young people interpret language literally, need clear instructions, and time to process information. When explanations are rushed or incomplete, they may miss key points. A lack of understanding can increase young people's stress and anxiety, lead to feelings of exclusion and impact self-esteem.

The young women and girls in this sample reported that they were often not informed about what was happening, why they were being questioned, who was present, or the outcomes of investigations. This led to confusion, fear, and a sense of exclusion from processes that directly affected them.

> “NOTHING WAS EVER EXPLAINED TO ME… I DIDN'T UNDERSTAND WHO THE LADY WAS WHO WAS THERE TO SUPPORT ME.” — YP4

Re-traumatisation and emotional harm

Police interactions exacerbated existing trauma for some of the young women and girls. They described panic attacks, fear, and emotional distress linked to disclosing abuse, ongoing investigations, or their closure. In some cases, this led to deteriorating mental health, including self-harm and suicidal ideation—especially when they felt dismissed or invalidated.

> “WELL, I'VE HAD POLICE SAY TO ME THAT IF I WANTED TO KILL MYSELF, I WOULD HAVE DONE IT BY NOW AND THAT IT'S ALL FOR ATTENTION… THAT MAKES IT 10 TIMES WORSE… I ENDED UP NEEDING STITCHES BUT REFUSED THEM AND NEARLY DIED, BECAUSE I CUT ON MY NECK WHILE UNDER ARREST IN POLICE CUSTODY.” — YP6

Two accounts highlighted the absence of trauma-informed responses by police officers, highlighting how a lack of responsiveness and sensitivity to distress during an interview or visit to a young person's home can affect them:

> “I STARTED HAVING A PANIC ATTACK IN FRONT OF EVERYONE… AND EVERYBODY JUST LOOKS AT ME. THEY JUST STARE… IT'S SO EMBARRASSING BECAUSE I CAN'T BREATHE… AND THEN EVERYBODY WAITS FOR ME TO FINISH.” — YP5

Stigma and identity reduction

Some of the young women and girls felt judged or labelled based on their past or mental health, leading to internalised stigma and feelings of worthlessness. There was a sense that their identities were often reduced to a case file or stereotype.

“THEY JUST BASICALLY PUT A LABEL ON YOU AS YOU'RE WASTING THEIR TIME.” — YP6

Desire for respect and empathy

Despite the negative experiences, the young women and girls expressed a strong desire for respectful, empathetic treatment. Positive interactions were noted when officers respected boundaries, listened, and offered choices. This was especially important for one young person who linked a sensitive police response to their ADHD-related needs:

“WHEN THE POLICE ASKED ME WHEN I WANT TO TALK ABOUT THINGS AND THEY RESPECTED IT WHEN I SAID NO. THEN I WASN’T RUDE TO THEM AND IT WAS FINE.” — YP3

One young person acknowledged that not all officers were the same:

“THERE’S SOME THAT ARE REALLY LOVELY AND DO UNDERSTAND.” — YP6

Court experience

Only one young person spoke about a court experience. The young person who did, diagnosed with ADHD and Obsessive-Compulsive Disorder (ODD), described a poor experience. Despite her social worker informing court staff of her needs, either no adaptations were made, or they were not effective. The young person felt overwhelmed, excluded, and confused by the formality of the process and lack of accessible communication.

“BECAUSE THEY (COURT PROFESSIONALS) WERE LIKE THE QUEEN, CAN TALK TO THE WHOLE OF ENGLAND, THEY JUST TALK AND TALK AND TALK... I DON’T EVEN KNOW WHO YOU ARE!” — YP2

5.7 Experiences of a youth worker

Two of the young people mentioned their experiences of youth workers, again showing some mixed experiences.

One young person described having two youth workers prior to the COVID-19 pandemic, both of whom disengaged without explanation. The first youth worker had been meeting with the respondent weekly and was perceived as helpful, particularly in supporting emotional processing. However, this relationship abruptly ended after the onset of COVID, with no further contact, which the respondent found distressing. The second youth worker also ceased contact, this time coinciding with the respondent’s withdrawal from school. These accounts highlight a pattern of service discontinuity, particularly when external disruptions (like the pandemic or school disengagement) occur. The respondent’s sense of abandonment and the loss of meaningful support relationships suggest a lack of continuity and follow-up in youth services, which may have compounded their emotional and developmental challenges.

The other young person had a highly positive experience, speaking warmly about a youth worker she had who “sticks out in my mind because that’s who I spent the most time with.” She described the youth worker as *“like having a friend,”* and valued the relationship for its authenticity and emotional support.

> “IT WAS JUST CASUAL CONVERSATION. IF I WANTED TO TALK ABOUT BEING UPSET OR HOW I WAS DEALING WITH SOMETHING, SHE’D JUST LISTEN. IT WASN’T LIKE TALKING TO A THERAPIST OR COUNSELLOR—IT WAS JUST SOMEONE WHO CARED ABOUT ME AND KNEW MORE THAN I DID ABOUT CARING FOR SOMEONE.” – YP4

Although her overall experience was positive, the young person also felt that the youth worker did not fully understand or recognise how autism might be influencing her difficulties. Like other professionals she had encountered, the youth worker seemed to unconsciously dismiss her concerns as ‘social anxiety’ and did not consider the possibility of neurodivergence. In hindsight, she would have appreciated a more open and informed exploration of this.

Youth work relationships, therefore, can be deeply impactful, but their effectiveness hinges-like with other professionals- on consistency, continuity, and informed understanding of young people’s needs, including neurodivergence.

5.8 Other service barriers

This chapter identified a range of experiences which both positively and negatively impacted on young women and girls’ views and perceptions of services and influenced their trust in services and willingness to seek further support. The descriptions above tended to focus on individual professionals and their styles, approaches, and relational skills.

The young women and girls’ accounts also either explicitly, or implicitly, identified service barriers that have to do with the way services are structured or delivered, rather than to do with individual professionals. For instance, one clearly expressed therapy was ‘not for them’, because therapists are not seen to be suited to their way of thinking (YP7).Other accounts also hinted at services which were too rigid, applying a one size fits all approach.

Verbal and phone-based communication could be experienced as anxiety-provoking for some:

> “THINGS LIKE PHONE CALLS AND STUFF THAT YOU HAVE TO DO CAN BE VERY, VERY DIFFICULT, BECAUSE I WAS A VERY ANXIOUS PERSON”-YP7.

Some of the young women and girls did not always know where they could get help, such as not knowing what services exist or how to access them.

5.9 Summary

Chapter 5 centred the voices of seven neurodivergent young women and girls—autistic and/or with ADHD—who shared their experiences of services following sexual exploitation. Their accounts reveal a complex and often contradictory picture of support, marked by both moments of compassion and significant systemic failures.
The young women and girls described:

- Inconsistent and fragmented support across education, health, social care, and justice systems.
- Misunderstanding and mislabelling of behaviours linked to neurodivergence, often resulting in punitive or dismissive responses.
- Emotional harm and re-traumatisation, particularly in interactions with police and mental health services.

    - A lack of accessible communication, with young women and girls feeling confused or excluded from decision-making processes.
    - Positive experiences when professionals built authentic, respectful relationships, adapted their communication, and advocated on their behalf.

Many of these findings are echoed in the Children’s Society’s Youth Voice Report (2025), based on conversations and consultations with 324 young people about how members of the public, business, and statutory services respond to children and young people who may be at risk of or experiencing child exploitation in a range of settings.

These findings also reinforce the themes identified in Chapter 4, particularly around the need for trauma-informed, neurodivergence-aware safeguarding.

However, Chapter 5 adds critical insight into how these systemic issues are felt and interpreted by young women and girls themselves. The poster on the next page visually summarises themes from their accounts.

Implications for services and professionals in supporting autistic young people and young people with ADHD following experiences of sexual exploitation

1 PROVIDE CONSISTENT SUPPORT

Young people frequently encountered inconsistent support across education, health, social care and justice systems. While consistent support is beneficial for all young people, it is particularly important for many neurodivergent young people. Disruptions-such as frequent changes in social workers or lack of continuity in mental health care-can exacerbate anxiety, reduce trust, and hinder progress.

2 NEURODIVERSITY-INFORMED PROFESSIONALS

Young people can feel misunderstood or unfairly labelled due to behaviours that might be linked to ADHD or Autism, whether or not these are known by professionals. Professional misinterpretation of behaviours can lead to punitive responses rather than supportive interventions.

3 TRAUMA-INFORMED AND INDIVIDUALISED APPROACHES

Positive experiences were rooted in trauma-informed, empathetic, and individualised care. Neurodivergent young people benefit from tailored approaches that consider sensory sensitivities, communication preferences, and emotional regulation needs. Trauma-informed care is especially critical given the intersection of neurodivergence and adverse experiences like exploitation.

4 AUTHENTIC, RESPECTFUL RELATIONSHIPS

Young people consistently valued professionals who treated them with respect, listened, and built genuine relationships. Trust and relational safety are particularly important for neurodivergent youth, who may have experienced repeated invalidation or exclusion.

5 ACTIVELY PREVENT EMOTIONAL HARM AND RE-TRAUMATISATION BY SYSTEMS

Interactions with police, courts, and even mental health services often caused emotional harm or re-traumatisation. Neurodivergent young people may be more likely to experience emotional dysregulation and sensory overload. Environments and responses that are not adapted to their needs can intensify trauma responses.

6 CLEAR COMMUNICATION AND ACCESSIBLE INFORMATION

Poor communication was a recurring issue for the young people, who often did not understand processes, roles, or decisions. Clear and accessible communication is essential. For many autistic young people and those with ADHD, accessible communication means literal communication. Lack of clarity can lead to confusion, distress, and disengagement.

7 REDUCE STIGMA AND AVOID IDENTITY REDUCTION

Young people felt reduced to labels, especially in interactions with police and mental health services. Neurodivergent young people often face compounded stigma – both from their diagnoses and their life experiences.This can lead to internalised shame and disengagement from support systems.

8 REASONABLE ADJUSTMENTS

Reasonable adjustments were sometimes absent or ineffective, even when needs were known. This may be a direct failure to uphold legal and ethical obligations under disability rights frameworks. It also reflects a lack of systemic preparedness to support neurodivergent young people.

9 ADVOCACY AND EMPOWERMENT

Effective professionals acted as advocates, empowering young people and challenging systemic barriers. Neurodivergent young people often need strong advocacy to ensure their voices are heard and their rights upheld, especially in complex systems like care or justice.

6. Intersecting risks: neurodivergence, gender, and systemic barriers in the lives of young women and girls

6.1 Introduction to chapter

This chapter explores the complex and often overlooked intersection of neurodivergence, gender, trauma, and systemic risk, focusing on the experiences of neurodivergent young women and girls who live in the Royal Borough of Kingston Upon Thames, as understood by local professionals.

Drawing on rich qualitative data from professionals across health, education, social care, and criminal justice sectors, it examines how neurodivergence—particularly autism and ADHD—is understood, identified, and responded to within systems that are frequently ill-equipped to meet the complex needs of this cohort of young women and girls. Professionals' reflections reveal working environments marked by diagnostic ambiguity, conceptual tensions, and systemic delays. These challenges are compounded by gendered patterns of underdiagnosis, cultural stigma, and fragmented service provision. Girls and young women often mask their difficulties, leading to late or missed diagnoses, and are frequently misunderstood or mislabelled—which may be heightened when trauma is also present.

The chapter explores professionals' understanding of:

1. neurodivergence
2. the intersection between neurodivergence and trauma
3. the gendered nature of identification and diagnosis of neurodivergence
4. cultural and familial influences on identification and diagnosis, and
5. the intersections between risk, harm and neurodivergence

6.1 Introduction to chapter

Understanding neurodivergence is important for social, educational, professional and ethical reasons. We explored professionals' understanding of neurodiversity in different ways within the professional interviews and in the survey.

Survey respondents reported moderate levels of confidence in their staffs' understanding of neurodiversity (in general), at 65%. They held higher levels of confidence in their staffs' understanding of domestic abuse and sexual exploitation, at 79% respectively. They were, overall, much less confident in their staffs' understanding of how neurodivergence intersects with domestic abuse and sexual exploitation: only 20% of respondents felt confident or somewhat confident about their staffs' understanding about this.

Professionals' understanding of neurodiversity was explored in further depth in the interviews, with the responses reflecting a mixed picture and varied levels of confidence among professionals, aligning well to the survey findings.

Definitions and conceptual ambiguity

Some interview participants expressed their understanding of neurodiversity as a broad and fluid concept, often difficult to define precisely. It is seen as encompassing a wide range of neurological differences, including autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), Dyslexia and Dyspraxia, PTSD and trauma-related conditions and Personality disorders.

A few participants suggested that everyone is neurodivergent to some extent, emphasising individual cognitive uniqueness rather than strict diagnostic categories.

> “I THINK EVERYONE'S A BIT NEURODIVERSE IF I'M HONEST. I THINK EVERYONE IS DIFFERENT AND I THINK THAT THAT'S OK.” – P11, POLICE OFFICER
> “I THINK WE'RE ALL NEURODIVERSE TO A POINT”. - P2, CHILDREN'S SERVICES STAFF

Some participants spoke from personal experience (e.g. being dyslexic or autistic), which shapes their understanding of neurodiversity as both a challenge and a strength.

> “NEURODIVERGENCE MEANS MYSELF AS A DYSLEXIC PROFESSIONAL WHO STRUGGLES SOMETIMES.” – P5, CHILDREN'S SERVICES STAFF

Linked to this was a recurring theme of conceptual ambiguity—participants struggled to define boundaries of neurodivergence, questioning what should or shouldn't be included (e.g. mental health conditions, learning delays).

> “I SUPPOSE IT DEPENDS ON WHAT WE CLASSIFY UNDER THE NEURODIVERGENT UMBRELLA. WE ALSO DEAL WITH A LOT OF MENTAL HEALTH ISSUES, BUT I'M NOT SURE WHETHER I WOULD CATEGORISE THAT AS A NEURODIVERSITY OR MORE AS CLINICAL DIAGNOSES.” – P6, CHILDREN'S SERVICES STAFF

> “I KNOW THAT DYSLEXIA, DYSPRAXIA, ETCETERA.TICKS ARE ALSO UNDER THE UMBRELLA OF NEURODIVERSITY HOWEVER” – P4, CHILDREN'S SERVICES STAFF

Tensions between medical and social models

There was some tension in the interviews between medicalised and social understandings of neurodiversity. Some participants avoided medical terminology, preferring to focus on strengths and differences rather than deficits.

> “I TRY AND AVOID SORT OF LIKE MEDICAL TERMS… BECAUSE I THINK THAT'S BEEN PART OF THE PROBLEM PREVIOUSLY.” – P3, CHILDREN'S SERVICES STAFF

Others acknowledged the clinical implications of diagnoses, especially in contexts like safeguarding or education.

Diagnostic trends and awareness post-Covid

Several participants had observed a rise in awareness and diagnoses, particularly post-COVID. This was attributed to greater societal and professional awareness, influence of social media, and improved training and visibility of neurodivergent traits.

However, this also leads to questions about over-diagnosis or changing thresholds for what is considered neurodivergent.

