Inclusive Crisis Alternatives

Research on the Workforce Development needs of the VCSE Crisis Sector to meet the needs of Neurodivergent Individuals

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CONTENTS

INTRODUCTION

This research project was commissioned by NHS England (NHSE) and undertaken by Touchstone, a specialist mental health and wellbeing charity based in West Yorkshire. It aims to create a workforce strategy that supports the NHS model of prioritising community-based interventions, improving access to support and providing alternatives to inpatient admission for those who are neurodivergent and/or have a learning difficulty[1]. The publication of 'Fit for the Future,' the NHS 10-year plan in July 2025 cemented the move to community-based services in policy and high-quality Voluntary, Community and Social Enterprise Sector (VCSE) services will be crucial for its success.

The focus is on neurodivergent people without a learning disability. Although individuals with a learning disability are especially vulnerable and often subject to diagnostic overshadowing, their needs fall outside this study and require dedicated research.

Key Terms[2]

We have used the NHS definitions of learning difficulty and learning disability below. As the learning difficulties listed below are forms of neurodivergence, we will often refer just to neurodivergence.

Learning Difficulty	a type of special educational need which affect areas of learning (includes dyslexia and dyscalculia)
Learning Disability	a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.
Neurodiversity	refers to the natural diversity in human brains
Neurodivergent	is the term for when someone's brain processes, learns, and/or behaves differently from what is considered "typical". Some neurodivergent conditions include autism, ADHD, dyslexia (or developmental coordination disorder (DCD) and dyscalculia

Language Choices Explained

When describing people with whom we are working in this project, we have carefully considered the language we use.

Autistic people – We have chosen to use identity-first language here, as this description is preferred by most autistic people. This is because most autistic people see being autistic as integral to who they are, not as something they 'have'. However, we do realise that some autistic people may prefer people-first language (i.e. people with autism) and we will always refer to individuals using the language they prefer.

In most other cases, we will use people-first language e.g. people with ADHD. Throughout the project, we will refer to Experts by Experience to describe people who bring lived experience of using crisis services and/or of identifying with a particular group or community. The term Experts by Experience highlights the valued expertise that this lived experience brings.

[1] This will include individuals from minority groups, those in the LGBTQ+ community, CYP particularly young people aged 16-25, homeless, care leavers, travelling communities, asylum seekers, ex-offenders.

[2] A full Glossary can be found in Appendix 1.

AIMS AND OBJECTIVES

Overall Research Project Aim

The aim of the research is to ensure that the VCSE workforce, working in commissioned, community crisis alternative services, has the right skills, behaviours and training to understand the specific needs of those with who are neurodivergent and / or have a learning difficulty.

Research Objectives

- To establish the specific needs of neurodivergent people and those with learning difficulties when facing a mental health crisis
- To establish the training and development requirements for VCSE mental health crisis staff to meet these specific needs
- To establish the best way of supporting neurodivergent young people and adults from diverse backgrounds facing mental health crisis.

Research Question

What are the workforce development needs of VCSE crisis alternative services for them to understand and meet the specific needs of those who are neurodivergent or have a learning difficulty?

RESEARCH METHODS

The research uses mixed methods to capture a diverse demographic. This included:

- Questionnaires to neurodivergent adults, young people and parents and carers
- Questionnaires to staff working in crisis alternative settings
- Focus groups within a wide range of settings. These focussed on groups and communities who were statistically less likely to access mainstream provision
- Specific focus groups for staff, covering the whole region and including Keyworkers[3]
- Interviews with individuals and stakeholders
- Case studies in four Integrated Care Board (ICB) areas.
- Existing reports or research for reference purposes

The questionnaires were co-produced with Experts by Experience and crisis alternative staff. They were open for two months from mid-April to mid-June 2025.

Further details on the design, methods and sampling can be found in Appendix 2.

[3] Keyworkers are a service commissioned to work with young people up to 25 with learning disabilities and /or autism who are at risk of hospitalisation.

PARTICIPANT INVOLVEMENT

A total of **410** individuals contributed to the research in the following ways:

- **Questionnaires**

272 Completed responses were received from:

1. 101 neurodivergent adults over the age of 18
2. 67 neurodivergent children and young people up to the age of 25
3. 41 parents and carers of children and young people aged up to 25
4. 63 crisis alternative staff

- **Focus groups and interviews with neurodivergent people or those from minoritised communities**

59 individual or potential service users were involved in focus groups or interviews. These included:

- Care experienced young people and young people who have been homeless
- LGBTQ+ young people
- Muslim women
- Refugees
- Users of crisis alternative provision including one specifically for ethnically and culturally diverse communities
- Neurodivergent young people and adults

- **Interviews with stakeholders from minoritised communities**

Information was also gathered through interviews with 15 stakeholders working with minoritised communities. This was particularly important for groups with language barriers or a mistrust of researchers. Interviews included stakeholders working with:

1. visually and hearing-impaired service users
2. asylum seekers
3. ethnically and culturally diverse communities including the Gypsy and Traveller community and South Asian communities.
4. people who self-harm
5. young people experiencing mental health issues.

- **Focus groups with crisis alternative staff**

Focus groups were held with 64 staff working in different contexts across adult and children and young people's services. These focussed on the skills they used (particularly for Keyworkers) as well as their existing training and training they felt was necessary.

- **Visits and case studies**

One Place was selected in each area in which to conduct more focussed research and to identify good practice. The four areas were Doncaster in South Yorkshire, Leeds in West Yorkshire, Hull in Humber and North Yorkshire and Newcastle in North East and North Cumbria (NENC).

A further demographic breakdown of the focus groups and interviews can be found in Appendix 3.

SCOPE

The research included the following scopes:

Age Range: All ages including children, young people and adults

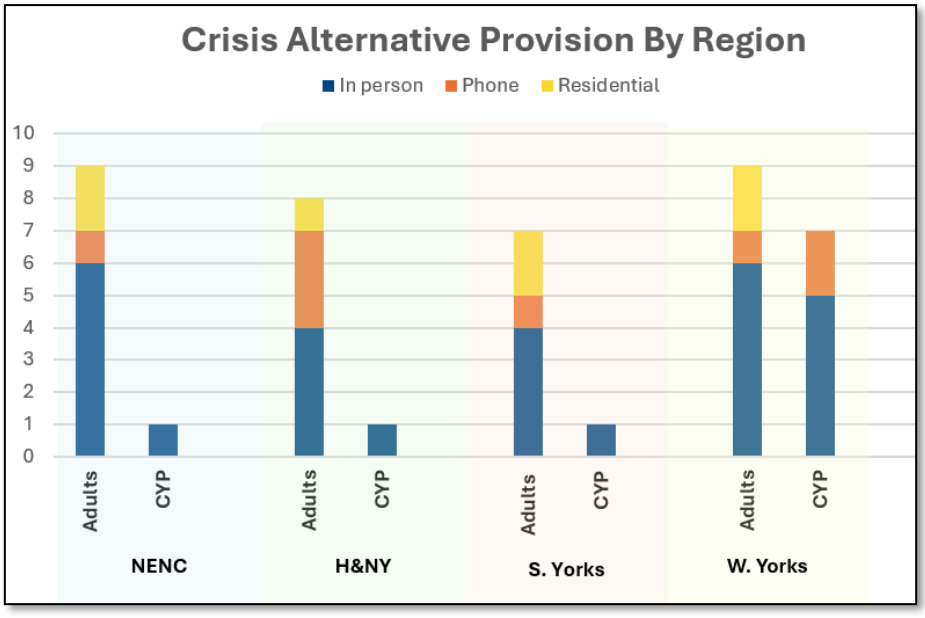
Provision: Initially limited to NHS commissioned crisis alternatives and any specialist pilots for people who are neurodiverse or have learning difficulties. However, the research was open for other professionals to contribute.

Area: The North East and Yorkshire NHSE region. This is a large region with limited research resources. One Place (town or city) in each ICB area was visited in person to ensure focus groups were from across the region

Disability: The research focussed on neurodivergent people without a learning disability. This is because the scope had to be kept manageable and trying to include those with a learning disability in this research would have done them a disservice.

CRISIS ALTERNATIVE AUDIT

To include as many crisis alternative services as possible a regional audit was conducted. ICBs were asked to identify commissioned services, and voluntary sector networks and infrastructure organisations were asked about local services. The totals shown are not necessarily 100% accurate as of writing, due to changes over the financial year end. Hospitals are also seeing the benefit of involving non-clinical services in their delivery and may have commissioned services (such as hospital navigators) all of which may not have been identified or included here.



The main feature that stands out here is **the lack of services for Children and Young People**. Whilst a number of adult services start at 16, many of them see very few young people and the provision for those under 16 is very limited. In fact, when the audit took place, there were only two services where young people could go for support without a professional referral and both were in West Yorkshire. North Cumbria was about to pilot drop in provision, but it had not started at this point. The full audit can be found in Appendix 4.

FINDINGS

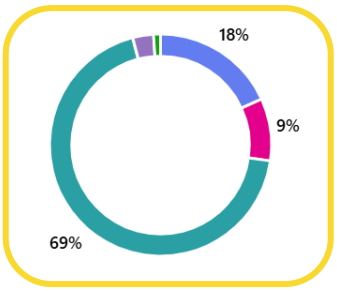
1. Questionnaires from Neurodivergent People:

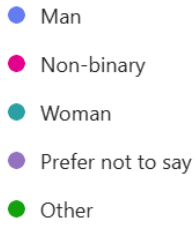
Section 1 summarises the findings from the questionnaires completed by neurodivergent adults, children & young people (CYP) and parents & carers (P&C). It moves from demographics onto responses on each section in turn - mental health crisis, sensory, predictability, acceptance, communication and empathy.