> **“IT ALMOST SEEMS LIKE THERE'S AN EXPLOSION OF DIAGNOSES OR SOMETHING'S CHANGED.” – P7, CLINICAL NURSE SPECIALIST, SEXUAL HEALTH**

6.3 Intersection of neurodivergence and trauma

Building on the conceptual challenges discussed above, the following section explores how trauma further complicates the identification and support of neurodivergent young women and girls.

Sexual and criminal exploitation and gendered patterns of harm

Most professionals highlighted autism and ADHD as the most common forms of neurodivergence they encounter. They described how these young people are often manipulated through grooming or exploitative relationships, typically by perpetrators known to them. Tactics such as affection, gifts, and threats are commonly used to gain and maintain control.

Professionals noted that girls are often exploited differently than boys. For example, girls may be used by perpetrators in roles designed to avoid detection. While the primary focus was on sexual exploitation, a few professionals also discussed criminal exploitation. They observed that boys are more frequently exploited through county lines operations. Additionally, unaccompanied asylum-seeking children (UASC), particularly boys, were identified as especially vulnerable due to trafficking-related debts.

Although the project aimed to explore both domestic abuse and sexual exploitation, most interviews centred on exploitation. When domestic abuse was mentioned, professionals highlighted how exposure to violence in the home can normalise abusive behaviour, leading to harmful peer relationships. A recurring theme was the lack of understanding among young people about what constitutes a healthy relationship.

Professional insights on vulnerability

Professionals also emphasised a strong connection between neurodivergence and vulnerability to exploitation. They consistently pointed out that neurodivergent young people face unique risks:

> **“SOMEBODY WHO IS NEURODIVERGENT IS MORE VULNERABLE TO BEING SEXUALLY EXPLOITED. SO JUST TAKING A BIT MORE TIME OVER THOSE QUESTIONS AND EXPLORING RELATIONSHIPS A LITTLE BIT MORE IS IMPORTANT.”-P7, CLINICAL NURSE SPECIALIST, SEXUAL HEALTH**

Professionals noted that neurodivergent young people often feel excluded or misunderstood, which they felt exploiters can manipulate by offering a false sense of acceptance or community.

“IF THEY ARE NEURODIVERGENT, THEY ARE MORE LIKELY TO FEEL ISOLATED... AND THEN IF YOU’RE LOOKING AT GROOMING AND GANGS, THEY’RE LIKE PERFECT TARGETS FOR THAT.”-P2, CHILDREN’S SERVICES STAFF

A professional from a local voluntary sector specialist service highlighted that some neurodivergent young women—despite being academically capable—may lack the social awareness or skills to recognise when they are being mistreated:

“THEY MIGHT NOT UNDERSTAND RELATIONSHIPS OR THAT PEOPLE SHOULDN’T TREAT THEM BADLY... EVEN ACADEMICALLY STRONG NEURODIVERGENT YOUNG WOMEN MAY LACK THE SOCIAL SKILLS OR AWARENESS TO RECOGNISE WHEN SOMEONE IS MISTREATING THEM.” —P16, LOCAL VOLUNTARY SECTOR SERVICE STAFF

While there was general recognition of the link between neurodivergence and vulnerability to exploitation, accounts varied occasionally across professionals. This suggests that understanding of how neurodivergence intersects with abuse may differ between services and individuals. For instance, although the above professional acknowledged that even high-achieving young women can be at risk, another professional from a different sector (role withheld to protect anonymity) did not make this connection:

“THE GROOMERS ARE VERY CLEVER AND SO...I THINK THE TYPE OF PEOPLE THEY TARGET ARE VULNERABLE... IF YOU'RE A GROOMER AND YOU MEET SOME STRONG-WILLED, HIGH-FLYING, CONFIDENT, LIKE ACADEMIC OR BRILLIANT WOMAN, THEY'RE GOING TO BE LIKE, THAT'S NOT FOR ME BECAUSE I CAN'T EXPLOIT HER.”—P11, POLICE OFFICER

Overlap and diagnostic ambiguity

Nearly half (n=6) of the professionals highlighted the complex challenge of distinguishing between neurodivergent traits and trauma-related behaviours. They observed that characteristics commonly associated with autism or ADHD can either mimic or be obscured by trauma responses, or emerge because of trauma, making accurate diagnosis particularly difficult.

“I DO THINK THAT PERSONALLY, THINGS LIKE ADHD, AUTISM CAN STEM FROM TRAUMA.” – P11, POLICE OFFICER

This diagnostic ambiguity is especially pronounced when working with young women and girls who have experienced abuse, neglect, or exploitation. In such cases, trauma can mask or distort neurodivergent traits, leading to delays in recognition and access to appropriate support.

Dual-lens approach: trauma-informed and neurodiversity-aware care

For a few professionals, this overlap raised fundamental questions about the relevance or validity of neurodivergence in certain cases. One social worker reflected:

> “THE TRAITS OF AUTISM AND THE TRAITS OF ASPERGER’S ARE VERY, VERY SIMILAR TO TRAITS OF TRAUMA AND THEREFORE I THINK IT’S VERY DIFFICULT SOMETIMES… SHE DISPLAYS CHARACTERISTICS OF AUTISM, BUT I DON’T THINK IT IS AUTISM. I THINK IT’S THAT SHE’S BEEN THROUGH SO MUCH TRAUMA AND ABUSE THAT THAT IS NOW PRESENTING IN A WAY THAT IS, IT LOOKS LIKE IT COULD BE AN AUTISM DIAGNOSIS.” — P2, CHILDREN’S SERVICES STAFF

This perspective, while grounded in clinical observation, risks overlooking the possibility that a young person can be both neurodivergent and traumatised. It may inadvertently dismiss the need to explore how these experiences interact, rather than viewing them as mutually exclusive explanations. Failing to acknowledge this interplay can result in misdiagnosis or inadequate support strategies.

In contrast, another participant with expertise in neurodivergence offered a more integrated view. They explained that neurodivergent children—particularly those on the autism spectrum—may process trauma differently. For instance, they might repeatedly relive traumatic experiences, often triggered by sensory or emotional stimuli, which can manifest as flashbacks or intense emotional reactions. Moreover, autistic individuals may have difficulty identifying, articulating, or regulating emotions, which can further complicate how trauma is recognised and addressed by professionals.

This participant strongly advocated for a dual-lens approach that combines trauma-informed care with a nuanced understanding of neurodiversity. Rather than treating these frameworks as separate or competing, they emphasised the importance of adapting interventions to meet the needs of neurodivergent individuals. Standard therapeutic models, such as Cognitive Behavioural Therapy (CBT)[3], may not always be suitable unless they are thoughtfully modified. As one Social Worker with lived experience of neurodivergence explained:

> “AS SOMEONE WHO IS NEURODIVERSE, THAT MAKES ABSOLUTELY NO SENSE. WHY WOULD I BE TRYING TO CHANGE A MEMORY AND TELL MYSELF THAT MEMORY DIDN’T HAPPEN WHEN I KNOW THAT IT DID?” — P13, CHILDREN’S SERVICES STAFF

This insight highlights the need for services to move beyond one-size-fits-all approaches and adopt flexible, person-centred models of care that respect both neurodivergent identities and the impact of trauma. This particularly supports the study’s broader findings on training needs (covered in more detail in Chapter 7), which reveal that training on neurodiversity and on sexual and interpersonal harm is often siloed. There is a clear need to integrate these distinct areas of knowledge to better support individuals at their intersection.

6.4 Gendered experiences in identification and diagnosis of neurodivergence

Underdiagnosis in girls

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[3] Cognitive Behavioural Therapy (CBT) is a structured, time-limited, and goal-oriented form of psychotherapy that helps individuals identify and change distorted or unhelpful thinking patterns, emotional responses, and behaviours (APA, n.d).

A recurring theme in professionals' accounts is that girls are significantly underdiagnosed compared to boys. Their professional experiences of supporting young women and girls have highlighted to them that neurodivergent traits for girls often present differently—more internalised and less disruptive—leading to them being overlooked by educators, clinicians, and caregivers. Some of the professionals spoke about 'masking' and misinterpretation, in that girls often mask their symptoms or are misdiagnosed with anxiety or depression and suggest that professionals and systems have tended to interpret their struggles as emotional or behavioural rather than neurodevelopmental.

“FOR GIRLS, IT'S MAYBE MORE INTERNALISED. IT'S NOT SHOWING EXTERNALLY LIKE IT WOULD WITH BOYS, BUT IT'S MORE INTERNAL. THAT MIGHT BE WHY PEOPLE DON'T PICK UP ON IT IN GIRLS BECAUSE THEY APPEAR TO BE HANDLING THINGS BETTER OR DOING WELL WHILE INTERNALISING THEIR STRUGGLES”-P8, CLINICAL NURSE SPECIALIST, SEXUAL HEALTH

Masking and late diagnoses

The professional interviewees also reflected that many girls only receive diagnoses in adolescence or adulthood, often after significant distress or crisis points, such as involvement with social services or the criminal justice system.

“PROFESSIONALS DON'T ALWAYS PICK UP ON IT UNTIL THE YOUNG PERSON IS REACHING THE END OF SECONDARY SCHOOL...YES, DEFINITELY-ESPECIALLY WHEN IT COMES TO AUTISM. ADHD IS DIAGNOSED MORE FREQUENTLY, BUT EVEN THEN, A LOT OF CASES INVOLVE LATE DIAGNOSES, PARTICULARLY FOR GIRLS” -P6, CHILDREN'S SERVICES STAFF

6.5 Identity and belonging

Professionals shared insights into how themes of identity and belonging emerge in their work with neurodivergent young women and girls. They observed that many neurodivergent young people—particularly those in care or with histories of trauma—often experience a deep sense of disconnection and isolation. This emotional distance can increase their vulnerability to abusive relationships or exploitation.

“THEY'RE DRAWN TO THAT BECAUSE THEY'RE LIKE, OH, THIS IS SOMEONE THAT I CAN BE FRIENDS WITH AND THAT THEY'LL CARE ABOUT ME AND PROTECT ME IN THAT SORT OF SENSE OF BELONGING. AND THEN I THINK... THEY GO ALONG WITH THINGS, DON'T THEY?”-P3, CHILDREN'S SERVICES STAFF

Through their work, professionals noted that young people frequently struggle to understand their identities, especially when neurodivergence intersects with trauma. Many express confusions about their emotions, behaviours, or diagnoses, and question whether something is inherently wrong with them.

“SHE WAS AWARE THAT SHE FELT QUITE DIFFERENTLY ABOUT THINGS COMPARED TO EVERYONE ELSE... BUT THEN SHE PUT THAT DOWN TO BEING A BAD STUDENT OR A BAD HUMAN.”-P15, LOCAL HE STAFF

Professionals also highlighted that girls tend to internalise their struggles. They often mask their difficulties and are more likely to question themselves. Because girls are frequently diagnosed later in life, this can delay access to support and deepen their confusion around identity.

“GIRLS ARE MORE LIKELY TO QUESTION THEMSELVES... THEY TEND TO LOOK WITHIN A LOT MORE.”-P2, CHILDREN’S SERVICE STAFF

“THERE’S A LOT OF PRESSURE ON YOUNG FEMALES TO BE MATURE AND STRAIGHT-THINKING... FEAR OF NOT BEING SEEN THE WAY THEY WANT TO PORTRAY THEMSELVES.”-P8, CHILDREN’S SERVICES STAFF

Cultural and social identity also emerged as significant themes. Professionals noted that cultural stigma surrounding mental health and neurodivergence can influence how young people and their families perceive and respond to diagnoses. In some cases, young people reject diagnostic labels due to cultural beliefs or fear of being seen as different. While these reflections relate to boys that professionals were speaking about, it is relevant for girls also.

“IN SOME CULTURES, MENTAL HEALTH SUPPORT IS SEEN AS A WEAKNESS... THEY MIGHT ONLY ENGAGE AFTER YEARS IN THE UK.”-P2, CHILDREN’S SERVICES STAFF

“HE DOESN’T REALLY WANT TO BE DIFFERENT AND DOESN’T WANT SUPPORT... JUST BECAUSE OF HIS DIAGNOSIS...HE JUST WANTS TO HAVE FRIENDS.”-P9, SPECIALIST SCHOOL NURSE

Finally, professionals reflected on the role of institutional identity and labelling. They expressed mixed views on the impact of diagnoses such as “autistic” or “ADHD.” While some young people find these labels empowering and helpful for accessing services or understanding themselves, others resist them to avoid further marginalisation.

THEY’VE ALREADY GOT THE LABELS OF CHILDREN IN CARE... IT’S JUST TOO MUCH TO THEN GO AND GET ANOTHER LABEL.”-P2, CHILDREN’S SERVICES STAFF

“THEY’VE HAD A LOT OF LABELS THROWN AT THEM...”-P15, LOCAL HE COLLEGE STAFF

6.6 Cultural and familial influences

It is noteworthy that participants primarily discussed diagnostic issues through the lens of gender differences. Strikingly, there was minimal consideration of race and ethnicity in these discussions, although some participants did reflect on broader cultural and societal influences.

A few professionals—particularly those working with young people from diverse cultural backgrounds—highlighted the role of parental influence and denial in shaping attitudes toward mental health and neurodivergence. For instance, young people from Iranian, Iraqi, and other non-Western backgrounds were described as facing stigma or having their needs dismissed.

It was also noted that seeking a diagnosis or engaging in therapy may be perceived as a sign of weakness, especially among boys, which can delay or prevent access to support:

> “IT’S SEEN AS A WEAKNESS BY A LOT OF OUR YOUNG BOYS... ONCE THEY’VE BEEN IN THE UK FOR TWO OR THREE YEARS... THEN THEY START GOING, ‘OK, I’LL GIVE IT A GO.’”— P2, CHILDREN’S SERVICES STAFF

Parents from certain cultural backgrounds were sometimes described as resistant to assessments or diagnoses for their children, due to stigma, limited awareness, or cultural beliefs. This resistance can lead to delayed support and greater challenges navigating systems later:

> “PARENTS DIDN’T WANT AN ASSESSMENT... THEN THEY FOUND IT VERY DIFFICULT WHEN THEY’VE GOT TO SECONDARY SCHOOL.”— P3, CHILDREN’S SERVICES STAFF

Family secrecy also emerged as a theme. In one case, a family chose not to disclose a diagnosis to their child, based on cultural advice and fear of labelling:

> “HIS MUM DIDN’T WANT HIM TO KNOW IT. SHE’D BEEN TOLD IT WASN’T A GOOD IDEA TO TELL HIM.”— P9, SPECIALIST SCHOOL NURSE

While the mother may have believed she was protecting her child, withholding this information can have significant consequences. Without understanding that they are autistic, young people may struggle to make sense of their experiences, feel isolated, or blame themselves for social and academic difficulties. It also deprives them of the opportunity to access appropriate support.

These insights underscore the importance of working closely with parents to raise awareness, challenge stigma, and ensure that cultural considerations are addressed in a sensitive and supportive manner.

6.7 Implications

Chapter 6 explored how neurodivergence intersects with gender, trauma, and systemic risk, drawing on insights from professionals across health, education, social care, and justice sectors. Professionals shared their views that neurodivergent girls and young women are often misunderstood, misdiagnosed, or overlooked due to gendered expectations, cultural stigma, and fragmented systems. The chapter identified diagnostic ambiguity and gender bias, trauma-neurodivergence overlap which could cause confusion, cultural and familial influences which delay or prevent access to support, issues of identity, belonging and their connection to vulnerability, and inconsistent professional understanding of neurodivergence.

This chapter deepens the systemic analysis from Chapter 4 and adds a critical lens on how gender and culture shape the recognition and response to neurodivergence. It also reinforces the lived experiences shared in Chapter 5, particularly around identity, stigma, and the need for nuanced, person-centred support.

7. How are services and professionals delivering support that meets the needs of neurodivergent young women and girls who have experienced sexual exploitation or domestic abuse?

7.1 Introduction to chapter

This chapter explores how services and professionals across services in the Royal Borough of Kingston Upon Thames are delivering support to neurodivergent young women and girls who have experienced sexual exploitation or domestic abuse. Building on the lived experiences shared in Chapter 4 and the professional insights in Chapter 5, this chapter focuses on both the what and the how of support delivery. It examines the specific needs expressed by young people—such as consistency, clear communication, and trauma-informed care—and evaluates how professionals are responding to these needs through adapted practices, advocacy, and multi-agency collaboration. Drawing on interviews, survey data, and literature, the chapter highlights promising approaches while identifying areas for improvement in tailoring support to neurodivergent young women and girls.

7.2 Building consistent support, trust and relationships

This theme emerged frequently in professionals' accounts as a central aspect of their work with young people, closely aligning with young people's desire for consistent support and authentic and genuine relationships, as discussed in Chapter 4. This reflects not only a practical support need but also young people's preferences for how services and professionals should engage them. A reflection from a young person, about what kind of support they wanted, is encapsulated in the following quotation:

> SORT OF PEOPLE THAT ACTUALLY LISTEN AND ACTUALLY TAKE IN WHAT YOU'RE SAYING AND ACTUALLY BELIEVE YOU, AND NOT SAY YOU'RE DELUSIONAL, AND ACTUALLY HEAR WHAT YOU'RE SAYING, AND ACTUALLY LISTEN TO IT RATHER THAN JUST HEARING THE WORDS AND THEN, GOING, “OH, WELL, YOU'RE A TEENAGER. IT DOESN'T MATTER.”-YP7

Professionals described consistent support as a steady, ongoing presence - essential for building trust particularly with neurodivergent and trauma-affected young people.

They emphasised that trust is not assumed but earned over time through repeated, reliable interactions.

> **“SOME YOUNG PEOPLE GET MORE [SESSIONS], ESPECIALLY NEURODIVERGENT YOUNG PEOPLE, BECAUSE IT TAKES TIME TO BUILD TRUST AND DELIVER INTERVENTIONS IN BITE-SIZED CHUNKS.”**
> **— PI5, CHILDREN’S SERVICES STAFF**

Long-term relationships with the same worker were seen as critical for sustained engagement. Professionals recognised that frequent changes in staff can disrupt progress and reinforce feelings of instability or rejection. Significantly, long-term relationships with the same worker are seen as critical for engagement.

> **“IF YOU’RE ONLY GOING TO THEM WHEN SOMETHING BAD HAS HAPPENED, WHAT KIND OF MESSAGE ARE YOU SENDING IN TERMS OF THEIR SELF-WORTH?”— PI1, CHILDREN’S SERVICES STAFF**

A consistent adult presence was understood to be a protective factor for young people lacking stable relationships elsewhere. This is especially important for those with histories of trauma or disrupted care.

> **“I TRY TO BE A SOLID, CONSISTENT PERSON FOR THEM… EXPLOITATION OR ABUSE IS RARELY THE FIRST TRAUMA THEY’VE EXPERIENCED.”— PI5, CHILDREN’S SERVICES STAFF**

Practitioners spoke about adapting their communication styles while maintaining predictability in their interactions. This included using consistent tools, language, and routines to help young people feel safe and understood.

> **“I OFTEN RECAP WHAT WE TALKED ABOUT LAST TIME OR SEND A FOLLOW-UP MESSAGE. IT HELPS THEM PROCESS AND FEEL SECURE.”— PI3, CHILDREN’S SERVICES STAFF**

Despite their efforts, professionals acknowledged that maintaining consistency is not always easy. Systemic issues such as short-term contracts, high caseloads, and service transitions (e.g. turning 18) were undermining consistency. The type and remit of a service is relevant here – those limited to providing short-term support (e.g. 6 sessions) to young people who have experienced trauma was seen to undermine relationship-building and reduce opportunities to really make a difference for neurodivergent and trauma-affected young people.

Practitioners talked about how they try to bridge these gaps by supporting transitions:

> **“I MIGHT SUPPORT THEM THROUGH THE TRANSITION INTO ADULT SERVICES… BUT I CAN SUPPORT THEM WHILE THEY GET COMFORTABLE.”— PI5, CHILDREN’S SERVICES STAFF**

Others act as advocates to ensure young people do not lose access to services due to age limits or contract changes. This includes pushing for flexibility in service provision or helping young people navigate new systems.

7.3 Personalisation and flexibility in practice

Young people's accounts, in chapter 5, also highlighted how positive experiences were rooted in trauma-informed, empathetic and individualised care, and how they wanted clear and accessible communication from professionals. Professionals' accounts of their approaches reflected the many ways they were attempting to provide this kind of care.

Professionals across all the different services consistently emphasised tailoring their support to each young person's communication style, cognitive needs, and emotional readiness. We asked professionals how, when and where they adapted their approaches, but the sense was that adaptation is not seen as an add-on but central to effective engagement. Professionals described different ways they adapted their practice to meet young people's needs:

(1) Using visual aids to facilitate learning and communication
(2) Communication style
(3) Session structure and environment
(4) Relationship based practice
(5) Attention to sensory and emotional regulation
(6) Cultural and identity sensitivity
(7) Trauma-informed practice

The use of visual aids to facilitate learning and communication were common approaches described by practitioners. Table 7a provides examples shared by professionals in the interviews.

What visual aids were used	How are these used?
Purpose: to enhance comprehension	
Social storyboarding	Used to explain social situations, expectations, or safety plans
Mind mapping	This helps young people visually organise thoughts, feelings or goals
Energy balance visuals	Illustrates what drains or replenishes energy using scales or diagrams
Purpose: to support memory and processing	
Text summaries, written lists or take-home materials	Used to help remind young people what was discussed in the session or what they needed to remember for next time
Take home materials	For young people to review and remind themselves what was discussed so they would remember for the next session

Use of visual prompts	These would be used during sessions to support recall and reduce anxiety
Purpose: to adapt to sensory and learning needs	
Using larger visuals or colour-coded materials	
Printing lyrics or handouts on yellow paper for visual comfort	
Offering videos or animations instead of text-heavy explanations	
Purpose: to facilitate emotional expression	
Feelings wheels	To help identify and label emotions
Drawing or art-based prompts	Used as creative therapy or to distract young people during emotionally laden conversations
Drama therapy	Using visual and performative elements
Promoting engagement and co-creation	
Vision boards and goal maps	For use by practitioners with young people
Card-sorting activities	To explore relationship dynamics
Co-designing safety plans	Using visual inputs from the young person

The use of visual aids to facilitate learning and communication were common approaches described by practitioners. Table 7a provides examples shared by professionals in the interviews.

> “I WILL SLOW THINGS DOWN A BIT OF THAT’S WHAT THEY NEED...I PACE MY WORK BECAUSE SOME TOPICS CAN BE QUITE TRIGGERING.”- P5, CHILDREN’S SERVICES STAFF

> “I MIGHT LIKE WRITE A LIST OR LIKE, I’LL TEXT THEM AFTER AND SAY, THESE ARE THE THINGS WE SPOKE ABOUT. HAVE A THINK ABOUT THIS.”-P3, CHILDREN’S SERVICES STAFF

Session structure and environment was highlighted as a key adaptation. Professionals recognised that some young people needed shorter or flexible session lengths, especially those with attention or sensory challenges. They described taking frequent breaks and pacing, to allow young people time to process emotionally difficult topics. Professionals would offer a choice of setting, such as home visits, community spaces, or quiet clinic times to reduce anxiety.

“WE MIGHT AIM FOR 30-45 MINUTES, WHICH CAN BE JUST AS IMPACTFUL AS STRETCHING IT TO AN HOUR, WHERE THEY MIGHT STOP ENGAGING FOR THE LAST 15 MINUTES.” – P6, CHILDREN’S SERVICES STAFF

Relationship-based practice was also seen to provide an individualised approach with young people. Professionals felt that consistency and trust-building were essential to foster safety and openness. Encouraging young people to choose topics or activities was seen as an important way to increase their engagement. Non-directive approaches were also seen as important, avoiding pressure to disclose or process trauma before they are ready.

Professionals described a range of approaches to promote sensory and emotional regulation. Examples of sensory tools mentioned include fidget toys, chewable items, or calming spaces. Grounding techniques such as the fight-flight-freeze response and using analogies to normalise trauma symptoms were also some examples. Professionals were also aware of the need to be emotionally neutral when needed to avoid overwhelming the young person.

“SOMETIMES, THE WORK I DO WITH A YOUNG PERSON INVOLVES GROUNDING TECHNIQUES WHEN THEY’RE FEELING TRIGGERED. SOME RESOURCES I USE HAVE NICE WAYS OF EXPLAINING THE FIGHT-FLIGHT-FREEZE RESPONSE”. – P5, CHILDREN’S SERVICES STAFF

7.4 Trauma-informed approaches

Professional narratives reflect a deeply embedded trauma-informed ethos across all aspects of direct work with neurodivergent young people. Practitioners demonstrated a nuanced understanding of trauma’s impact on cognition, behaviour, and relational dynamics, and this understanding informs both the structure and delivery of support.

A foundational principle evident throughout the document is the prioritisation of emotional safety and trust. Practitioners emphasised the importance of consistency, patience, and non-judgmental engagement, recognising that many young people have experienced fractured relationships with adults. Disclosures of trauma are often described as emerging gradually - sometimes over months - requiring professionals to maintain a stable and accepting presence.

Sessions are tailored to the individual’s emotional readiness and sensory needs. This includes flexibility in session length, the use of visual and concrete communication tools, and the incorporation of grounding techniques to support emotional regulation. For example, practitioners use feelings wheels, body-based cues, and analogies such as the fight-flight-freeze response to help young people identify and process emotions.

The document also highlights the intersection of trauma and neurodivergence, noting that trauma can both mask and mimic neurodevelopmental conditions. Practitioners are careful not to pathologise behaviour without context and often work without formal diagnoses, focusing instead on observed needs and strengths.

Multi-agency collaboration further reinforces trauma-informed care. Practitioners work closely with CAMHS, social care, schools, and families to ensure wraparound support. They also act as advocates and intermediaries, facilitating communication between young people and their caregivers, and co-developing safety plans that are meaningful and actionable.

7.5 Talking about neurodiversity

The previous chapter identified the ways in which professionals, in the interviews, talked about their understanding of neurodivergence. That chapter showed clear awareness across professionals, with some themes relating to conceptual and diagnostic ambiguity. One young person struggled, in the interview, to explain their autism, highlighting a need for professionals to understand that self-expression may be a challenge for them.

Within their practices, practitioners emphasised the need for honesty and sensitivity in conversations with young people about neurodiversity. Several professionals emphasised being transparent while also being sensitive to how a young person might receive information about neurodivergence. They avoid overwhelming young people with labels and instead focus on what the labels might mean for support, rather than for identity:

“IT DOESN’T CHANGE WHO YOU ARE… BUT IT MIGHT OPEN SOME DOORS FOR YOU.” — PI2, CHILDREN’S SERVICES STAFF

Discussions are often timed carefully, based on the young person’s emotional state or openness. Professionals’ accounts suggest they “pick their moment,” such as when a young person is reflective or calm, rather than during crisis.

“IF THEY’RE IN A REFLECTIVE MOOD, USE THE OPPORTUNITY.” -PI2 CHILDREN’S SERVICES STAFF

Other professionals spoke about framing neurodivergence as a difference in processing or communication, rather than a deficit, and advocated avoiding labels altogether. Some professionals spoke about helping young people understand themselves better, often using metaphors, visuals or analogies.

“I TELL THEM, ‘YOUR BRAIN JUST WORKS DIFFERENTLY.’”-PI15, LOCAL HE COLLEGE STAFF

“DON’T EVEN CALL IT NEURODIVERSITY… SAY SOMETHING LIKE, ‘THIS CHILD PREFERS TO COMMUNICATE IN ABC.’” — PI2, SOCIAL WORKER

Some professionals explained that they avoid using diagnostic terms unless necessary, especially if the young person is undiagnosed or resistant. Instead, they describe preferences and needs in neutral, descriptive language.

Professionals’ discussions with young people often appeared to intersect with questions of identity, especially when young people are trying to understand why they feel ‘different’. The professionals who mentioned this explained that they seek to validate these experiences and help young people explore them safely.

“THEY ALL QUESTION, ‘WHAT’S GOING ON IN MY BRAIN?’ SOMETIMES IT JUST TAKES A PROFESSIONAL TO SAY, ‘LET’S TALK ABOUT IT.’” -PI5 CHILDREN’S SERVICES STAFF

However, some young people expressed frustration with the support available to them, noting that it often fails to accommodate their neurodivergent needs. One young person reflected:

“OH, DEFINITELY, BECAUSE A LOT OF IT IS VERY NOT SUITED. IT’S PART OF THE REASON WHY I HAVEN'T SOUGHT OUT AN ACTUAL THERAPIST, BECAUSE MOST OF THE TIME THEY'RE JUST NOT SUITED TO THE WAY THAT MY BRAIN WORKS.”-YP7, CLINICAL NURSE SPECIALIST, SEXUAL HEALTH

This highlights the importance of professionals not only being sensitive in their approach but also ensuring that the support offered is genuinely accessible and aligned with neurodivergent ways of thinking and processing.

Some professionals spoke about how they work with families to help them understand that their child’s behaviours may stem from neurodivergence or trauma, rather than being troublesome young people.

“SOME PARENTS WORRY THAT NEURODIVERGENCE IS BEING USED AS AN EXCUSE… WE HELP REFRAME THAT.” — PI6, CHILDREN’S SERVICES STAFF

A specialist school nurse working in alternative education (specifically, a Pupil Referral Unit) reflected on the challenges of addressing neurodivergence-related needs among the young people she supports. She highlighted how the nature of her role—operating within a consent-based framework—can act as a barrier to initiating conversations about neurodivergence.

In consent-based services, professionals can only engage with young people about their specific needs if the young person is willing to participate. This limitation often shapes the scope of support that can be offered. The nurse noted that although many of the students she works with are neurodivergent or exhibit traits of neurodivergence, they are frequently hesitant to discuss their diagnoses or related needs.

She emphasized the importance of being sensitive and adaptable in her approach to building trust. However, she acknowledged that the young person’s readiness and willingness to engage ultimately determine how far these conversations can go.

“TO BE HONEST, I’M NOT FINDING A LOT OF YOUNG PEOPLE ACTUALLY WANT TO TALK ABOUT THEIR DIAGNOSIS THAT MUCH… IT’S CONSENT-BASED SEEING ME. I CAN’T GO ANYWHERE WITH SOMEONE IF THEY DON’T WANT TO SPEAK.” — PI9, SPECIALIST SCHOOL NURSE

7.6 Advocacy and empowerment

Professionals described a range of ways they advocate for neurodivergent young women and girls. A common theme across many interviews was their role as intermediaries—facilitating challenging conversations between young people and their families, or with services such as schools, general practitioners (GPs), and Child and Adolescent Mental Health Services (CAMHS).