DEMOGRAPHICS[4]

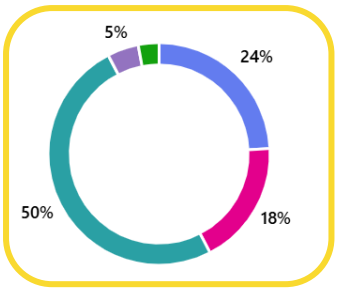
Gender

Adults





Children & Young People

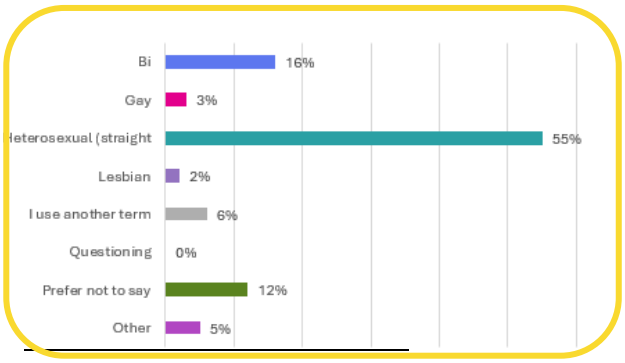


17% of young people identified as trans

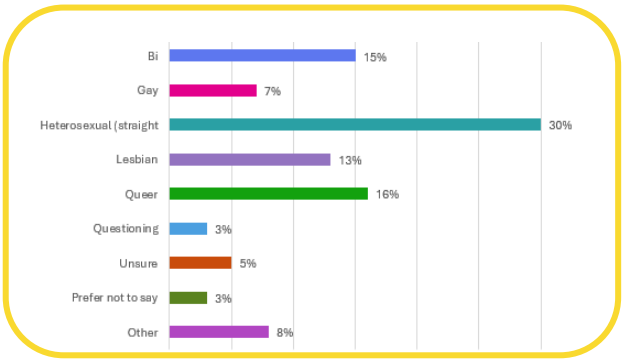
68% of adult respondents identified as a woman with only **18% identifying as a man**. Whilst more women are generally accessing crisis alternative services than men, this is not a representative sample of men using these services. Slightly more young men responded than adult males and more young people identified as non-binary. 9% of adult and **18% of younger respondents identified as non-binary** with **5% of adults and 17% of young people identifying as trans.** In the 2021 Census 0.06% of the population across England and Wales identified as non-binary. However, we know that non-binary and trans people are two to three times more likely to experience common mental health problems than the general population with around 70% experiencing anxiety or depression[5]. The number of young people identifying as trans is strikingly high at more than 3 times the number of adults. Of the adults a further two of those identifying as trans fell into the 18-25 age range.

Sexual Orientation

Adults



Children & Young People



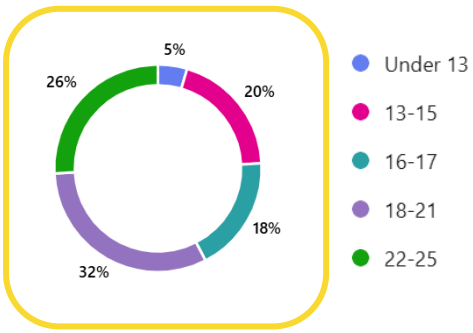
[4] Further demographic breakdown can be found in Appendix 3.

[5] LGBT in Britain Health Report, Stonewall. 2018

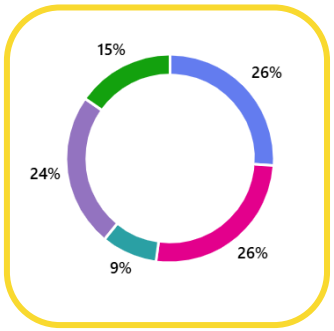
As can be seen in the charts above, the sexual orientation of respondents was varied and inclusive. Other terms used by individuals included *pansexual*, *asexual* and *aromantic*. According to the Office for National Statistics[6], in 2023 in the North East region, 95% of respondents described their sexuality as heterosexual. The data here supports the research showing that individuals who are LGBTQ+ struggle with their mental health more than their heterosexual and cis-gender peers. It is notable that **only 30% of young respondents described themselves as heterosexual.**

Age

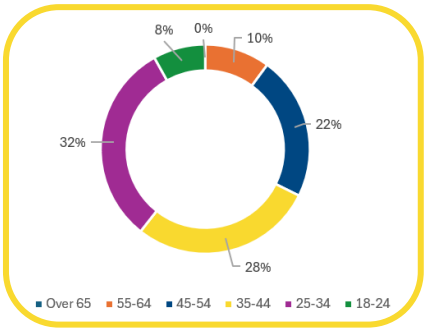
Children and Young People



CYP of Parents &Carers



Adults



- Respondents ranged in age from under 13 to 65. There were no responses from anyone over the age of 65, a limitation to the study.
- By far the largest age group to respond was 18–24-year-olds. A total of 64 or 24% of participants fell into this age bracket.
- For children aged under 13 a parent or carer was more likely to respond than the child themselves.
- It is quite striking that **39% of parents and carers** were **responding** about a person who was an **adult over the age of 18.**

Ethnicity

84% of all participants were White British with only one questionnaire being completed by an individual of Black Caribbean heritage and two of Black African heritage. This was despite an effort on the part of the researcher to circulate questionnaires to Black led organisations. Although the percentages aren't far off representative of the ethnic makeup of the North East and Yorkshire NHSE region, we know that people from minority groups experience more prejudice, stigma and discrimination which contribute to higher levels of mental health issues[7]. We would therefore hope to see higher numbers taking up the support of crisis alternative service

Religion and First language

11% of participants told us they (or their child) had a religion. Although Christianity was the largest faith group, it was clear that those from non-White British backgrounds were much more likely to have a religion than their White British counterparts.

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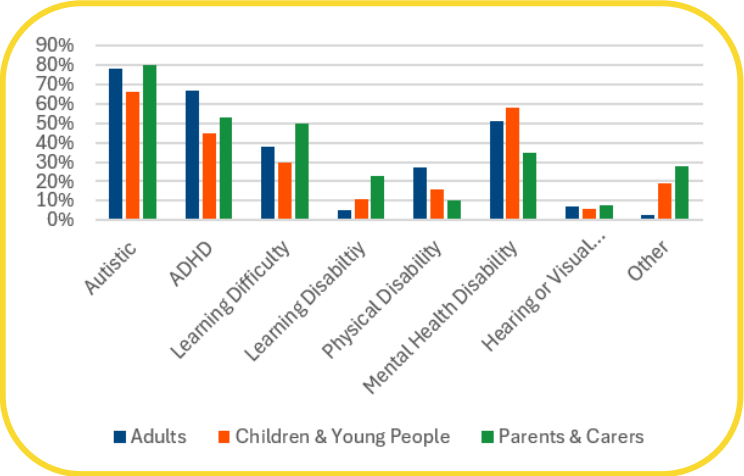
[6] Sexual orientation, UK - Office for National Statistics

[7] Racial disparities in mental health: Literature and evidence review Tracey Bignall, Samir Jeraj, Emily Helsby and Jabeer Butt 2019; Link here

It is notable that no adults who completed the questionnaire for themselves had English as a second language, although 4 young people did. It may be that younger people are more likely to be fluent in English even if it is not their first language and therefore more able to complete the questionnaire. One parent had sign language as their first languauge. The offer of translation was made, but was not taken up. This could have been due to not having information available in other languages which was outside of the budget.

Disability



The disabilities identified with, by participants across all ages, can be seen in the chart opposite. Unsurprisingly, almost all participants identified as autistic or having ADHD or a learning difficulty. There were, however, a small number who did not identify as neurodivergent but had a mental health disability.

Life Experiences of Young People.

The questionnaires were circulated amongst a range of agencies and reached young people who had been in care, been a young carer, or been homeless. One young person had been an unaccompanied asylum seeker and one a young parent. It is notable that there were no responses from young people who had been involved in the criminal justice system. This may be something to explore further.

RESPONSES

The questionnaires were created with Experts by Experience who suggested using the Autistic SPACE framework[8] as a guide. SPACE covers the five main areas that Doherty and colleagues believe healthcare professionals should address when considering autistic patients. These are **sensory experience**, **predictability**, **acceptance**, **communication** and **empathy** as shown in Figure 1 below. Although the framework is designed around autism it also resonates with people with other types of neurodivergence.

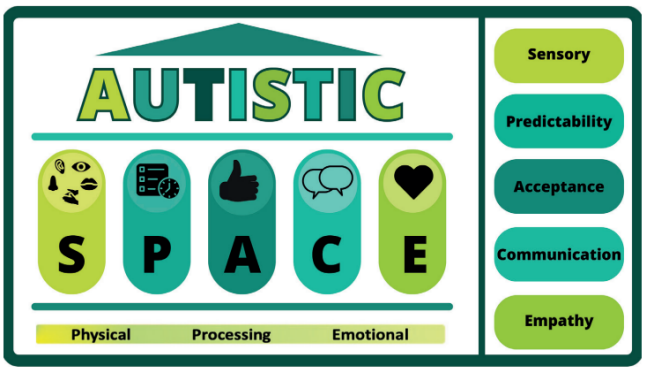


Figure 1:

The Autistic SPACE Framework

(Doherty et al, 2023)

[8] Doherty, M., McCowan, S., & Shaw, S. C. (2023). Autistic SPACE: a novel framework for meeting the needs of autistic people in healthcare settings. *British Journal of Hospital Medicine*, *84*(4), 1-9.