Some professionals spoke about supporting young people through key life transitions, including the shift from child to adult services. They emphasised that becoming an adult is not a sudden change at age 18, but rather a gradual and uneven process that differs for everyone.

A number of professionals highlighted the lack of continuity between children's and adult services. This gap can leave young people without support at a critical time—a challenge that is especially significant for neurodivergent individuals. Adults' services tend to be more fragmented, diagnosis specific, and focussed on individual responsibility which can be overwhelming for neurodivergent individuals who may need continued support with communication or self-advocacy:

> **"ONCE THEY TURN 18, I AIM TO CLOSE MY WORK WITH THEM, BUT I CAN SUPPORT THEM WHILE THEY GET COMFORTABLE WITH ANY ADULT SOCIAL CARE THEY MIGHT RECEIVE." — P15, CHILDREN'S SERVICES STAFF**

> **"MOST OF MY YOUNG PEOPLE WHO TURNED 18 HAVE DECLINED FURTHER REFERRAL TO ADULT SERVICES." — P6, CHILDREN'S SERVICES STAFF**

Several professionals also discussed how they promote independence without creating a sense of abandonment. Their goal is to empower young people to build agency and confidence, while continuing to provide necessary support:

> **"INSTEAD OF DOING THINGS FOR THEM, IT'S EITHER DOING IT WITH THEM OR SHOWING THEM HOW AND LETTING THEM DO IT. IT GIVES THEM THE CHOICE."— P18, CHILDREN'S SERVICES STAFF**

7.7 Education and healthy relationships

While none of the young people expressed explicit need for education and healthy relationships, this provision appears to be a cornerstone of direct work with neurodivergent young people who have experienced trauma or are at risk of exploitation. Practitioners emphasised the importance of equipping young people with the knowledge, language, and confidence to navigate interpersonal relationships safely and meaningfully.

A key focus of this work is preventative education, which includes structured learning around consent, boundaries, emotional literacy, and the identification of healthy versus unhealthy relationship dynamics. Resources such as 'Real Love Rocks' were given as examples of how to facilitate these discussions, offering visual and interactive tools that resonate with young people.

These sessions are often adapted to meet individual cognitive and emotional needs, employing simplified language, repetition, and concrete examples to ensure accessibility.

Practitioners also integrate relationship education into therapeutic practice. Rather than relying solely on formal instruction, they use everyday interactions—such as walks, games, or creative activities—as opportunities to explore relational themes. This informal approach was seen to help build trust and allows for more nuanced conversations about personal experiences and challenges.

Cultural and gender sensitivity is a critical component of this work. Practitioners recognised that cultural norms and gender expectations can shape how young people understand and engage in relationships. As such, they explained how they tailor content and delivery methods to reflect the lived realities of the individuals they support. In some cases, this involves delivering gender-specific sessions or adapting materials to align with cultural values.

Another significant theme is the challenge of conceptual understanding. Many neurodivergent young people struggle with abstract reasoning, which can hinder their ability to internalise safety plans or understand the implications of risky behaviour. Practitioners address this by using visual metaphors, feelings wheels, and scenario-based learning to bridge the gap between knowledge and application.

Finally, the work around healthy relationships is deeply intertwined with efforts to build self-esteem and a positive sense of identity. Practitioners aim to help young people recognise their worth and develop a vision for relationships that are respectful, supportive, and empowering. This often involves challenging internalised beliefs that may normalise exploitation or abuse and replacing them with affirming narratives of self-worth and agency.

Overall, the document highlights a holistic, person-centred approach to relationship education—one that is responsive to the diverse needs of neurodivergent young people and grounded in empathy, creativity, and collaboration.

7.8 Parent and carer support and collaboration

Professionals describe their work with parents and carers as multi-faceted, collaborative, and adaptive, aiming to support neurodivergent young people effectively. A key aspect of this work involves helping parents build both understanding and acceptance of neurodivergence.

Some parents are described as well-informed and proactive, while others may struggle to understand or accept their child’s neurodivergence—at times perceiving it as an “excuse” for certain behaviours. In these cases, practitioners support parents in reframing behaviours as expressions of unmet needs or characteristics of neurodivergence.

“SOME PARENTS WORRY THAT NEURODIVERGENCE IS BEING USED AS AN EXCUSE... WE HELP REFRAME THAT AND SUPPORT THEM TO ADJUST THEIR PARENTING APPROACH.”-PI6, CHILDREN’S SERVICES STAFF

To aid this process, services provide education and resources tailored to the needs of neurodivergent children and their families. This includes offering or referring parents to specialised parenting programmes and local support networks. Peer support groups are particularly valued by parents for the emotional reassurance and practical advice they offer.

“THE MOST IMPORTANT THING IS BUILDING THE NETWORK AROUND THE PARENTS... THEY’RE THE ONES MANAGING THIS DAY-TO-DAY.”-PI10, CHILDREN’S SERVICES STAFF

Professionals often act as intermediaries, facilitating sensitive conversations between young people and their parents—especially around complex issues such as mental health or substance use.

“WOULD IT HELP IF I SPOKE TO MUM ABOUT THIS? YOU CAN BE THERE IF YOU WANT, OR I CAN DO IT SEPARATELY.”-PI6, CHILDREN’S SERVICES STAFF

Cultural sensitivity is also a crucial part of this work. Practitioners adapt their language and approach to align with each family’s values and level of understanding.

“SOME CULTURES DON’T RECOGNISE AUTISM... WE START BY UNDERSTANDING WHERE THE PARENTS ARE IN THEIR JOURNEY.”-PI13, CHILDREN’S SERVICES STAFF

In situations involving trauma or exploitation, professionals work collaboratively with parents to identify risks and develop appropriate safety strategies.

“WE PRE-WARN PARENTS THAT IF SOMETHING HAPPENS AGAIN, DON’T SCREAM AT THEM—SUPPORT THEM DIFFERENTLY.”-PI3, CHILDREN’S SERVICES STAFF

Support also extends to guiding families through the diagnostic process and helping them navigate the often-challenging period that follows a diagnosis.

“WE HAVE A POST-DIAGNOSTIC SUPPORT PLAN CALLED THE A PLAN... FAMILIES GET CHECK-INS AND ACCESS TO WORKSHOPS OVER A YEAR.”-PI4, CHILDREN’S SERVICES STAFF

Throughout, professionals emphasised co-production—working with parents rather than for them—to ensure they feel empowered, involved, and supported in their role.

7.9 Opportunities for social connection

The young people we spoke to highlighted that isolation was a particular problem they faced, and wanted more chances to socialise with peers, especially in educational or care settings. Normal activities like attending school, making friends, and having routines were seen as essential to feeling 'normal'.

As noted above, social connections were promoted through consistent, long-term relationships with social workers, therapists or other key workers. Approaches to connection were seen in ways of reflective listening and conversational support during walks, creative activities, or informal chats. The use of flexible communication styles supports trusting relationships.

"SOMETIMES I MEET THEM FOR A WALK IN THE PARK. THE INTERVENTION IS THE CONVERSATION." — PI5, CHILDREN'S SERVICES STAFF

Opportunities for social connection were also observed through group work and peer interactions. These could take place in healthy relationship workshops, tailored by age, gender, and cultural background, or within therapeutic groups, social groups and expressive arts environments.

"WE RUN EXPRESS YOURSELF GROUPS... THEY FOCUS ON SOCIAL ENGAGEMENT AND LEARNING ABOUT RELATIONSHIPS." — PI16, VOLUNTARY SECTOR SPECIALIST SERVICE

Professionals talked about informal and community-based spaces which promote engagement, such as drop-in cafes and enrichment hubs in colleges or community centres. Sometimes however, these could cause anxiety, particularly relevant for young women and girls with sensory needs. Home visits or meetings in safe, familiar environments were seen to help reduce anxiety and increase comfort. Peer mentoring and parent champion networks were mentioned to support both young people and their families.

"THERE'S A CAFÉ YOU CAN DROP INTO EVERY DAY... BUT SOME YOUNG PEOPLE FIND GROUP SPACES INTIMIDATING." — PI15, LOCAL HE COLLEGE STAFF

A few professionals perceived risks that may come with promoting social connections in groups

"ONE THING I FEEL IS MISSING, PARTICULARLY FOR GIRLS, IS DEDICATED YOUTH WORK-BASED SPACES. THERE ARE EXISTING OPTIONS, BUT SOMETIMES PLACING A NEURODIVERSE YOUNG PERSON IN CERTAIN SETTINGS CAN ACTUALLY INCREASE THEIR RISK—ESPECIALLY IF THEY FORM WHAT THEY PERCEIVE AS FRIENDSHIPS WITH CERTAIN INDIVIDUALS WHO MAY EXPOSE THEM TO HARMFUL INFLUENCES" - PI6, CHILDREN'S SERVICES STAFF

This same professional also highlighted a particular gap in provision for girls who may have neurodivergent traits but present as 'neurotypical', and therefore may not identify with groups labelled for neurodivergent young women and girls:

> “THERE ISN’T REALLY A SPACE FOR YOUNG GIRLS WHO PRESENT AS NEUROTYPICAL—WHERE THEIR ADDITIONAL NEEDS MAY NOT BE IMMEDIATELY OBVIOUS TO OTHERS. WE NEED A SAFE PLACE FOR THEM TO CONNECT WITH PEERS, ACCESS TARGETED SUPPORT, AND HAVE CONVERSATIONS ABOUT IMPORTANT TOPICS"-P16, CHILDREN’S SERVICES STAFF

Finally, professionals talked about methods of empowering young people through co-design, which also offered opportunities to create close social connections. Examples such as the co-creation of safety plans and goals with young people were described, ensuring young people’s voices were central. Encouraging young people’s self-expression through use of vision boards, mind maps, or storytelling were examples also discussed.

7.10 Challenges in direct work with neurodivergent young women and girls

While the professionals provided a wealth of rich insight into the ways they were adapting their practices to support neurodivergent young women and girls, there were notable challenges identified that span systemic, interpersonal, diagnostic, and therapeutic domains. Many of the challenges to direct support were highlighted in the previous chapter, such as the gendered experiences of young women and girls which can complicate identification and tailoring of support, the neurodivergence and trauma overlap which can confuse young women and girl’s needs, the cultural and parental dynamics which can prevent or frustrate identification of young women and girls’ needs, and the complexities of abuse and exploitation.

Also, as already highlighted in the previous chapter, and hinted at within this one, professionals noted the diagnostic and systemic barriers that proved frustrating in their work. In particular, the long waiting times was a notable theme. Post-diagnosis support was also highlighted as a challenge, where families can feel abandoned after receiving a diagnosis, with little follow up or guidance. The shift from child to adult services is particularly difficult, with concerns that young people may fall through the cracks.

Communication and engagement challenges were also evident in professional accounts. Professionals are themselves adapting to communication needs in creative ways, but this can take time to get right. It was noted that establishing rapport often requires more time and consistency, especially for those with trauma histories. Neurodivergent young women and girls may need longer to understand and articulate their experiences, and their communication and engagement needs often means their timeline for support may need to be longer than for neurotypical young women and girls - which is particularly problematic when support offered is short-term in nature.

7.11 Summary

Chapter 7 explored how services in the Royal Borough of Kingston Upon Thames are currently supporting neurodivergent young women and girls affected by sexual exploitation or domestic abuse.

Drawing on professional interviews and survey data, it highlights promising practices while identifying persistent challenges in delivering inclusive, trauma-informed, and neurodivergence-aware support.

This chapter builds on chapters 4-6, reinforcing the need for systemic change while showcasing the commitment of professionals to adapt and advocate within existing constraints.

8. Internal Service Readiness

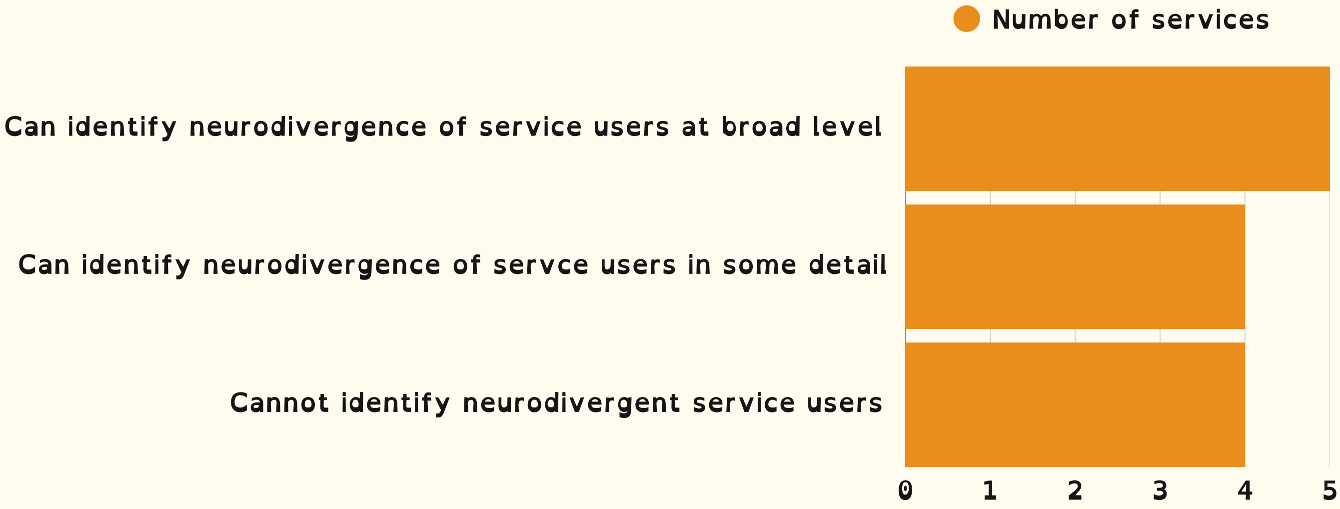
8.1 Introduction to chapter

This chapter examines the internal capacity of local services to identify and support neurodivergent young women and girls, particularly those at risk of or affected by domestic abuse and sexual exploitation. Drawing on professional interviews and survey data, it explores three key areas: workforce training and development, service capacity and referral readiness, and the integration of lived experience into service design. The findings reveal both promising practices and persistent gaps that affect the ability of services to respond effectively and equitably.

8.2 Understanding the needs of service users

Understanding the unique needs of service users is critical for services to provide tailored support and interventions. We explored, theoretically, with services who completed the survey whether they could provide a profile of their service users in respect of neurodivergent traits. The responses revealed a varied landscape in terms of data availability and detail. Chart 8a below provides visual representation of this variability.

Chart 8a: Data held on neurodivergent young women and girls, Survey responses, by number of services



Just over a third of the 14 services who responded to the survey reported that they could identify neurodivergent individuals, but only at a broad level. These services were able to acknowledge the presence of neurodivergent users within their systems yet lacked the capacity to break this down by specific types of neurodivergence such as autism, ADHD, or dyslexia.

Just under a third demonstrated a more advanced capability. These services could provide detailed information, categorising service users by specific types of neurodivergence. This group included a mix of sectors: two services from the voluntary sector, one from the statutory sector, and one operating as a community interest company (CIC).