After an initial section asking about participants understanding of mental health, and their experience of using crisis services, questions were then divided into sections based on the SPACE framework.

Section 1 – Mental Health Crisis

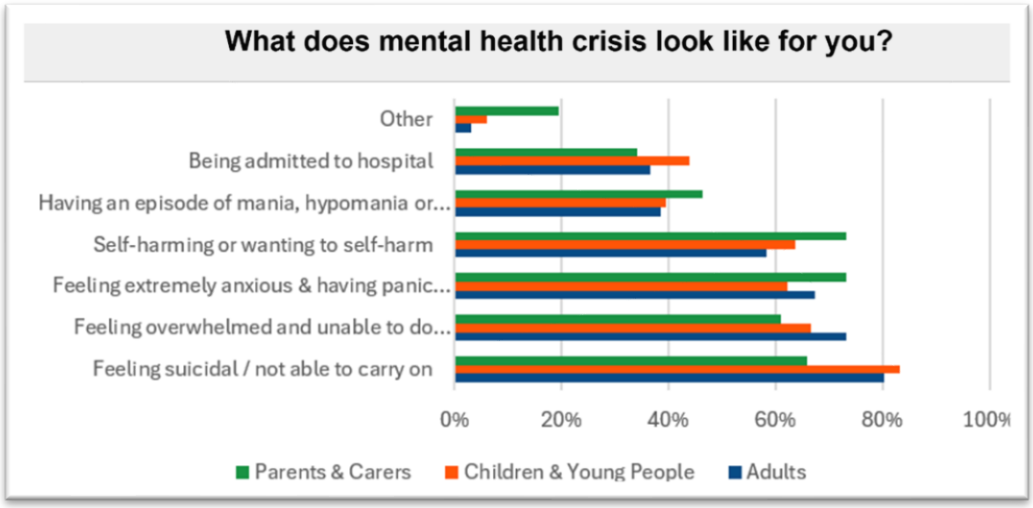


Figure 1a

The chart above shows that participants see crisis as having a range of different presentations. Strong themes arising out of the 'other' category were:

a) violence and anger which may be expressed towards others or self (particularly mentioned by parents and carers).
b) completely shutting down and not being able to function bodily, even if their mind is racing
c) feeling out of control and not being able to carry on, even if not suicidal

There were also other one-off definitions specific to individuals such as not eating and drinking, or OCD escalating. A comment was also made by an individual that they feel dismissed and have their crisis classed as behavioural which causes escalation.

Services Used

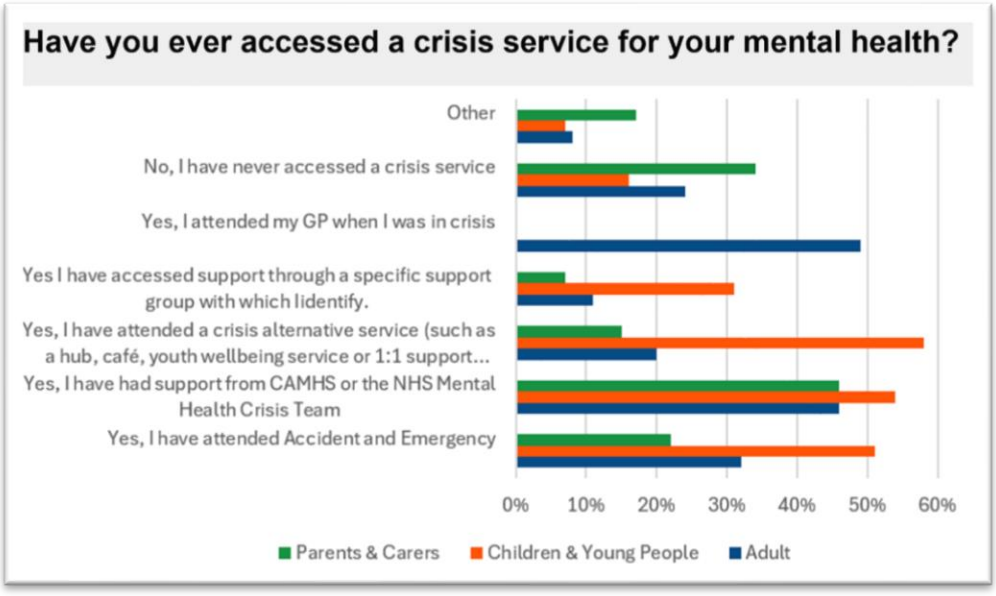


Figure 1b

For reasons of space and the choice of Experts by Experience, GP visits were not included in the list of options that young people.had visited in crisis. As this was the most used service for adults in crisis, it would have been useful to see how this compares to other services preferred by children and young people. GPs were not mentioned at all in the 'other' option for these groups. The main themes from the 'other' option were:

- Telephone or text helplines such as Shout or Samaritans
- Place of work or study (including school and university)
- A therapist with whom they were already meeting
- People having tried to get help but not being able to find or access it. This was particularly raised by parents and carers.

One parent of a **deaf** young person stated that he had access to Deaf CAMHS as a child, **but now as a young adult has no support.**

Services Preferred by Children & Young People and Parents & Carers

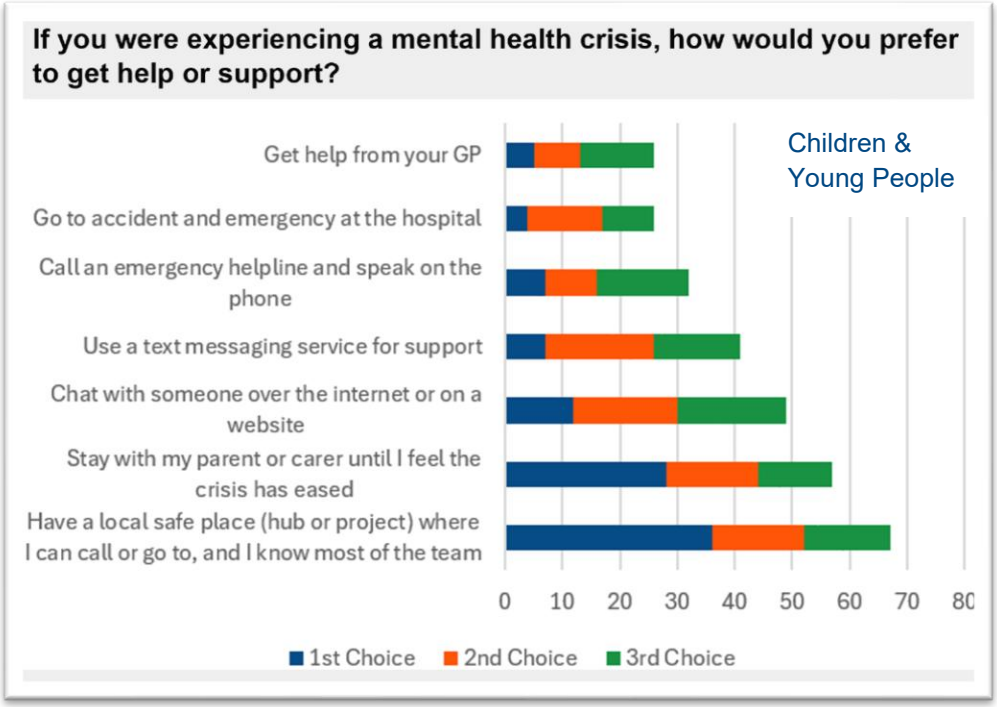


Figure 1c

Comparing the results in figures 1c) and 1d), we can see that parents and carers are more likely to want to stay at home and get advice, whilst the CYP would generally prefer to go somewhere else. This may of course be affected by the symptoms and the severity of the crisis.

Crisis alternative provision within a non-clinical environment would be the first choice of CYP, but this is distinctly lacking.

27 parents & carers answered a follow-on question about what other kind of support they would want. These are all listed in Appendix 5, but the two most common responses which are echoed throughout the research were:

1. asking for **a face-to-face appointment** with someone who had **professional** expertise and the **ability to relate** to their child or young person. Examples included CAMHS, GP, and professionals trained in autism (6)
2. wanting a **named person** who could be contacted to get support (5)

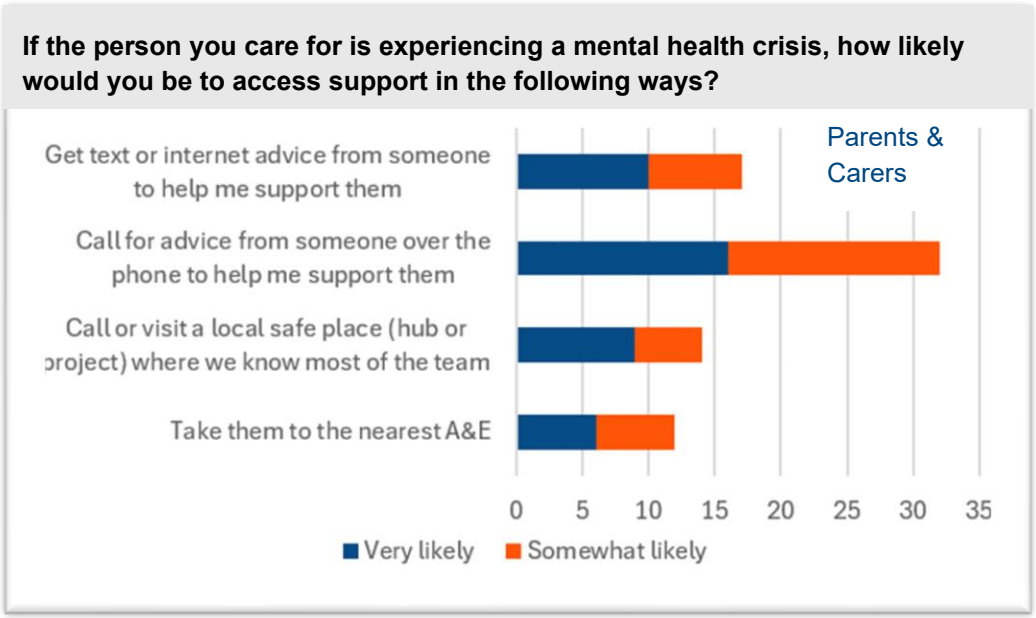


Figure 1d

Section 2– Sensory Needs

The charts reflecting the answers to each of the SPACE elements can be found in Appendix 5. Results showed, not only how important the environment is when providing a service to neurodivergent individuals, but how important it is **to let them know clearly how to change this if they need to.** A further point worth highlighting here is not actually one of physical environment, but **of creating an environment where people feel heard and understood** and do not feel judged. Of all the statements included, this was rated as by far the most important.

Section 3 – Predictability

Once again, participants highlighted across all areas that **knowing what to expect** was very important. **Consistency** and seeing the **same person regularly** were slightly more important to CYP and their parents & carers than they were to adults, but still significant to everyone. People asked for **clear information** before, during and after accessing the service.

96% of all respondents felt it was important or very important to be told plainly what will happen next.

93% of all respondents felt it was important or very important to be assured that they were not wasting other people's time.

Knowing where to go and who to ask for. Having a script

Having a step-by-step guide of what will happen

A reassurance that my crisis *is* a crisis

Section 4 – Acceptance

This section was about offering a standard of service to everyone, so that those who are neurodivergent won't feel that they are the exception or need to mask to fit in.

As with section 1 (environment), although practical adaptations are welcome, the ***attitude of staff*** is actually of more importance to people's experience of care. **Feeling they are accepted** for who they are and **being offered support for what they have come for** received the highest favourable responses.

Also worth noting were:

- 81% of Children & Young People felt it was important to be able to **bring someone to support** them
- 70% of adults felt it was important to see a **diverse** staff team

In the light of the gender and sexuality demographics, it is pertinent to note the **difference in importance, given between CYP and their parents and carers**, to the use of **pronouns** and preferred name. Young people place high importance on this whilst their parents generally do not.

I'm lactose intolerant so finding somewhere to eat and drink adds another layer of stress

As well as being neurodiverse, I am also a wheelchair user and from a cultural/religious minority, so intersectionality needs to be taken into consideration.

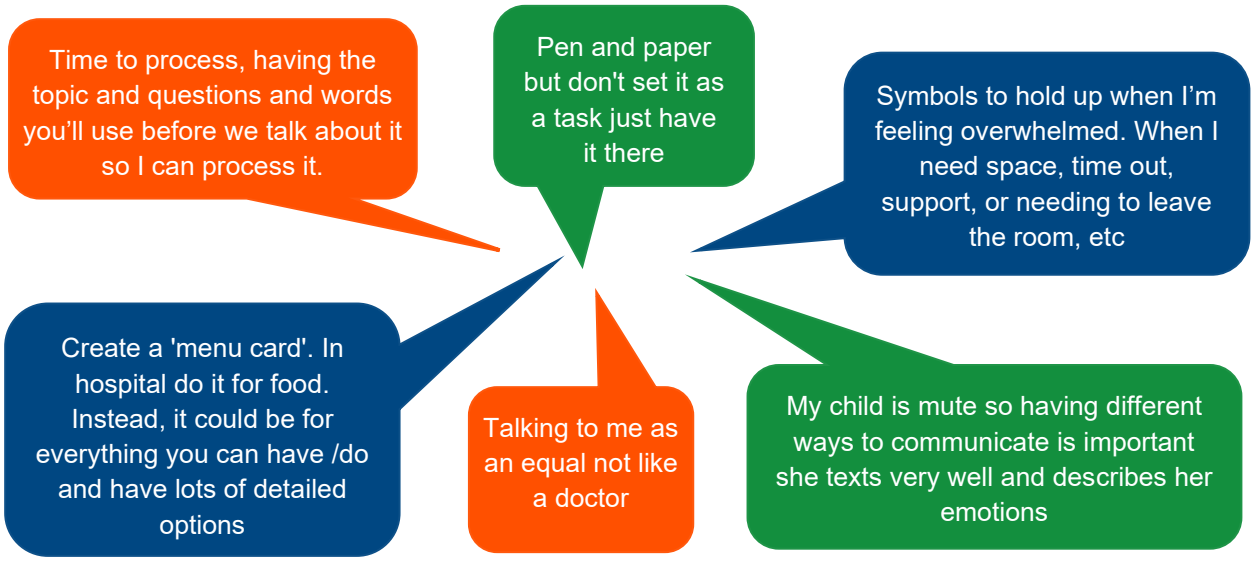
Not seeing me as "difficult" and "refusing to engage in the service" if I can't answer your standard questions (YP)

Posters on the wall making it clear that LGBT+ people are welcome

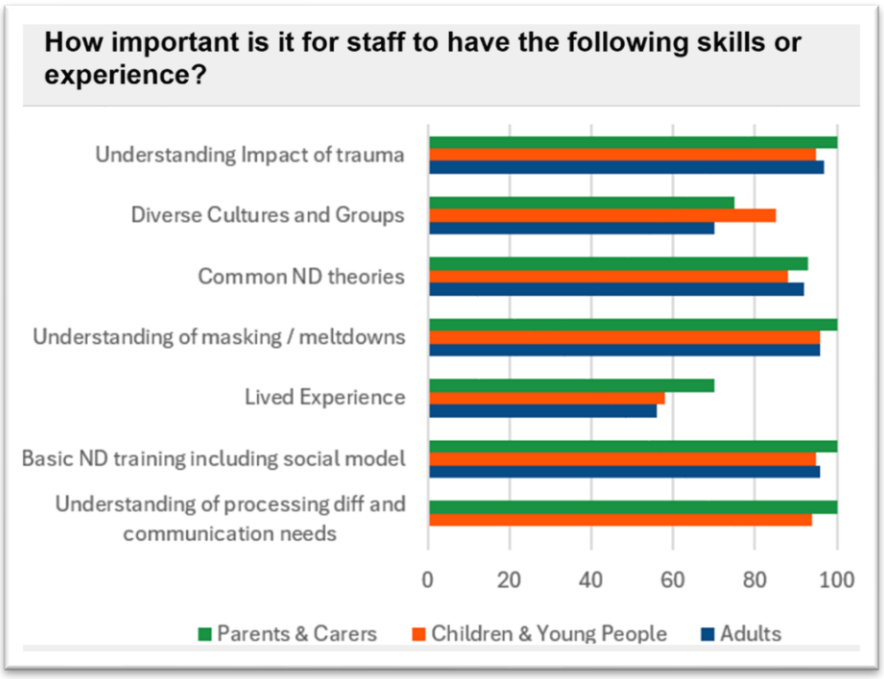
All settings should have a room for individuals who need a safe place to protect themselves and others from violent outbursts.

Section 5 – Communication

The two responses which score most highly in communication are **being asked direct questions in straightforward language** and **allowing for regular breaks and processing time.** Comments in the freeform box included several requests for **pen and paper or alternative communication methods.** As with all the areas addressed, large numbers of neurodivergent individuals feel they would benefit from **adaptations and support**, but some simple changes that would benefit large numbers can be clearly identified. One of the pieces of feedback that was received regularly is that neurodivergent people are often people pleasers and will not find it easy to ask for things. So, asking people to 'tell me if you need a break' may not be the way to go about including extra processing time!



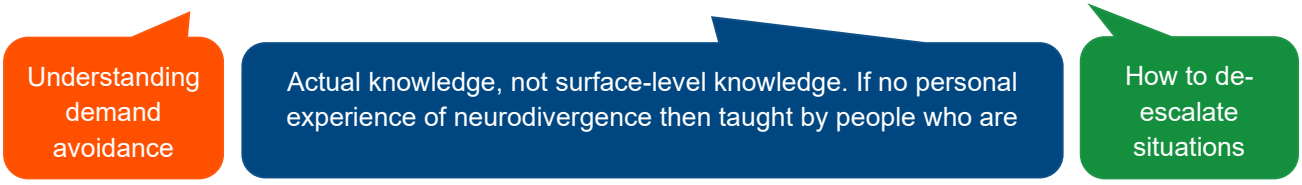
Section 6 – Empathy and Training Needs



Responses across all participants

Figure 6a

Section 6 asks about the skills and experience that participants feel staff need to understand them as neurodivergent individuals. This enables them to offer an empathic response. The table above shows clearly that neurodivergent service users feel it is very important that staff understand them and their needs. Users feel that **a wide range of training on neurodivergence is important for staff** including understanding communication needs and processing differences, masking and meltdown and the impact of trauma.