Just under a third, all from the statutory sector, indicated that they either did not collect data on neurodivergence at all or that the data they had was unreliable. The limitations varied: one service had only recently begun recording autism and ADHD diagnoses and noted that the data was not yet dependable. Another recorded only the primary support need, which offered a narrow view. A third could identify children with Education, Health and Care Plans (EHCPs), but this did not necessarily reflect the type of neurodivergence—and not all neurodivergent children have EHCPs.

The final service (7%) gave a response that was unclear or did not fit neatly into the other categories. It may have overlapped with one of the existing groups but lacked enough detail to be definitively placed.

8.3 Workforce training and development

Professionals across sectors expressed a strong recognition of the need for training on neurodiversity. However, access to such training remains uneven. While some professionals described a well-developed training offer—particularly within statutory services—others reported limited or no access to neurodiversity-specific training.

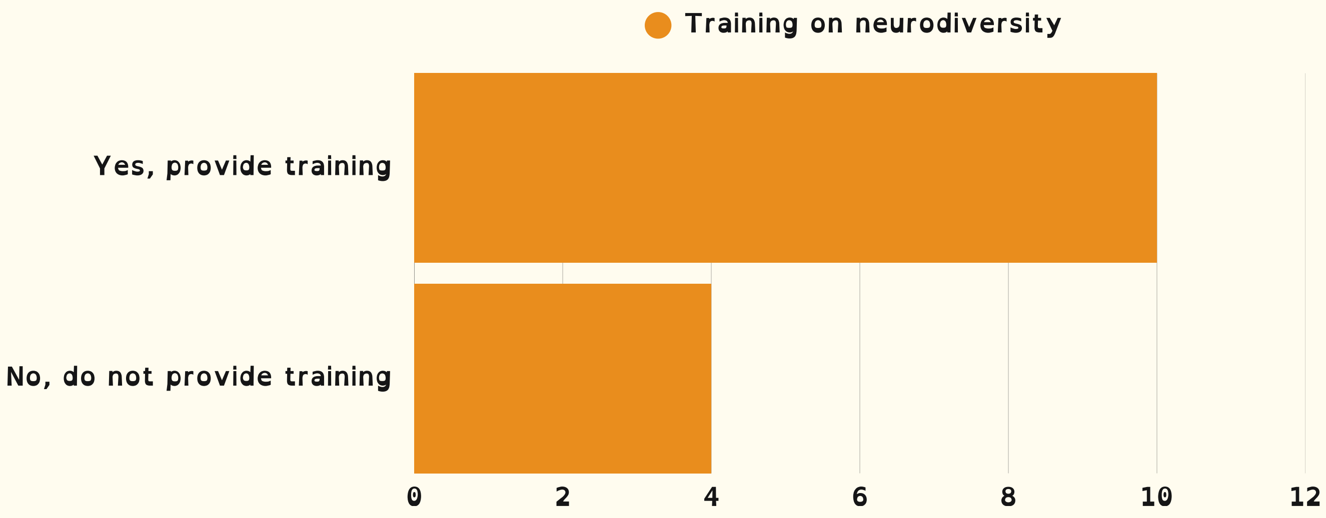
> “THERE’S A LOT OF TRAINING THAT SOCIAL WORKERS CAN ACCESS… SCHOOL STAFF AND UNQUALIFIED STAFF TOO.” — PI2, CHILDREN’S SERVICES STAFF

In contrast, in a commissioned service, there was, at present, no formalised training on offer:

> “IT’S SOMETHING WE COULD BENEFIT FROM—SOME TRAINING ON NEURODIVERGENCE.”
> — PI7, CLINICAL NURSE SPECIALIST, SEXUAL HEALTH

Survey data confirmed this inconsistency: nearly one-third of services reported not offering direct training on neurodiversity. This included both statutory and voluntary sector services.

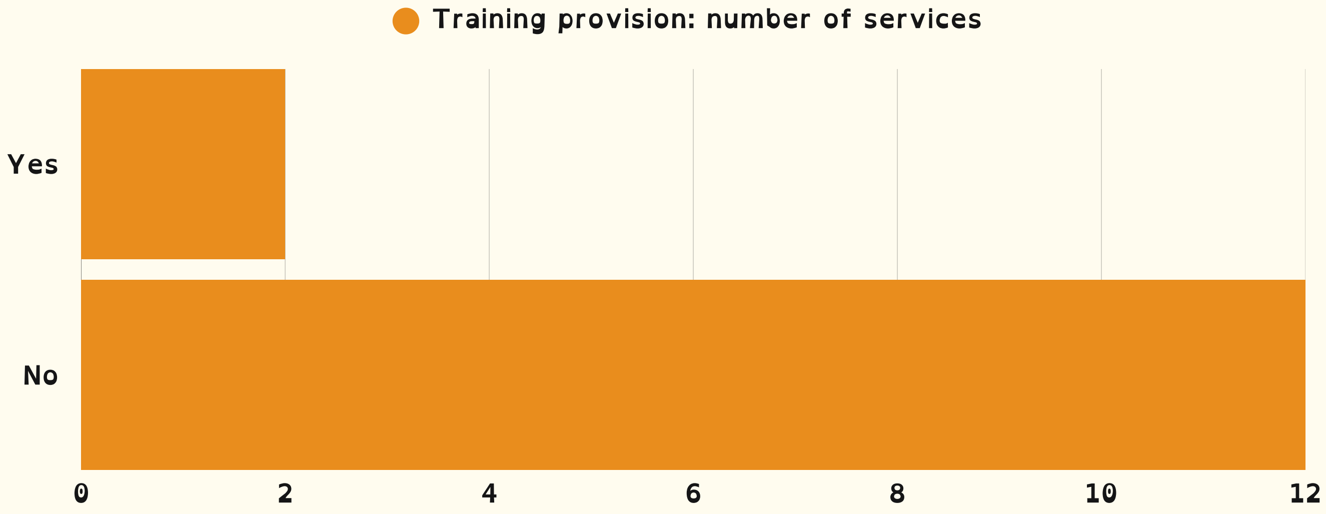
Chart 8b: Number of services providing training to staff on neurodivergence (survey responses)



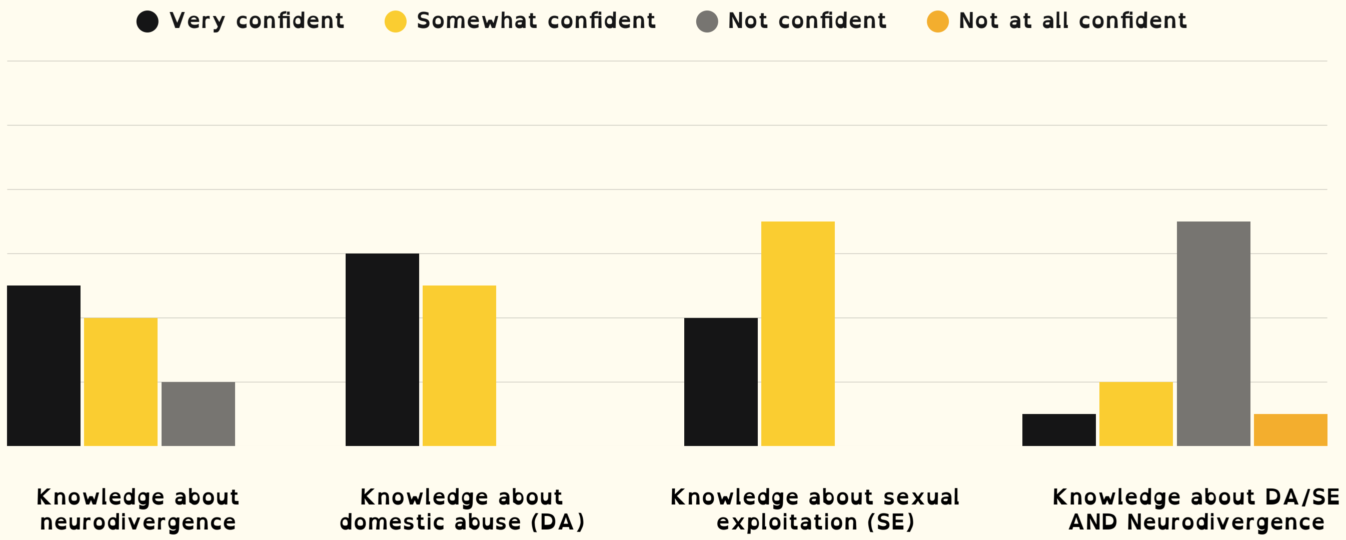
Gaps in training content

A significant gap exists in training on the intersection of neurodivergence with domestic abuse and sexual exploitation, particularly in how these issues manifest in girls, young women, and culturally and racially diverse populations. While most services in the survey confirmed general training on neurodivergence is provided by the service they represent, Chart 8b below illustrates that the specific interconnections between domestic abuse and/or sexual exploitation and neurodivergence does not form part of this training. This was also evident in professionals' reflections on training.

Chart 8c: Number of services providing training on the intersection between DA or exploitation and neurodivergence (survey responses)



This pattern was reflected in survey respondents' data on their confidence levels of staff within the service they represented. Chart 8b below illustrates generally high levels of confidence in staff knowledge of neurodiversity among 11 service respondents who answered this question, with similarly high levels of confidence in staff knowledge about domestic abuse and sexual exploitation. However, confidence levels were much lower when domestic abuse and sexual exploitation are considered in concert with neurodivergence.



Survey respondents also expressed a desire for more training on these intersections within qualitative open-text boxes:

> **“TRAINING FROM SPECIALISTS IN THIS AREA TO INCREASE AWARENESS AND GIVE STAFF A CHANCE TO REFLECT ON THIS TOPIC”.**

In the interviews, although trauma-informed practice is mentioned, few training programmes were reported by participants to deeply explore the overlap between trauma and neurodivergence, despite professionals acknowledging its importance:

> **“THE TRAINING ACKNOWLEDGED THAT AUTISTIC TRAITS CAN SOMETIMES RESEMBLE TRAUMA RESPONSES, BUT IT DIDN’T GO INTO DETAIL ABOUT HOW TO DIFFERENTIATE THE TWO…HOWEVER, IN PROFESSIONAL NETWORKS WE ARE VERY AWARE OF THIS OVERLAP.” – PI6, CHILDREN’S SERVICES STAFF**

Training was described by some participants as focussed on stereotypical presentations (e.g. boys involved in county lines), overlooking more nuanced signs in girls or children from diverse backgrounds:

> **“I THINK A LOT OF THE TRAINING IS VERY FOCUSED ON LIKE THE VERY STEREOTYPICAL SIGNS THAT WE SHOULD BE LOOKING FOR” – PI2, CHILDREN’S SERVICES STAFF**

Interview participants also highlighted some specific topical areas they would like to learn more about:

> **“ONE OF THE GAPS IS AROUND THE PARENTS SO WE KNOW HOW TO WORK WITH THE CHILDREN WHO ARE NEURODIVERSE, HOW DO WE WORK WITH THE PARENTS?” – PI13, CHILDREN’S SERVICES STAFF**

Informal learning and peer support

Many professionals, whether they had accessed training on neurodiversity, reported learning through experience, supervision, and peer support. This included:

- Learning directly from neurodivergent young people
- Drawing on the expertise of colleagues (e.g. speech and language therapists, designated social care officer)
- Participating in reflective practice and team discussions

“I’VE LEARNED ON THE JOB… THE YOUNG PEOPLE THEMSELVES TAUGHT ME.”— PI5, CHILDREN’S SERVICES STAFF

While valuable, this informal learning is not scalable and often depends on a few knowledgeable individuals, creating vulnerability in the system.
Demand for specialised and practical training

Professionals expressed a strong desire for training that is:

- Practical and intervention-focused

“IT’S ALWAYS GOOD TO HAVE MORE WAYS OF WORKING—HOW TO MAKE INTERVENTIONS STICK.” – PI5, CHILDREN’S SERVICES STAFF

- Regularly updated to reflect evolving understanding

“IT’S A FIELD THAT’S EVER-EXPANDING. I WANT TO STAY UP TO DATE.” – PI6, CHILDREN’S SERVICES STAFF

- Tailored to short-term work, such as goal-focused approaches, particularly relevant for services commissioned to deliver short-term work

“I’M ACTUALLY QUITE KEEN TO GO ON A COURSE FOR SHORT-TERM, BECAUSE ALL OF MY TRAINING IS ALL REALLY WORKING WITH LONG-TERM CLIENTS…OBVIOUSLY, HERE, I’VE GOT SIX SESSIONS, SO BASICALLY THAT WHOLE THING GETS RIPPED UP AND THROWN OUT THE WINDOW, AND ACTUALLY I COULD DO WITH REALLY MORE OF A…GOAL-FOCUSED APPROACH” – PI15, LOCAL HE COLLEGE STAFF

- Delivered by experts with lived or professional experience

8.4 Service capacity and referral readiness

Types of neurodivergence supported
In the survey, we asked service providers to identify the types of neurodivergence they are equipped to support within their services. All respondents indicated that they can support autistic young women and girls and those with learning disabilities. Table 8a below sets these out.

Most services also reported being able to support young women and girls with ADHD and epilepsy. Additionally, over three-quarters said they can support individuals with dyslexia, dyspraxia, and OCD. However, support for conditions such as Tourette’s Syndrome, Down Syndrome, and dyscalculia appears to be more variable.

One possible explanation is that these conditions are less frequently encountered, which may lead to lower levels of knowledge or confidence among providers. If services are genuinely unable to support these forms of neurodivergence, the reasons for this were not clearly articulated in the responses.

Importantly, the variation in support does not appear to be linked to whether a service is statutory or voluntary—both types reported a mixed ability to support these conditions.

Table 8a: Types of neurodivergence local services can support

Neurodivergence type	Number (percentage)
Autism/ Aspergers	14 (100)
Learning disability	14 (100)
ADHD	13 (92.9)
Epilepsy	12 (85.7)
Dyslexia	11 (78.6)
Dyspraxia	11 (78.6)
OCD	11 (78.6)
Tourette's syndrome	9 (64.3)
Downs syndrome	8 (57)
Dyscalculia	8 (57)
Other	2 (14)

One service additionally said (under the 'other' category) that they also work with young women and girls who are autistic with a PDA profile. The other service indicated they work with mental health conditions such as bi-polar disorder (BPD) and complex post-traumatic stress disorder (C/PTSD). Survey respondents' mention of these conditions possibly reflects the idea of acquired neurodivergence as mentioned in Chapter 1.

Participants were also asked to share, via open-ended text, the most common types of neurodivergence they encountered within their service provision to young women and girls with experiences of domestic abuse or sexual exploitation. Autism and ADHD were clearly the most common forms noted, aligning with the professionals' experiences as expressed in the interviews. Table 8b shares these findings.

Table 8b: Most common forms of neurodivergence encountered by survey respondents

Neurodivergence type	Number of respondents who mentioned this
Autism/ Aspergers	12
ADHD	11
Learning disability	6
Dyslexia	3
OCD	1
Downs syndrome	1
PDA	1

One service additionally mentioned anxiety, one mentioned C/PTSD, and one mentioned undiagnosed additional need.

Facilitators of good practice at the service level

Interview participants in both strategic and frontline practice roles spoke explicitly or implicitly about what they felt were positive embedded practices that facilitate effective support for neurodivergent young women and girls. These facilitators, however, often coexist with systemic challenges that limit their reach or impact.

Continuity of care

One of the most consistently cited facilitators was continuity of care. Practitioners across various services emphasised that neurodivergent young women and girls often require more time to build trust and engage meaningfully with support. Long-term services were seen as particularly beneficial in fostering relationships and developing a nuanced understanding of individual needs. In contrast, short-term interventions were described as ending prematurely, often before a young person's needs had been fully addressed. This was especially problematic in services where time-limited models are the norm, leaving young people without sustained support. Sexual health services, for example, highlighted the importance of repeated contact, noting that disclosures of abuse or neurodivergence often emerged only after trust had been established over time. Short-term models could also leave professionals feeling ill-equipped to address complex needs, and their professional wellbeing negatively impacted when they were unable to continue helping young women and girls who needed support. This was particularly acute when appropriate services for referring onward to were not available or where professionals were unaware of relevant services that might help.

Multi-agency collaboration

Multi-agency collaboration was cited as another key facilitator, with many professionals describing the value of working alongside external specialists such as Emotional Health Teams and Designated Social Care Officers (DSCOs).

Collaborative information gathering—particularly with schools, GPs, and families - was seen as essential in building a comprehensive picture of a young person's needs, especially in the absence of formal diagnoses. Integrated mental health support through Mental Health Support Teams (MHSTs), embedded in schools, was also seen as positive for offering a tiered approach that included individual and group interventions, parent workshops, and staff training. However, challenges in multi-agency working were also widely reported. Access to CAMHS was frequently described as difficult, with some professionals noting a decline in service quality. Others pointed to the limitations of collaboration that was confined to occasional panels or informal contact, and described some services as operating in silos, which hindered coordinated responses.

Strategic forums

Strategic forums such as Pre-MACE and VASA panels were identified as mechanisms for sharing intelligence and coordinating safeguarding plans. These panels often used risk scoring systems that could trigger earlier intervention for neurodivergent young people. Moreover, themed pre-MACE panels were seen as innovative approaches to raising awareness among internal staff and external partners of specific topics, sharing cross-case learning on themes such as education, sexual health, and neurodivergence. While these structures were valued by some, others expressed concern that they added to their workload without delivering tangible benefits to frontline practice. Inconsistent attendance from key stakeholders further limited their effectiveness, and some participants felt that the insights generated were more strategic than operationally useful.

Pre - and post - diagnostic support

The availability of post-diagnostic and pre-diagnostic support was another area of both strength and concern. Services offering structured follow-up after diagnosis—such as the "A Plan", which includes a year of check-ins, workshops, and signposting—were highly valued by professionals and reported to be valued by families. These models were seen as helping to avoid the "cliff edge" that often follows diagnosis. However, many professionals noted that such support was not universally available. One local service specialising in neurodiversity steps in to support young people awaiting diagnosis, filling critical gaps left by overstretched statutory provision. Yet these efforts are often unfunded or underfunded, limiting their capacity and sustainability.

Accessibility and equity

Accessibility and equity in service delivery were also highlighted as important facilitators. Some commissioned services offered walk-in flexibility and did not require a formal diagnosis for access, which was seen as particularly beneficial for vulnerable young people. Reception staff are trained to escalate concerns, and internal safeguarding structures—such as monthly case discussions—support timely responses.

Workforce culture

A strong workforce culture was spoken about by multiple professionals as another enabler of good practice.

Several services intentionally recruit staff with experience in Special Educational Needs or neurodivergent settings, including individuals with lived experience. These staff bring empathy, insight, and a commitment to peer learning, often sharing their expertise with colleagues. Internal cultures of reflection, peer supervision, and shared learning resources were also seen as enhancing practice. The Designated Safeguarding Officer role was particularly valued for its ability to bridge gaps between SEND and social care, offering coaching, role-play, and translation of professional language to help build trust with families. Notably, one participant advocated for expertise or lived experience, combined with trauma-informed knowledge, as the best model for supporting neurodivergent young people, noting the harm that had been caused by previous, inexperienced therapists, to many young people they support.

Early intervention and integrated systems

Helpful practices at the service level also included early intervention and integrated systems. Some services used indicators such as school exclusions and family instability to identify risk early and intervene before harm escalated. The integration of SEND and social care databases enabled more timely assessments by providing visibility of key vulnerabilities such as exclusions and EHCPs. Some teams undertook ‘trajectory’ work, which aimed to identify key early points in young people’s lives. This was seen as highly useful in helping to identify needs at an earlier point, understand young people holistically, personalise support, and monitor on-going progress.

Sustainability

Finally, while many services expressed a strong willingness to do more for neurodivergent young people, the sustainability of good practice remained a significant concern. Services were often open to partnership and innovation but lacked the long-term funding and strategic alignment needed to embed and scale effective models. Promising practices were frequently vulnerable to budget cuts or short-term commissioning cycles, and strategic ambitions did not always translate into operational capacity.

In summary, while there are numerous examples of good practice at the service level, these are often undermined by structural and systemic challenges. Addressing these barriers—particularly around funding, workforce development, and inter-agency coordination—will be essential to ensuring that neurodivergent young women and girls receive the consistent, tailored, and equitable support they need.

Involving lived experience in service design

This final section in this chapter addresses how services seek to engage with neurodivergent young women and girls to improve and tailor services to their needs. The survey explored the ways in which services were fostering the engagement of young neurodivergent young women and girls in shaping the services designed to support them. This revealed mixed findings. Overall, the data suggests that service learning from neurodivergent young women and girls remains limited and largely informal.

Out of 14 services surveyed, 10 reported that they “seek input from our service users where we can”. However, none provided further details in the open-ended text boxes on how this input is gathered or integrated into service design.

One respondent noted the presence of a specialist champion within their service, while another said:

“WE HAVE NEURODIVERGENT MEMBERS OF STAFF WHO ARE WILLING TO USE THEIR KNOWLEDGE TO SUPPORT AND ADVISE ON OUR SERVICES.”

In the open-text responses, two participants expressed a lack of awareness regarding any structured approach to incorporating service user input:

“I AM NOT AWARE OF ANY SERVICE USER INPUT WITHIN THE SERVICE THAT SPECIFICALLY RELATES TO GIRLS AND YOUNG WOMEN WHO ARE NEURODIVERGENT.”

Another respondent acknowledged the need for improvement in this area:

“THIS CAN BE IMPROVED TO ENSURE THE SPECIFIC NEEDS OF NEURODIVERGENT YOUNG WOMEN AND GIRLS ARE MET.”

The lack of detailed strategies suggests that either respondents are unaware of mechanisms in place in their services, or they reflect a gap in formal mechanisms for involving neurodivergent young women and girls in service design. While the presence and willingness of neurodivergent staff members is a positive step, neurodivergent young women and girls with specific experiences of domestic abuse and/or sexual exploitation are likely to have different and more nuanced needs. Involving them in service design could better enhance services tailored specifically to their needs. Developing structured, inclusive consultation processes could enhance service relevance and effectiveness.

8.5 Summary chapter specific recommendations

Chapter 8 examined the internal capacity of local services in the Royal Borough of Kingston Upon Thames to support neurodivergent young women and girls affected by sexual exploitation or domestic abuse. It focused on three key areas: workforce training and development, service capacity and referral readiness, and the integration of lived experience into service design. The chapter highlights perspectives from professionals and services that suggest there is inconsistent training provision, confidence gaps among staff, that good practice exists but is vulnerable to or dependent upon individual staff or short-term funding, making them difficult to sustain or scale, and that there is limited participation or co-production activity for service improvement for neurodivergent young women and girls. The chapter reinforces the need for systemic reform and investment in workforce development, while also highlighting the importance of embedding lived experience and inclusive practice into service infrastructure.

9. Structural and systemic barriers

9.1 Introduction to chapter

This chapter consolidates the structural and systemic challenges that hinder effective support for neurodivergent young women and girls, particularly those affected by domestic abuse and sexual exploitation. Many of the themes have been noted explicitly, or appear implicitly, in previous chapters.

9.2 Diagnostic delays and service transitions

Delays in diagnosis and fragmented transitions between services emerged as significant systemic barriers to effective support for neurodivergent young women and girls. Professionals described lengthy waiting times for neurodevelopmental assessments—often stretching into years—which hindered timely intervention and contributed to missed opportunities for tailored support.

> “TRYING TO GET AN ASSESSMENT… IS AN ABSOLUTE NIGHTMARE. IT TAKES MONTHS AND SOMETIMES YEARS.”— PI2, CHILDREN’S SERVICES STAFF

These delays were compounded by diagnostic ambiguity, particularly where trauma symptoms overlapped with neurodivergent traits, and by disparities in access linked to geography and socioeconomic status. Transitioning to adult services at age 18 was identified as a critical disruption point, with young people frequently removed from child service waiting lists and required to restart processes in adult systems that are often less relational, and trauma informed.

> “THERE ARE TWO SEPARATE PROCESSES FOR ADULTS… A LOT OF THESE KIDS ARE JUST WAITING FOR ASSESSMENTS.”— PI4, CHILDREN’S SERVICES STAFF

Post-diagnostic support was also described as inconsistent or absent, leaving families feeling abandoned. Despite policy intentions to base support on need rather than diagnosis, professionals reported that formal diagnoses remained a de facto gateway to services such as EHCPs and specialist interventions. These challenges were further exacerbated by short-term service models, rising thresholds for support, and limited pre- and post-diagnostic pathways—particularly for ADHD and exploitation-related vulnerabilities. Collectively, these systemic issues contribute to a cycle of unmet need, disengagement, and increased vulnerability among neurodivergent young women and girls.

“THERE USED TO BE A PRE-DIAGNOSIS SUPPORT GROUP FOR PARENTS... IT WAS INCREDIBLE, BUT IT’S NO LONGER IN PLACE.”— PI8, CHILDREN’S SERVICES STAFF

9.3 Geographic and socioeconomic disparities

The report highlights professionals’ views that significant geographic and socioeconomic disparities exist in access to diagnosis, support, and service navigation for neurodivergent young women and girls. A few professionals noted that families in more affluent areas, such as Kingston and Richmond, were often more proactive and better resourced to pursue private assessments and advocate for support, whereas those in less affluent areas like Croydon experienced delayed diagnoses and limited access to services. These disparities are compounded more generally by systemic issues such as rising thresholds for support, over-reliance on formal diagnoses to access interventions, and the absence of structured pre- and post-diagnostic pathways. Socioeconomic status was also thought to influence parental engagement, with some families lacking the knowledge, confidence, or capacity to navigate complex systems. Additionally, cultural stigma around mental health and neurodivergence is perceived to further hinder access to timely support in some communities. These intersecting factors likely contribute to unequal outcomes and reinforce the need for equity-focused service design, culturally responsive engagement, and policy reform that prioritises need over diagnosis.

9.4 Over-reliance on diagnosis for access to support

Findings across the report reveal a persistent over-reliance on formal diagnosis as a gateway to support, despite policy intentions to base provision on assessed need. Professionals described how services such as Education, Health and Care Plans (EHCPs), specialist interventions, and tailored educational placements were often inaccessible without a confirmed diagnosis, creating barriers for neurodivergent young women and girls—particularly those awaiting assessment or whose traits were masked by trauma. This reliance reinforces inequities, delays early intervention, and excludes those with complex or overlapping needs. Participants called for a shift toward needs-led models that recognise neurodivergent traits and vulnerabilities without requiring diagnostic confirmation.

“THERE WAS THIS MYTH THAT... IN ORDER TO GET AN EHCP, YOU HAVE TO HAVE A DIAGNOSIS.”
PI4, CHILDREN’S SERVICES STAFF

9.5 Short-term service models

Short-term service models were consistently identified as a structural barrier to effective support for neurodivergent young women and girls. Many services operate under time-limited frameworks—often capped at six sessions or six months—which professionals described as insufficient for building trust, completing assessments, or delivering meaningful interventions, particularly for those with trauma histories or awaiting diagnosis.

“IT’S VERY UNLIKELY WE’LL SEE THAT CHILD THROUGH TO THE DIAGNOSIS.”— PI10, CHILDREN’S SERVICES STAFF

These models often result in premature case closures, fragmented care, and missed opportunities for sustained engagement. Practitioners highlighted that neurodivergent young people may require longer to engage and process support, yet current commissioning and funding structures rarely accommodate this. The lack of continuity, especially during critical transitions such as turning 18, further compounds vulnerability. There is a clear need for more flexible, relationship-based service models that prioritise consistency and long-term support.

> “WE KNOW THAT NEURODIVERGENT PEOPLE MIGHT NEED LONGER TO ENGAGE... AND WE’RE ALREADY TALKING ABOUT FINISHING UP.”— PI4, CHILDREN’S SERVICES STAFF

9.4 Over-reliance on diagnosis for access to support

The report identifies persistent gaps in the education system that hinder effective support for neurodivergent young women and girls, particularly those affected by trauma and exploitation. Delays in securing Education, Health and Care Plans (EHCPs) were common, with some children reaching secondary school without appropriate support due to poor attendance or lack of early identification.

> “CHILDREN GET ALL THE WAY TO THE END OF PRIMARY SCHOOL WITHOUT AN EHCP... IT IS SO UNLIKELY THAT THEY GET IT LATER ON.”— PI1, CHILDREN’S SERVICES STAFF

Even when EHCPs were in place, they often failed to reflect the full extent of neurodivergent needs. Schools were described by professionals as lacking the training and capacity to recognise and respond to neurodivergent traits—especially in girls, whose presentations may be more internalised or masked. Inconsistent training among school staff was seen to contribute to variable support quality.

> “THE LARGEST PROPORTION OF THEIR STAFF... HAVE A LOT LESS TRAINING ON NEURODIVERGENT NEEDS.”— PI, CHILDREN’S SERVICES STAFF

These systemic shortcomings underscore the need for trauma-informed, neurodivergence-aware educational planning and sustained, inclusive support throughout a young person’s educational journey.

9.7 Cultural and societal barriers

Cultural and societal factors emerged as significant barriers to timely and effective support for neurodivergent young women and girls. Stigma surrounding mental health and neurodivergence could lead to resistance to diagnostic labels, masking of traits, and reluctance to engage with services. Professionals described how some parents were hesitant to pursue assessments or disclose diagnoses due to fears of labelling, shame, or perceived weakness. In some cases, families actively withheld diagnostic information from their children, believing it would protect them, though this often resulted in confusion, isolation, and missed opportunities for support. Girls were seen to be especially affected, facing intersectional dynamics which meant they frequently internalised their struggles and masking symptoms to conform to social expectations, which contributed to underdiagnosis and misinterpretation of behaviours.

These dynamics were compounded by a lack of culturally responsive services and limited awareness among professionals of how cultural beliefs shape engagement, which is supported by recent findings from the Child Safeguarding Practice Review Panel in their report on Race, racism and safeguarding children (CSPRP, 2025). Addressing these barriers requires sensitive, inclusive approaches that build trust with families, challenge stigma, and validate diverse identities and experiences.