Section 7 – Access

92% of all participants felt it was important or very important to be able to use **texting or the internet to refer themselves to a service** as well as the telephone. Neurodivergent people consistently expressed **difficulty with communicating over the phone** and the high levels of anxiety that this can cause.

Over 80% of each group also felt it was helpful to be able **to visit the service before they reached crisis point.** 100% of parents and carers felt it was important or very important to be able **to refer directly** to a crisis service and not have to go through a third party.

Section 8 – Support for Parents & Carers:

The questionnaire for parents and carers had an additional section asking about the support they needed. Research has shown that caregivers of autistic children are at a substantially increased risk of poorer mental health and psychological well-being compared to the general population[9] and even compared to caregivers of children with other types of disabilities including physical and

[9] Werner, S., & Shulman, C. (2013). Subjective well-being among family caregivers of individuals with developmental disabilities: The role of affiliate stigma and psychosocial moderating variables. *Research in developmental disabilities*, *34*(11), 4103-4114.

learning disabilities[10] It is important to be aware that parents themselves may benefit from being signposted or referred to local support services.

Parents and carers were asked '*How easy do you find it to access support in the community sector for the person you support, when they are in or approaching a mental health crisis?* (e.g. Do you know what is available, how to access it & can you get there?)' The response was '*very difficult*'.

74% said it was difficult or impossible to access support for their child in a crisis

The most highlighted statements in this section, also reinforced in the comments, were the parent and carers' **desires to be heard and for their child to be listened to**. They wanted to be **trusted** and **not blamed** and to have **access to support when they needed it**. As autistic traits have been reported to be present in around 1 in 5 parents of autistic children[11], it is likely that some parents may find it difficult to recognise their own emotions or to be understood.

Immediate support. Not a phone call 24 hours later

Acknowledgement & validation

Be kind and listen to parents, especially those with children who can't verbally communicate. We know our children more than anyone and just want the best for them. We also desperately need support.

Parents and Carers were asked what support they needed to support their family members. They overwhelmingly felt that **a named professional they could contact, and accessible advice** when they began to spot signs of escalation was most important. Comments in this section were often about **services not listening to parents or carers** and there being no suitable support.

It's not that I wouldn't want to be able to access these means of support, it's that in the past we've been told none of these avenues are available to us. There ARE no means of support because my son is still of primary school age "too young" and his neurodiversity, although he's medicated for it, is deemed "insufficient" for us to access support

Section 9 - Crisis Alternative Services Ratings

Participants were initially asked to identify the crisis services they had accessed (see Section 1, page 11). Those who used **crisis alternative services** or other voluntary sector support, were then

[10] Blacher, J., & McIntyre, L. L. (2006). Syndrome specificity and behavioural disorders in young adults with intellectual disability: Cultural differences in family impact. *Journal of Intellectual Disability Research*, *50*(3), 184-198.

[11] Gerdts, Jennifer, Bernier, Raphael, The Broader Autism Phenotype and Its Implications on the Aetiology and Treatment of Autism Spectrum Disorders, *Autism Research and Treatment*, 2011, 545901, 19 pages, 2011. https://doi.org/10.1155/2011/545901

asked to rate the extent to which their needs were met under each theme. The responses for those who had utilised crisis alternative services can be seen below.

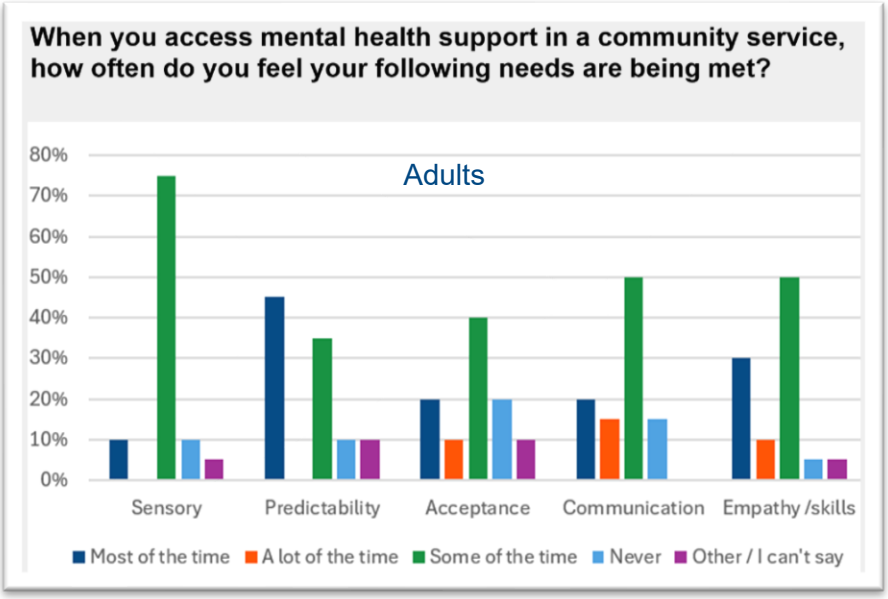


Figure 9a

The interpretation of these findings requires caution. Evidence suggests that a substantial proportion of respondents did not clearly distinguish between crisis alternative services and statutory mental health provision. This is indicated by the number of individuals who completed the relevant questions, despite not reporting attendance at a crisis alternative or other voluntary sector service. Although these respondents were excluded from the subsequent analysis, it is notable that many of those retained for analysis reported engagement with multiple service types. Consequently, their responses may reflect a generalised experience of mental health support rather than a specific evaluation of crisis alternative provision. Furthermore, only 21 out of 101 adult participants confirmed direct use of a crisis alternative service, highlighting a significant limitation in the dataset and the need for cautious interpretation of these results.

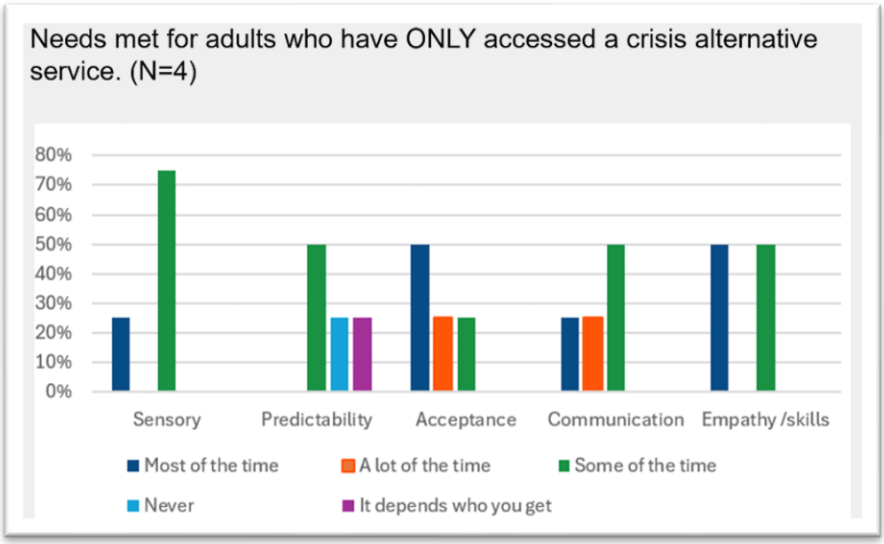


Figure 9b

The chart on the left, shows the results of individuals who said they had ***only*** accessed a Crisis Alternative service. The numbers (only 4 individuals) are too small to have any real significance but still indicate room for improvement. The option 'All of the time' was not included in the graphs as it was not indicated by any participants.

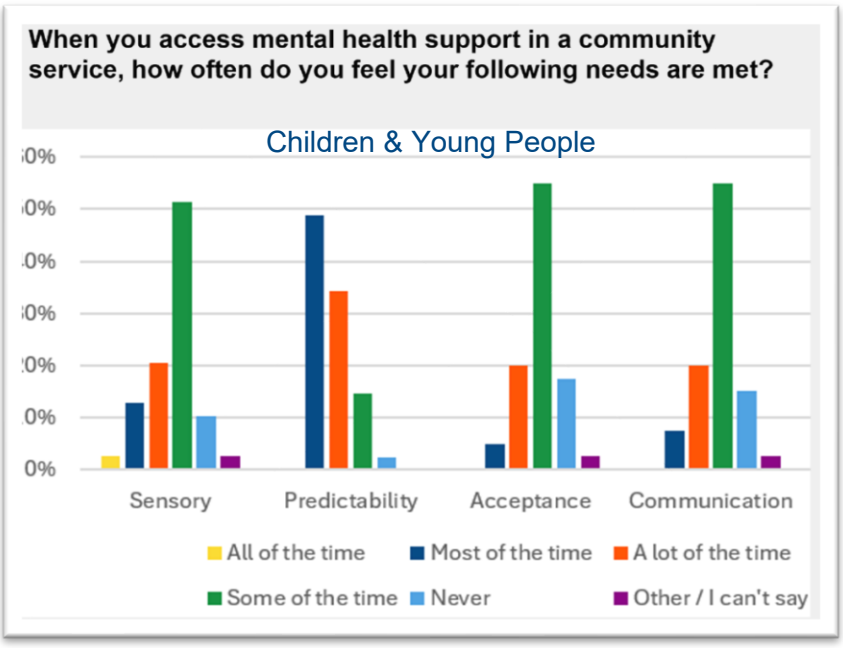


Figure 9c

41/67 children and young people had used what was classed as a crisis alternative service. The services used by children and young people are not mostly funded as, or described as, crisis alternatives, but are groups focussed on wellbeing and low-level mental health issues. However, they are often accessed by young people in crisis and need to be recognised for the work they are doing.