9.8 Funding and resource constraints

The report identifies chronic funding and resource limitations as a major barrier to effective, sustained support for neurodivergent young women and girls. Many services operate under precarious or short-term funding arrangements, which restrict their ability to offer long-term, relationship-based support and contribute to high staff turnover and service discontinuity.

Professionals described how referrals from statutory services often come without accompanying financial support, creating a reliance on informal signposting rather than integrated care. Specialist interventions—such as sensory therapies or tailored educational placements—are often unavailable or under-resourced, and some services are only accessible through specific funding streams, creating inequities in access. Cuts to services have raised thresholds for support, leaving professionals to manage higher levels of risk with fewer resources.

> “EVERY BOROUGH IS SO CASH-STRAPPED... THRESHOLDS GOING UP AND RESOURCES BEING PULLED.”— PI10, CHILDREN’S SERVICES STAFF

These constraints undermine the capacity of services to respond flexibly to complex needs and highlight the urgent need for sustainable, needs-led commissioning models that prioritise continuity, equity, and early intervention.

9.9 Gaps in provision

The report highlights multiple, intersecting gaps in provision that undermine effective support for neurodivergent young women and girls, particularly those affected by trauma and exploitation. Services sometimes are seen to fail to meet the needs of those who do not present with overt or recognised traits, especially girls who mask their difficulties or do not identify with diagnostic labels. Amongst professionals, there was a perceived lack of tailored spaces and support for neurodivergent girls who appear neurotypical, leaving them isolated or at increased risk of harm. As noted above, gaps also appear to exist in pre- and post-diagnostic support, with families frequently left without guidance during long assessment waits or after receiving a diagnosis. Transition points—such as moving from child to adult services—could be better managed, with many young people likely falling through the cracks due to fragmented pathways and inconsistent eligibility criteria. Additionally, some services were seen to lack the flexibility to adapt to complex, overlapping needs. These gaps reflect a broader systemic failure to design inclusive, needs-led services that recognise neurodiversity.

9.10 Gaps in intersectionality-awareness

The report underscores the importance of an intersectional lens in understanding the experiences of neurodivergent young women and girls, particularly those affected by sexual exploitation and domestic abuse. Intersectionality—how overlapping identities such as gender, neurodivergence, trauma history, race, and socioeconomic status shape lived experiences—emerged as an under-addressed theme. Participants certainly reflected on gendered patterns, noting that neurodivergent girls often face compounded barriers due to gendered patterns of underdiagnosis, cultural stigma, and systemic gaps in trauma-informed care. These challenges are acknowledged to be further intensified for those from racially minoritised or lower-income backgrounds, who may encounter additional stigma, delayed diagnoses, or reduced access to services. Professionals acknowledged the complexity of supporting young people whose needs do not fit neatly into service categories, and called for more integrated, flexible, and identity-affirming approaches. However, there was a notable lack of explicit discussion about race and ethnicity in many professional accounts, suggesting a gap in awareness or confidence in addressing racialised experiences, again supported by the Child Safeguarding Practice Review Panel report (CSPRP, 2025). Similarly, while gender identity was mentioned as critical by a few participants, it did not consistently emerge as central to professionals' practice reflections in addressing diverse needs.

9.11 Summary

Chapter 9 synthesised the structural and systemic challenges that hinder effective support for neurodivergent young women and girls, particularly those affected by sexual exploitation and domestic abuse. While earlier chapters focused on practice-level insights and service readiness, this chapter zoomed out to examine the broader policy, commissioning, and infrastructure-level issues that shape local delivery.

10. Conclusion and recommendations

10.1 Introduction to chapter

This study set out to explore how neurodivergent young women and girls can be better supported and protected from sexual exploitation and domestic abuse in the Royal Borough of Kingston Upon Thames. While the original scope was broad in approach to allow relevant practice to arise across forms of neurodivergence and sexual exploitation and abuse, the data collected focused primarily on autistic and ADHD young women and girls who had experienced sexual exploitation. This narrowing reflects the lived realities of participants and the professional landscape and understanding in the borough.

Despite the study's small scale and localised focus, the findings offer valuable insights into the lived experiences of young women and girls, the practices of professionals and service-level approaches, and the systemic conditions shaping support. This chapter revisits the three research questions and synthesises the key learning from across the report.

10.2 Answering the Research Questions

1. How can autistic young women and girls, and those with ADHD, be better supported and protected from sexual exploitation?

The research highlights that effective support is rooted in relational consistency, neurodivergence-aware practice, and trauma-informed care. The young women and girls we spoke to valued professionals who were consistent, empathetic, and adapted their communication and environments to individual needs—sentiments echoed in other research and consultations with young people (The Children's Society, 2025).

Importantly, many of the findings shared by the young people in this study are not new. They reflect themes identified in earlier research (e.g. Beckett & Warrington, 2015), particularly around the importance of trusted relationships and tailored support. However, this research builds on that foundation by highlighting the intensified and specific needs of neurodivergent young women and girls—needs that are often overlooked or misunderstood in mainstream safeguarding responses.

Many professionals we spoke to described practices aligned with the young women and girls' needs, although systemic challenges—such as service fragmentation, under-resourcing, and rigid institutional cultures—could undermine the support provided.

The young women and girls also described experiences of being misunderstood, pathologised, or dismissed, particularly in education, policing, and mental health settings.

This finding reflects wider research, albeit with adults (Pearson et al. 2024). This may stem from a lack of understanding of neurodivergence and its interaction with trauma. These misunderstandings can increase vulnerability to exploitation and reduce the likelihood of appropriate intervention and support.

To better protect and support this cohort, services must:

- Prioritise long-term, relationship-based models of care.
- Train professionals to recognise and respond to neurodivergent traits, especially in girls.
- Offer flexible, needs-led support that does not rely on formal diagnosis.
- Embed trauma-informed, neurodivergence-aware practice across all sectors.

2. How does neurodivergence intersect with experiences, risks, and support needs related to domestic abuse and/or exploitation?

Neurodivergence was not a background factor—it actively shaped how the young women and girls we spoke to experienced harm, interpreted relationships, and engaged with services. Traits such as difficulties with social communication, sensory sensitivities, and emotional regulation were understood by professionals to increase vulnerability to grooming, coercion, and abuse. These risks were perceived by professionals to be compounded by gendered patterns of underdiagnosis, masking, and societal expectations of compliance.

Professionals often struggled to distinguish between trauma responses and neurodivergent traits. This diagnostic ambiguity may be more pronounced in girls, whose presentations diverged from perceived stereotypical (male) models.
The intersection of neurodivergence and trauma also shaped how young people experienced services. Some of the young women and girls we spoke to experienced retraumatisation by systems that failed to make reasonable adjustments or recognise their needs. This was especially evident in interactions with police, courts, and mental health services.

To address these intersecting risks, services must:

- Adopt a dual-lens approach that integrates trauma-informed and neurodiversity-aware perspectives.
- Recognise neurodivergence as a safeguarding factor.
- Ensure early identification and holistic assessment of needs.
- Provide culturally responsive, gender-informed, and identity-affirming care.

3. Are the interventions and tools used with neurodivergent young women and girls who have experienced domestic abuse and/or exploitation evidenced in academic research as effective, and are they fit for purpose to meet the needs identified?

While professionals demonstrated strong commitment and creativity in adapting their practice, few reported using formally evaluated or evidence-based interventions tailored to neurodivergent young women and girls. Most adaptations—such as visual aids, co-designed safety plans, and flexible communication—were developed informally and lacked systematic evaluation.

The literature review confirmed a lack of robust evidence on effective interventions for this group, particularly those that integrate trauma and neurodivergence (Brown-Lavoie et al. 2014; Kalisch et al.2025). Where evidence exists, it supports approaches that are:

- Less reliant on verbal processing.
- Flexible in structure and delivery.
- Grounded in co-production and lived experience.

Training gaps persist across sectors, particularly in understanding the intersection of neurodivergence, trauma, and gendered harm. This is consistent with wider literature in this area (Hanlon et al. 2022; Franklin et al. 2024). Systemic barriers—such as short-term commissioning, diagnostic gatekeeping, and fragmented pathways—further limit the implementation of fit-for-purpose interventions (Vo & Webb, 2024).

To improve practice, services should:

- Invest in the development and evaluation of adapted interventions.
- Provide targeted training on neurodivergence and trauma.
- Embed lived experience into service design and delivery.
- Shift from diagnosis-dependent to needs-led models of support.

10.3 Recommendations

Set out below are recommendations for professionals, service managers/ leaders, and Kingston Council leaders. The recommendations are primarily rooted in the findings of this research, although a few provide direction where gaps were noted to assist in decision-making.

Table 10a provides some key recommendations for professionals who work, whether regularly or irregularly, with neurodivergent young women and girls who have experienced sexual exploitation – particularly autistic young women and girls or those with ADHD. Although this research did not involve young women and girls with experiences of domestic or interpersonal violence, the recommendations are likely relevant to them as they focus on the neurocognitive needs of young women and girls.

Theme	Recommendation
Early identification	Recognise neurodivergence early, especially in girls who may mask traits. Use a dual-lens approach combining trauma-informed and neurodiversity-aware perspectives.
Relationship building	Prioritise consistent, empathetic relationships. Avoid short-term engagement models where possible.
Communication & practice adaptation	Use clear, concrete language and visual aids. Tailor session length and environment to individual sensory and attention needs.
Trauma-informed practice	Ensure emotional safety. Be patient, non-judgmental, and responsive to distress. Use grounding techniques and adapt therapeutic models.
Identity & belonging	Validate experiences and avoid pathologising behaviours. Create safe spaces for identity exploration and peer connection.
Advocacy & empowerment	Act as intermediaries with systems (e.g. schools, CAMHS). Support transitions and involve young people in co-designing support.
Family engagement	Work collaboratively with families. Address cultural stigma and provide accessible resources and post-diagnostic guidance.
Intersectionality awareness	Reflect on how gender, race, and culture intersect with neurodivergence. Tailor support accordingly.
Social connection	Facilitate peer engagement through group work and creative activities. Be mindful of sensory needs and risks in group settings.

Table 10b sets out key recommendations for those leading or managing services across sectors where there is potential to encounter and support neurodivergent young women and girls who have experienced sexual exploitation.

Table 10b: Recommendations for Service Managers

Theme	Recommendation
Workforce training	Provide consistent, practical training on neurodiversity, trauma, and their intersection—especially in girls and diverse populations. Promote peer learning and reflective practice.
Service capacity	Build capacity to support a broader range of neurodivergent profiles. Ensure referral pathways are inclusive and not diagnosis dependent.
Continuity of care	Prioritise long-term, relationship-based models. Avoid rigid, time-limited interventions where possible. Provide practical resources and guidance for staff working in short term models of delivery and ensure onward referral pathways are up-to-date, and staff are aware of these. Support flexible commissioning.
Multi-agency collaboration	Strengthen partnerships across education, health, social care, and voluntary sectors. Ensure strategic panels are impactful and well-attended.
Diagnostic support	Offer structured pre- and post-diagnostic support. Develop clear pathways for families navigating assessment.
Inclusive culture	Recruit diversely and embed trauma-informed, neurodivergence-aware values into organisational culture.
Lived experience integration	Establish formal mechanisms for co-design and consultation with neurodivergent young women and girls. Move beyond informal feedback.
Data & evaluation	Improve data collection on neurodivergent service users. Use insights to inform service planning and delivery.

Finally, this report concludes with recommendations for Kingston Council strategic leaders, where recommendations have been selected to promote improvements strategically across the Borough (See Figure 10a).

Figure 10a
Key recommendations for strategic leaders in Kingston Council

10 STRATEGIC STEPS TO SUPPORT NEURODIVERSITY

01.
Build a neurodiversity-informed workforce

Invest in borough-wide training on neurodivergence, trauma, and gendered harm; consider opening access to partners and local services to build cross-sector understanding.

02.
Support needs-led, flexible service models

Commission or build services that offer pre- and post-diagnostic support for children and families. Identify solutions for existing-short term service models.

03.
Embed trauma-informed, person-centred practice

Ensure services adopt trauma-informed approaches that are sensitive to neurodivergent traits such as sensory needs, communication styles, and emotional regulation

04.
Improve data collection and intelligence systems

Review systems to improve capture of neurodivergence data; consider alternative methods to collect data on neurodivergence; share local best practices in inclusive data collection

05.
Improve transitions between services

Create integrated pathways that support young people through transitions, ensuring continuity of care and support. Consider how adult services and local colleges can improve their offers to neurodivergent young people and support their transitions.

06.
Promote equity and inclusion

Monitor service access and outcomes by gender, ethnicity and other important characteristics. Use this data to address disparities and inform targeted outreach and services.

07.
Centre youth voice and participation

Resource, develop and promote sustainable mechanisms for involving neurodivergent young women and girls in service design, delivery, and evaluation

08.
Strengthen multi agency collaboration

Develop shared digital platforms and protocols for cross-sector working. Ensure education, health, social care, and justice systems can contribute to and access holistic support plans..

09.
Support families with compassion and clarity

Provide culturally sensitive education and peer support for parents and carers. Help families understand neurodivergence and trauma, and how to support their children effectively.

10.
Advocate for systems change

Use local insights to influence regional and national policy—on diagnostic pathways, commissioning models, and safeguarding frameworks. Position Kingston as a leader in inclusive practice.