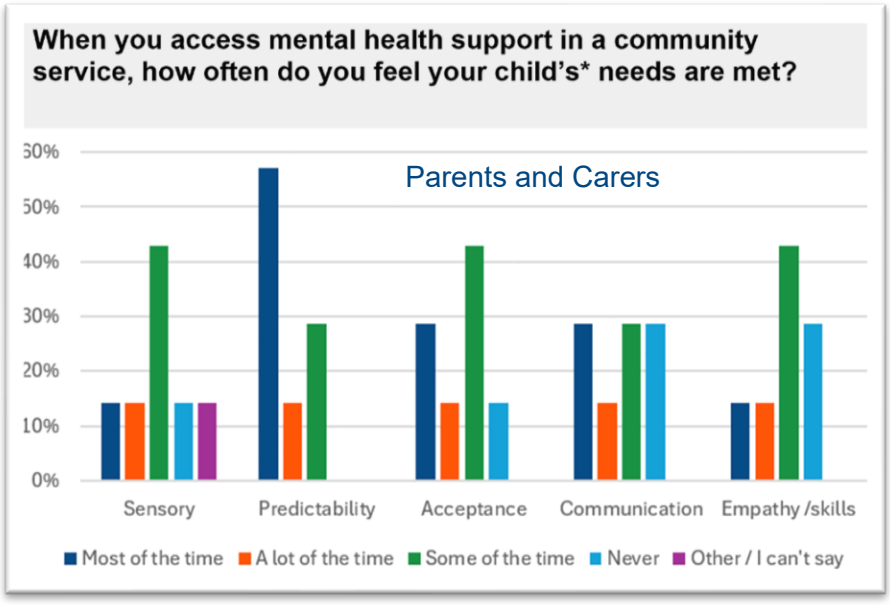


Figure 9d

Only 7/41 Parents and carers had used crisis alternative services. The lack of services, their frustration at having nowhere to go and not being able to get support for the children was a main theme for this group.

**Child has been used here for reasons of space but means any young person being supported by a parent or carer*

Looking at the graphs in figures 9a to 9d, the following points are worth highlighting:

- For all groups of participants, *'some of the time'* was the most frequently chosen option. Given that the choices *were 'all of the time', 'most of the time', 'a lot of the time', 'some of the time* and '*never'*, this was the option one up from never and gives much room for improvement
- In all the graphs, except 9b, predictability scored higher than the other areas.
- However, for adults who only attended crisis alternatives, predictability was marked as 'some of the time' or lower and, in fact, worse than for all other areas of need.
- For every group, participants were more likely to say that they felt their needs were '*never'* catered for, than they were to say they were catered for '*all of the time'*.

2. Focus groups and Interviews within local communities:

i. Young People

Six focus groups were conducted with a total of 33 young people aged between 13 and 24. A diverse range of individuals were consulted including:

- care leavers,
- young people who had been homeless,
- LGBTQ+ young people
- young people seeking support for their mental health.

Feedback from these participants has been synthesised to identify overarching themes, summarised below. A detailed, group-specific analysis is provided in Appendix 6 to support further exploration of nuanced requirements within specific demographic contexts. Appendix 7 provides a more detailed account of interviews with individuals and stakeholders.

1. **Understanding Mental Health Crisis**
    - Crisis often involves *emotional distress* (panic attacks, suicidal ideation, self-harm) and *behavioural signs* (isolation, substance abuse).
    - There are many different understandings of what crisis is, and it varies for each individual
    - **Young people struggle to *recognise when they are approaching / in crisis***, especially neurodivergent individuals. They look to adults for support with this and need help to identify an emerging crisis before it becomes full blown.

2. **Stigma and Intersectionality**
    - Young people reported not being taken seriously by adults who didn't understand them and felt that they were exaggerating. This cut across parents, carers and professionals.
    - Young men felt unable to ask for help and under pressure to adhere to a 'strong' stereotype.
    - The intersection of LGBTQ+ and neurodivergence is significant, with 87% of the two LGBTQ+ groups identifying as neurodivergent.
    - Young people felt the effects of stigma and intersectionality (particularly the dismissal of LGBTQ+, neurodivergent, care experienced and disabled identities) strongly.

3. **Barriers to Accessing Support**
    - Long waiting lists and poor service quality.
    - Stigma and stereotypes: gender norms, dismissal of LGBTQ+, neurodivergent, and disabled identities.
    - Phone-based systems are inaccessible for many, lack of alternative contact methods.
    - Age-related gaps: poor support for 16–18-year-olds and difficult transitions from CAMHS to adult services.
    - Digital exclusion and transport barriers (highlighted more in marginalised groups).

4. **What Builds Trust**
    - Non-judgemental, relatable staff who understand lived experience.
    - Clear, accessible information and predictable processes.
    - Multiple communication options: text, chat, email, phone, drop-in.

- Inclusive representation in staff (gender, race, neurotype, sexuality).

5. **Ideal Crisis Support Service**
   - Drop-in access without appointments.
   - Non-clinical, welcoming environments with sensory-friendly spaces.
   - Separate age-based provision (e.g., 13–17 and 18–25).
   - Holistic support addressing mental health and practical needs.
   - Offers support before during and after crisis
   - Youth involvement in service design.

There were also **distinct points** made by groups with multiple needs. These included:

- **digital exclusion** and **transport barriers**,
- the fear of being labelled "too complex."
- the need for **mobile/outreach support** and **peer support** as key solutions.
- the need for **publicising strategies** (social media, QR codes, Google visibility).

Finally, the focus groups held at charities who were there to support their mental health were very positive about the support they gave and felt that more similar provision was needed.

"The ideal crisis provision would offer real-life coping mechanisms (healthy), distraction techniques, real advice / help to resolve the issue, not just self-care tips, there would be a mix of formal (professional) and informal support which makes you feel more comfortable."

HOME (Helping Our Mental 'Ealth) is an early support mental health and emotional wellbeing hub for young people aged 11-25 in Barnsley. It provides open access, flexible, early support in a non-judgemental welcoming, safe space.

HOME – Barnsley

A young person can be involved with HOME at their own pace, for as long as they would like (up to the age of 25) choosing which elements to access. Funding for these Hubs is due to stop in March 2026, but this research would use this model as an excellent example of supporting neurodivergent young people before, during and after crisis. It is what young people want.

YOUNG PEOPLE SAY

…without the HOME Staff I wouldn't be here today (19)

…HOME has got me through some of the lowest points in my life (14)

…effectively keeping me alive during a very dark period. (15)

…has helped me with my gender and helped me feel less sad (17)

…It is a place where I can feel normal about my anxiety ADHD and autism (12)

ii. Adults

Focus groups and semi-structured interviews were conducted with a total of 31 adults across diverse settings. Namely,

- Two focus groups involving 9 adults from ethnically and culturally diverse communities
- Interviews with 7 neurodivergent individuals with a range of backgrounds and ages.
- Interviews with stakeholders including those working with asylum seekers, the gypsy and traveller community, South Asian elders, African families, and people with sensory impairments

Feedback from these participants has been synthesised to identify overarching themes, summarised below. A detailed, group-specific analysis is provided in Appendix 6 to support further exploration of nuanced requirements within specific demographic or cultural contexts.

1. **Understanding Mental Health Crisis**
   - Crisis is a highly individualised experience with neurodivergent individuals describe it as anything from autistic shutdowns and sensory overwhelm to active suicidality. For some, "constant high distress" is their norm, so they only seek help at life-threatening points.
   - Service definitions are often narrow, and not all services have the same thresholds. This creates uncertainty, particularly for neurodivergent people as they want to know that they are in the right place and not wasting other people's time.
   - Language matters and the Eurocentric language used, including the term 'mental health crisis' is off-putting and stigmatising; everyday language (e.g., stress, wellbeing) is preferred.

> "A lot of people suffer with mental health issues but don't know it. They say there are 'Bad with mi nerves.' They don't understand that it is something you can get help with."
>
> Staff member working with Gypsy and Traveller Families

2. **Stigma and Intersectionality**
   - Neurodivergence stigma intersects with race, gender identity, immigration status, and LGBTQ+ identity. Black men report criminalization; LGBTQ+ neurodivergent youth face cultural divides.
   - Cultural and faith barriers: individuals from some communities reported that mental health "doesn't exist" or is spiritualised, delaying care.
   - Diagnostic overshadowing can arise in any domain where intersectionality exists. It was reported particularly by neurodivergent individuals with a visual or hearing impairment.
   - Neurodivergence is less accepted and underdiagnosed in many ethnically and culturally diverse communities.

3. **Barriers to Accessing Support**
   1. Communication Challenges:
      i. **phone-only contact deters help-seeking**, specifically with neurodivergent individuals.
      ii. text services can be **too fast paced not giving processing time**.

iii. QR-code-heavy information is overwhelming. Need for **visual aids, easy-read materials, and multiple contact modes**.
iv. **Language barriers** are significant for those without English
v. Services fail to meet **additional needs**. (The NHS still sends out appointment letters to blind patients with no extra notification)

2. Practical Barriers:
   i. **Transport** costs, fragmented locations, limited 24/7 options, and poverty restrict access.
   ii. Some people do not feel safe enough to physically access a crisis alternative when in crisis.
3. Digital Exclusion:
   i. The focus on the use of a **phone or electronic device excludes many people**. Those with visual or hearing impairments, elderly people, asylum seekers and homeless people all mentioned this.
4. Fear and Distrust**:**
   i. Fear of judgment, confidentiality concerns, and **lack of trust** in mainstream services persist, particularly amongst asylum seekers and refugees and some ethnically and culturally diverse communities.
   ii. Within some cultures, **fear of stigmatisation** within one's own community can also prevent help seeking.
5. Information Gaps:
   i. **Poor advertising of crisis alternatives**, including exactly who they are for and who is welcome. (Some neurodivergent people feel excluded from mental health settings)
   ii. **Unclear thresholds** with all services being termed 'crisis alternatives' but having different definitions of what is accepted.
   iii. **Lack of awareness** amongst professionals
6. Multiple intersecting needs:
   i. Some individuals are dealing with continuous problems such as poverty, housing, immigration status, education needs or physical health and have **no time to prioritise their mental health** until it is too late.
   ii. This was particularly raised by those seeking asylum and those working with Gypsy and Traveller communities

4. Overcoming Barriers - What Makes Good Practice

1 Person-centred, **flexible** provision with **adjustments** for neurodivergence:
   i. Consider **processing** needs - adjust pace, recap sessions, offer advocacy, and avoid rigid protocols.
   ii. Have **clear information** to create predictability whilst still being flexible when necessary
   iii. Having a **diverse** staff team with a mix of age, gender and ethnicity to offer choice and a broader understanding.

2. Ensure sensory-friendly environments:
   i. Offer **quiet spaces** where stimulation can be altered

ii. Ensure provision of **equipment** such as ear defenders, fidget tools, blankets with clear signage of who can access them and how.

3. Offer multiple access referral routes:
    i. Participants requested drop-in options, **non-phone contact routes** and 24/7 availability.

4. Offer clear, visual information:
    i. On websites and written literature advertising the service including **a video** of what **the venue** looks like.
    ii. business cards with opening times and contact number that can be kept in phone.
    iii. On all materials used in the service, use **infographics and simple language**

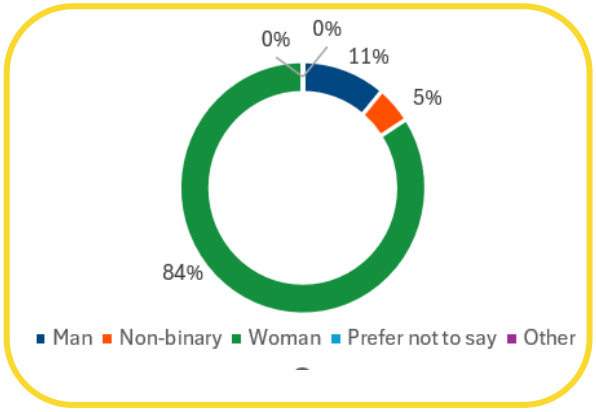
5 Offer relationship-based care and joined up working
    i. Build trust through **continuity**, **non-judgemental staff**, and **lived-experience** peer support.
    ii. The best services are linked in with local community support **before during and after crisis.**
    iii. **Sharing information** and referring to ensure people don't have to repeat themselves and their trauma multiple times.

6. Cultural competence:
    i. Ensure all staff **understand neurodivergence** and have **attended training**
    ii. Offer training on **cultural competence** and ensure a thorough understanding of local issues.
    iii. **Engage community leaders** in understanding and raising awareness of mental health and neurodivergence.
    iv. Recognise that some communities will **deliver the best support** to their own people.

3. Questionnaires from Staff in Crisis Alternative Services

a. Demographics[12]

Staff Age and Gender



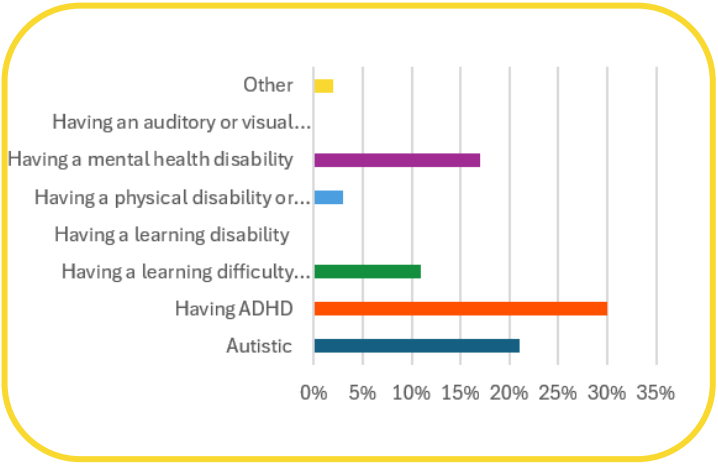
In general, the age of the workforce reflects a range of ages as would be expected in this type of role. However, **cis-gender women made up 84%** of the workforce. This is not uncommon in caring roles or in the voluntary sector in general. It may, however, contribute to men not seeing 'people like them' in services when they attend. Addressing the gender balance in the workforce would be a positive move. In a separate question**, 2 participants said they were trans.** The number of staff identifying as non cis gender is not as high as the number of users doing so but is greater than in the general population.

Staff Ethnicity and Religion

87% of staff participating in the research were white, with 79% of these being British. 8% were Asian or Asian British, but there were no respondents at all from Black Caribbean or Black African Backgrounds, Roma or Gipsy or Irish Traveller backgrounds. Although these communities may be less represented in the region than others, they are present and the fact that there are no staff at all involved in these questionnaires is a cause for concern.

21% of staff participants stated that they had a religion. Christianity and Islam were the main faiths represented. As with the neurodivergent participants, most individuals from an Asian or British Asian Background professed a faith in contrast with those from White British Backgrounds where the majority did not.

Staff Disability



37% of staff participants identified as neurodivergent in some way. The largest group (30%) had ADHD with over 20% identifying as autistic. Whether the questionnaire attracted a disproportionate number of neurodivergent staff due to its subject matter, is unknown, but it is clear that the sector has a higher-than-average number of neurodivergent staff which should be beneficial in terms of expertise within teams.

[12] Further demographic charts can be found in Appendix 8.

b. Responses

63 staff completed the questionnaires with most answering every question. Where one or two people declined to answer the occasional question, the percentages have been altered to accurately reflect the smaller number of replies.

Section 1 – Service Type and Role

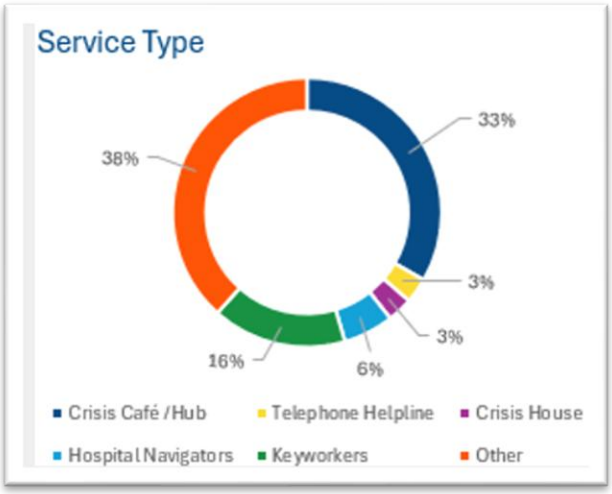


Figure 10a

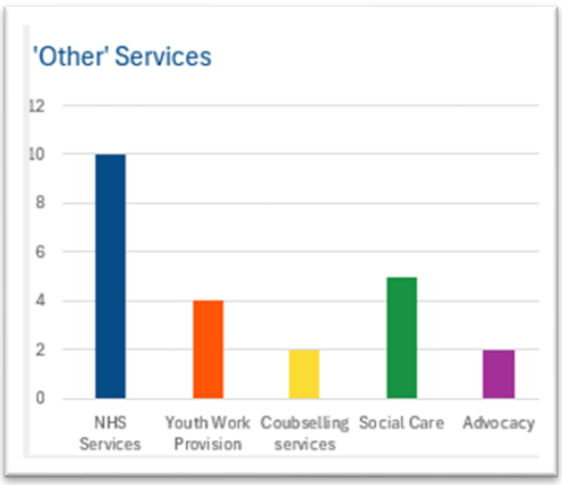


Figure 10b

Crisis Alternative services offering a physical space for people to attend were the single most represented provision. 21 participants worked within these. Only one member of staff from a crisis house responded, this may be because the researcher spoke individually with all crisis house managers. Keyworkers for young people with autism or a learning disability were the second most represented group. This service will be expanded on later in the report. Amongst the 'other' responses, the greatest number of participants worked for the NHS. These staff held a wide range of roles from working in mental health teams to child / infant services and a physiotherapist.