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Appendix A – Detailed methodology

Strand 1: Analysis of local data

This strand was led by Kingston Council in collaboration with the Safer Young Lives Research Centre (SYLRC) to explore the prevalence and characteristics of neurodivergent young women and girls aged 13–25 who had experienced domestic abuse and/or sexual exploitation in the Royal Borough of Kingston upon Thames.
The analysis drew on three key datasets:

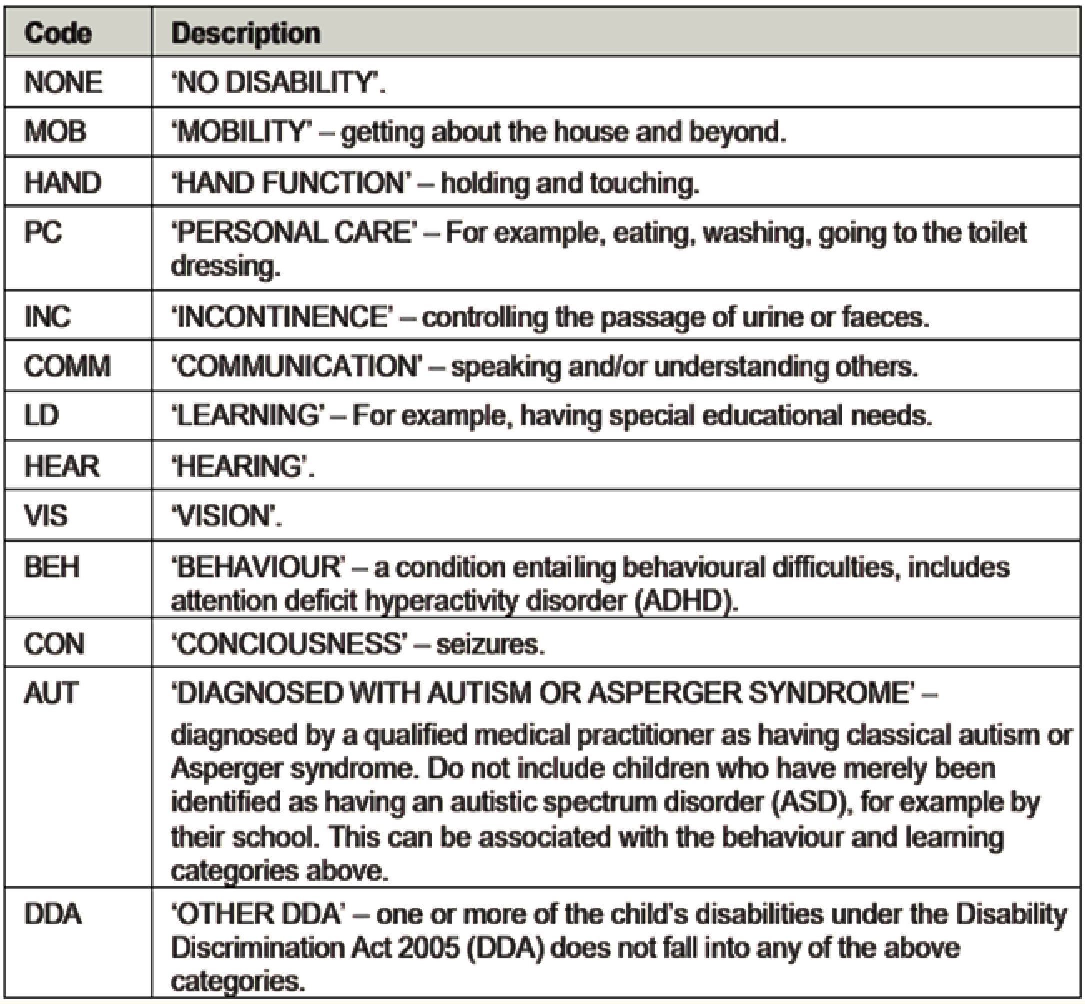
1. Children's Services Contact Data (01 April 2024 – 09 July 2025): This dataset was generated from Kingston Council's Liquidlogic Children's System (LCS) and included all contacts recorded by Children's Services teams for young women and girls aged 13–25 with "Female" recorded as their gender. Contact reasons were selected based on a comprehensive list developed in consultation with the research team and other internal Kingston Council data experts. These were recorded as primary, secondary, or tertiary reasons for contact.The tables below indicate the contact reason, the disability field (based on DfE Child in Need Census), and EHCP needs lists.

Neurodivergence was identified through:

- Structured disability fields (e.g. Autism Spectrum Disorder [ASD], Behavioural and Emotional Health [BEH] needs such as ADHD/ADD).
- Education, Health and Care Plans (EHCPs) or SEND involvement where ASD or Social, Emotional and Mental Health (SEMH) were recorded as the primary need.

Contact Reasons selected
Abuse - Child on Child
Abuse - Child to Adult
Abuse - Peer on Peer
Arrest of Young Person
Behaviours of concern - child
Child Sexual Abuse
Contextual Safeguarding & Exploitation

Contextual Safeguarding & Exploitation
Domestic Abuse
Honour based abuse
Hospital Presentation
Indecent images of children
Missing from care
Missing from home
Online safety
Police welfare check
Sex offender - adult
Sexual Abuse
Sexual Assault
Victim of Crime - Adult
Victim of crime - Child



Code	Description
NONE	'NO DISABILITY'.
MOB	'MOBILITY' – getting about the house and beyond.
HAND	'HAND FUNCTION' – holding and touching.
PC	'PERSONAL CARE' – For example, eating, washing, going to the toilet dressing.
INC	'INCONTINENCE' – controlling the passage of urine or faeces.
COMM	'COMMUNICATION' – speaking and/or understanding others.
LD	'LEARNING' – For example, having special educational needs.
HEAR	'HEARING'.
VIS	'VISION'.
BEH	'BEHAVIOUR' – a condition entailing behavioural difficulties, includes attention deficit hyperactivity disorder (ADHD).
CON	'CONCIOUSNESS' – seizures.
AUT	'DIAGNOSED WITH AUTISM OR ASPERGER SYNDROME' – diagnosed by a qualified medical practitioner as having classical autism or Asperger syndrome. Do not include children who have merely been identified as having an autistic spectrum disorder (ASD), for example by their school. This can be associated with the behaviour and learning categories above.
DDA	'OTHER DDA' – one or more of the child's disabilities under the Disability Discrimination Act 2005 (DDA) does not fall into any of the above categories.

EHCP needs	Description
ASD	Autism Spectrum Disorder
SEMH	Social, Emotional, and Mental Health

Due to known under-recording in structured fields, the analyst combined disability and EHCP/SEND data to improve identification accuracy. This approach was necessary because staff may not always have access to formal diagnoses at the point of contact, and disabilities are often only recorded in narrative case summaries rather than structured fields. As such, the figures presented likely underestimate the true prevalence of neurodivergence.

2. Multi-Agency Risk Assessment Conference (MARAC) Data (January 2022 – December 2024): This dataset included 145 high-risk domestic abuse cases involving young women aged 18–25 and was drawn from referral forms. Neurodivergence was recorded in only 11% of cases, all of whom were autistic, with over half also diagnosed with ADHD. A dip sample revealed under-recording, with some individuals later identified as neurodivergent despite being initially recorded as not. The data also highlighted gender and ethnic disparities in recording practices.

3. Vulnerable Adolescents Supported into Adulthood (VASA) Panel Data (September 2022 – May 2025): This dataset focused on nine young women aged 17–25 referred to the VASA panel and drawn from the referral forms. Four had confirmed or suspected neurodivergence. These individuals had more complex care histories, longer engagement with services, and higher rates of sexual exploitation compared to their peers without recorded neurodivergence.

Strand 2: Interviews with neurodivergent young women and girls

As part of the partnership approach, and in the context of a short project delivery timetable, Kingston Council led the recruitment and interviewing of young women and girls, completing five interviews with young people from the local area. The SYLRC researchers boosted the sample by recruiting two additional young people using their own networks. All six of the young people who took part were autistic or had ADHD and had experienced sexual abuse or exploitation. Only the two interviews undertaken by the SYLRC researchers met the criteria but were not local to the Royal Borough of Kingston Upon Thames; nevertheless, their insights are valuable in informing the research questions.

Seven young women and girls
took part in interviews

The SYLRC research team developed the interview materials (including information sheets, consent forms, creative materials and interview schedule) and obtained ethical approval via the Institute for Social Research (IASR) Research Institute Ethics Panel, received on 4th of February 2025. The SYLRC research team also provided support and training for four Kingston Council staff who were poised to undertake the interviews; all four had frontline practice backgrounds with this cohort of young people. Key aspects to the approach included:

- Working with services to identify young women and girls: Council staff liaised with agency social workers or support staff to identify potential young people to involve in the research. The research was also promoted through local voluntary sector services, and through the Autism and ADHD Partnership Board although no young women and girls were identified through these routes.
- Risk and needs assessment: Council staff and SYLRC researchers undertook an assessment with support workers who knew the young women and girls, before they were approached to be invited to take part in the research. This assessment gathered information to enable a decision to be made about whether it was suitable to approach the young women and girls to take part. It also enabled the identification of communication preferences and any other needs, such as support for attending the interview.
- Parental consent, where applicable: Council staff, working with young people's social or support workers, obtained parental consent for those under the age of 15.
- Youth consent: Council staff and SYLRC researchers, or the young person's social or support worker, obtained direct written and verbal consent from young people before the interview started.

Initially, the partnership had planned for Kingston Council staff to work with young women and girls' support workers to organise a time and place for the interview to be undertaken, with Council staff undertaking the interviews. This approach had to be abandoned in favour of a more flexible recruitment approach, however, as the team encountered barriers to recruitment.

These barriers were primarily around young people feeling hesitant to speak with Council staff—especially when they hadn't met them before. Additionally, meetings often had to be rescheduled due to the young women and girls being unable to attend in person or because their availability changed at the last minute.

To address these challenges, the Council worked closely with support workers to tailor the approach to each young person's needs and comfort levels. For example, the young people were offered the option of conducting interviews online, with the young person at home and their support worker either in the same room or nearby. This helped ensure they felt safe and supported by someone they trusted.

They were also given the option for their support worker to conduct the interview themselves and take notes on our behalf. In one instance, a worker accompanied the young person to the Council office, waited in a nearby room during the interview, and then took them home afterward.

To further reduce pressure, the Council became more flexible with scheduling. Instead of setting a fixed time, an entire day was blocked out, allowing Council staff to meet with the young person whenever they felt ready and available.

The interviews were structured to initially map, with the young people, the varied professionals they had encountered in relation to domestic abuse and/or sexual exploitation and discuss their experiences of being supported by those professionals. Questions were designed to explore specific connections between young people's neurodivergence and the support they received, though this proved challenging. For some of the young people, articulating clearly about their experiences of service provision, as specifically linked to their neurodivergence, was not simple. It is possible that because they are still forming their identities, they do not understand how their brain works differently and the implications of this for their experiences. They may also not have had the language to articulate their experiences clearly, especially if they have not been taught about neurodivergence in accessible ways.

The interviews took place between February and May 2025.

The interviews were thematically coded and analysed using framework analysis and have been synthesised across the report with other strands of the research.

Strand 3: Interviews with professionals supporting young women and girls

Fifteen professionals from across statutory and non-statutory services in Kingston upon Thames took part in one-to-one interviews

The SYLRC researchers, supported by Kingston Council staff, led this strand of the research. Council staff identified a mix of roles from children's services, partner agencies and local services, sharing the project information sheet with them and suggesting days and times for interviews to be undertaken with the researchers. The researchers then liaised directly with participants to obtain the consent forms and set up a Teams link for the interview.

All interviews took place online and were recorded using the Teams function with consent of participants. The interviews lasted between 40 minutes and just over one hour.

Table A1: Interview representation

Service represented	Roles of participant
Children's services (Achieving for Children) (n=9)	Social workers across a range of relevant teams
Health services (n=2)	Health practitioners (one located with a Pupil Referral Unit
Police (n=1)	CSE specialist officer
Local FE Community College (n=1)	Psychologist
Voluntary sector (n=2)	Neurodiversity specialist service Domestic Abuse

In these interviews, participants discussed their roles in supporting young women and girls, their understanding of neurodivergence and their experience in supporting neurodivergent young women and girls. The researchers explored their approaches to support and intervention, particularly challenges they had experienced in providing support for this cohort of young women and girls, and about what they think is needed to improve and advance support in this area.

Framework analysis was used to analyse the interviews, which were first thematically coded using NVivo 20 (Ritchie et al. 2003).

Strand 4: A survey of local support services

The SYLRC researchers, supported by Kingston Council staff, developed a short survey to distribute to local services in the local area to explore their views and experiences regarding the provision and support for neurodivergent young women and girls who had experienced domestic abuse and/or sexual exploitation.

14 services from the Royal Borough of Kingston Upon Thames completed a survey

All interviews took place online and were recorded using the Teams function with consent of participants. The interviews lasted between 40 minutes and just over one hour.

Table The survey was developed using Qualtrics, a survey platform that distributes surveys electronically. It was aimed at service managers, although it could be delegated to another member of staff. Once participants clicked on the survey link, they were taken to an information sheet followed by a request for their consent to take part.

The survey contained five distinct sections:

1. About your service/organisation: This section explored key characteristics of the services and participants completing the survey, such as the remit of the service, length of time services had been in operation, and whether the service is statutory, voluntary, or other.
2. About the neurodivergent young women and girls: the service is in contact with – This section explored the types of neurodivergence services work with, the most common neurodivergent conditions they encounter, and whether services record neurodivergence characteristics to enable a service-level understanding of the neurodivergence of their service users.
3. Staff readiness to support neurodivergence: This section asked questions about whether services provide their staff with training and/or other activities to support staff awareness and understanding of neurodivergence, and about their confidence in staff knowledge in this area.
4. Direct support to young women and girl: This section asked questions about referrals, assessment, one-to-one therapeutic support, group activities, advocacy, and practical support provided to young women and girls. It explored whether, and how, these services might be adapted and what issues are present in provision to neurodivergent young women and girls.

5. Good practice, gaps, and challenges: The final section focussed on questions about whether, and how, neurodivergent young women and girls may be involved in service improvement activity, what novel approaches to provision for neurodivergent young women and girls' services want to share, and the top three challenges for services in improving their provision to neurodivergent young women and girls.

How services were selected for inclusion

The services to receive a survey were selected based on local partnership meetings linked to Violence Against Women and Girls (VAWG) and Community Safety. Kingston Council staff reviewed membership of their Safer Kingston Partnership meeting and VAWG Strategic board to identify services who we were aware would be encountering neurodivergent young people impacted by exploitation. Both adult and children's services colleagues were consulted for suggestions on services they were referring to/working with.

How services were approached and invited to participate

Services received an email invitation that included a brief amount of information about the survey alongside a survey link. A more detailed information sheet was embedded in the survey.

A total of 17 services received the survey; all 17 opened the link. Three participants consented to participate but did not proceed to the survey. Fourteen participants consented and proceeded to complete the survey, representing an 82% completion rate. All 14 surveys were included in the analysis. Although one participant stopped completing the survey after section four, their responses to the first four sections were included as they held relevant information to inform the research.

Table A2 below provides a descriptive breakdown of the services who completed a survey. Most services were statutory services (children's and adult services), with almost a third voluntary sector. One was a 'community interest' organisation. The services also varied in terms of their focus and remit. Nine services reported delivering a broad range of support, although young women and girls with experience of domestic abuse and sexual exploitation would be included within that. The remaining five described themselves as being specifically focussed on delivering support to young women and girls with experiences of domestic abuse and sexual exploitation.

Table A2: Survey sample by sector and remit

	VAWG specific services	**Other**	**Total % by sector**
Statutory sector	2	7	9 (64%)
Voluntary sector	3	1	4 (29%)
Other	0	1	1 (0.7%)
Total % by remit	5 (36%)	9 (64%)	14 (100%)

A descriptive analysis of the quantitative survey responses was undertaken, along with a qualitative thematic analysis of open-ended questions. The findings from this analysis will be synthesised with findings from other strands of the research throughout the report.

Strand 5: Case file analysis/ journey mapping

The final strand of the research comprised a ‘journey mapping’ exercise to understand neurodivergent young women and girls’ journey through Kingston Council children’s services. A data protection impact assessment was undertaken and approved by the University’s and Kingston upon Thames Data Protection Officers and a Data Sharing Agreement was agreed and put in place. Additionally, ethics approval for this strand was granted by the University’s IASR Research Ethics Institute Panel and internally, Kingston upon Thames’ received approval following a research evaluation application process.

This multi-stage analysis was conducted using five anonymised case files selected for safeguarding and neurodivergence relevance from Kingston upon Thames’ children’s services case file system. The SYLRC researchers attended Achieving for Children’s offices, provided with a local laptop to access the case system, making two trips to undertake data extraction from the files. Using a template, each file was systematically reviewed to extract key information related to neurodivergence diagnoses, safeguarding concerns, service involvement, and intervention strategies. A thematic analysis was performed to identify recurring patterns across domains such as mental health, education, family dynamics, and professional practice. A cumulative timeline was constructed to map significant events chronologically across all cases. The safeguarding journey was then visualised using a ten-stage framework - ranging from pre-referral to case closure - highlighting the presence, partial presence, or absence of each stage per case