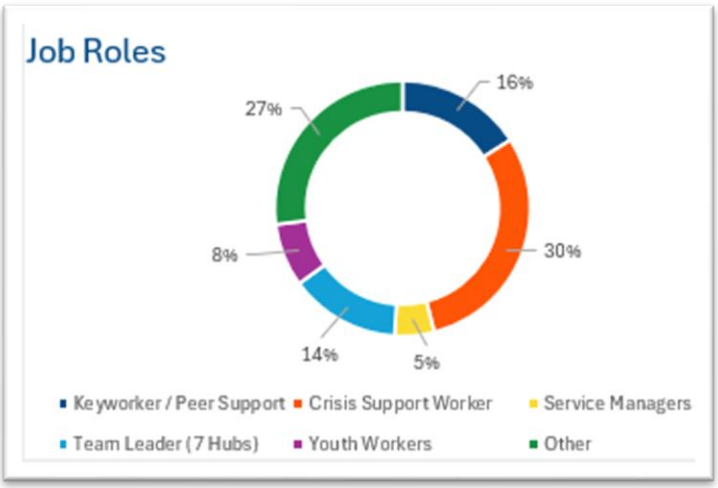
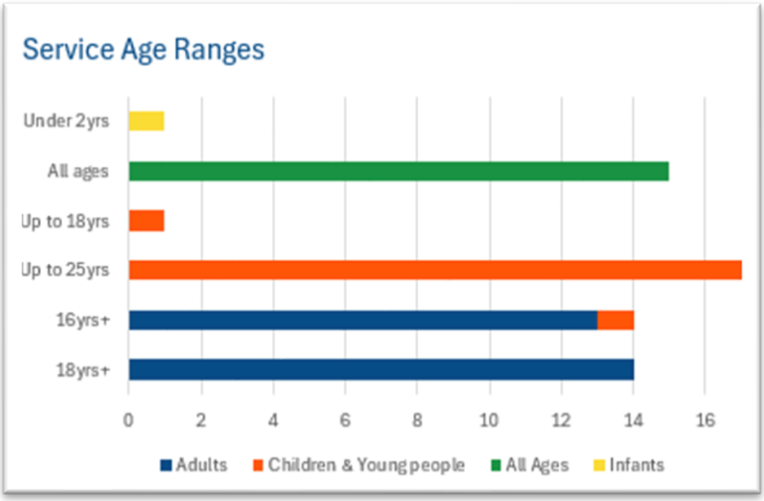


Figure 10c

The largest number of participants described themselves as Crisis Support Workers. The majority of these were within crisis alternative services, but some were also within statutory provision. Of the Team Leaders, 7/ 9 individuals also worked in crisis alternative provision. The 'Other' roles included counsellors, advocates, social workers and a physiotherapist as well as voluntary sector charity workers. There were also 10 specialist Key Workers supporting families of autistic children or those with learning disabilities.

Most participants who worked in crisis alternative services worked either with adults or children. However, there were two members of crisis alternative staff working with any age from 5 or 7 upwards.

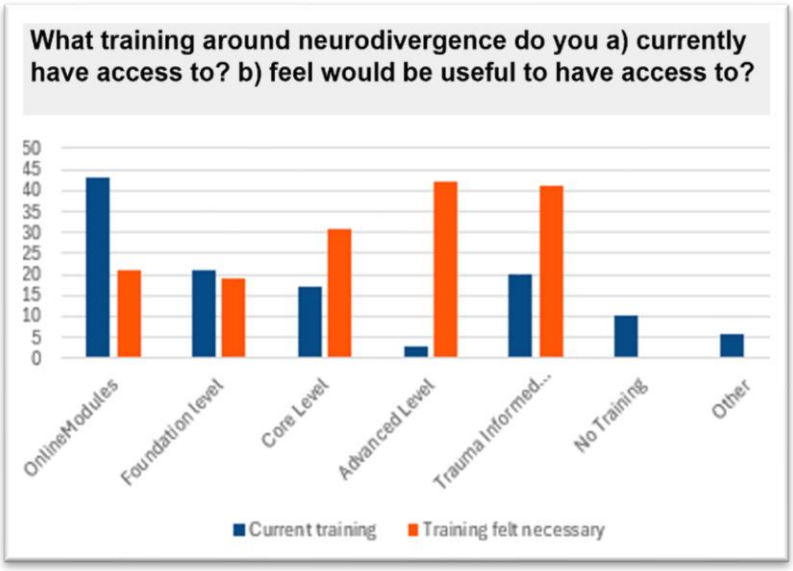


Keyworker services represented 65% of those working with young people up to the age of 25. One youth work service worked with young people up to the age of 18.

Overall participants worked across a range of ages that reflected the scope of the research.

Figure 10d

Section 2 – Training



Participants were asked to indicate the current level of training they received on neurodivergence and the level they felt would be beneficial in the role in which they are working. A slightly more in-depth explanation of the training levels can be found below. It can be seen clearly from the graph above that participants felt they needed more in-depth training than that which they were currently receiving.

Figure 10e

Online modules	A basic Introduction containing videos and e-learning
Foundation level training	Covering a basic understanding of neurodivergence such as neurodivergent traits and the social model of disability
Core level training	Covering an understanding of mental health issues experienced by neurodivergent service users
Advanced level training	Covering more complex understanding of neurodivergent service users experiencing mental health crisis and risk assessments
Trauma Informed Practice training	Specifically, when working with neurodivergent people

Training Delivery Style

Participants were asked to rate their preferred training delivery style from a range of options including online, face-to-face and mixed options, ranking each style from 1-7[13]. The two aspects that came out on top were **face-to-face training which is delivered in partnership with people who have lived experience.** Some people, particularly those in rural areas where transport is an issue would prefer online training, but that was a second option behind face-to-face training for the majority.

When asked if there were any other methods of training, they would find helpful, responses were:

- Case study-based training, learning from previous incidents or when things went wrong.
- Workshops as part of a smaller staff team of a service including role play and scenarios
- Ways to reflect on my current practice
- Gamification

The first three of these points would suggest that **training for managers / supervisors on neurodivergence and reflective practice might also be useful.**

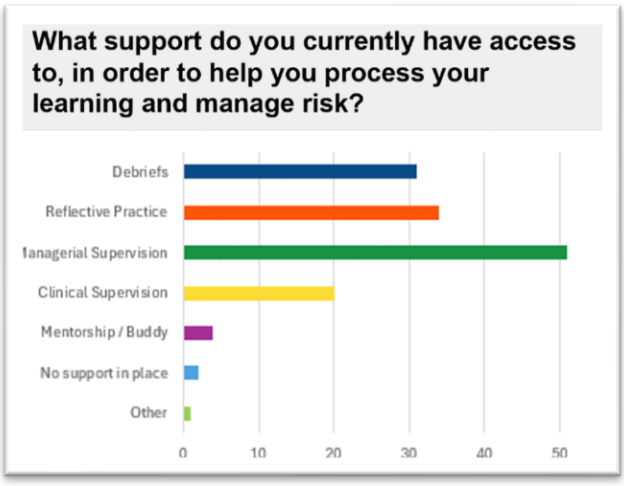


Figure 10f

Figure 10g

Figure 10f shows that 51 out of 63 staff or 81% said they had access to managerial supervision to help them to process their learning and manage risk. This still means that almost 20% of staff either do not get managerial supervision or do not feel they can use it for this purpose. This is the most common way for staff to process their learning which may be through training or practice. Reflective practice and debriefs were accessed by about 30% of staff which would suggest that this is not embedded in most services.

Barriers to accessing training are seen, in figure 10g, to be focussed on funding and the available time to compete the training (which ultimately comes down to funding). **This is something commissioners will need to take seriously if they want services that are able to keep neurodivergent people out of hospital**. The other barrier is the time or location of the training. Comments were made asking for part- time staff to have training provided within their normal working hours, which may be evenings or weekends.

[13] The graph to support this can be found in Appendix 8.

Support from Managers

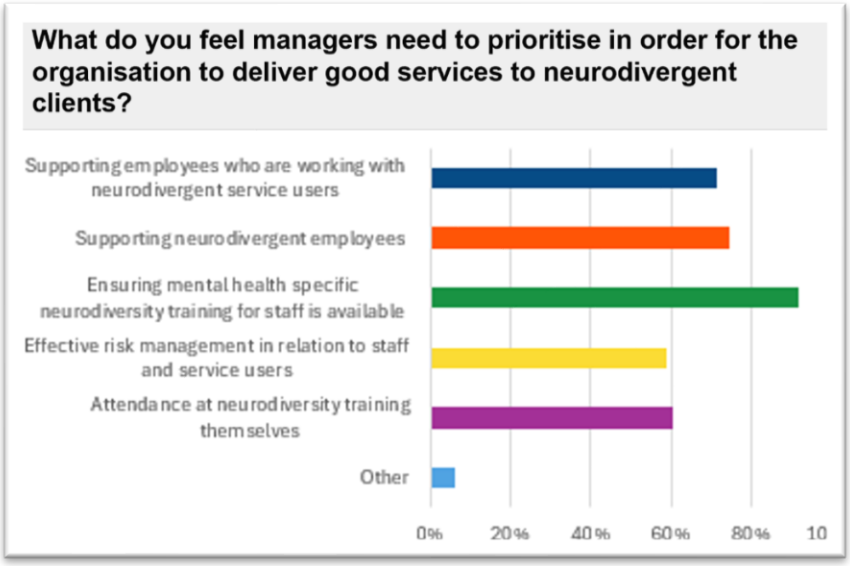


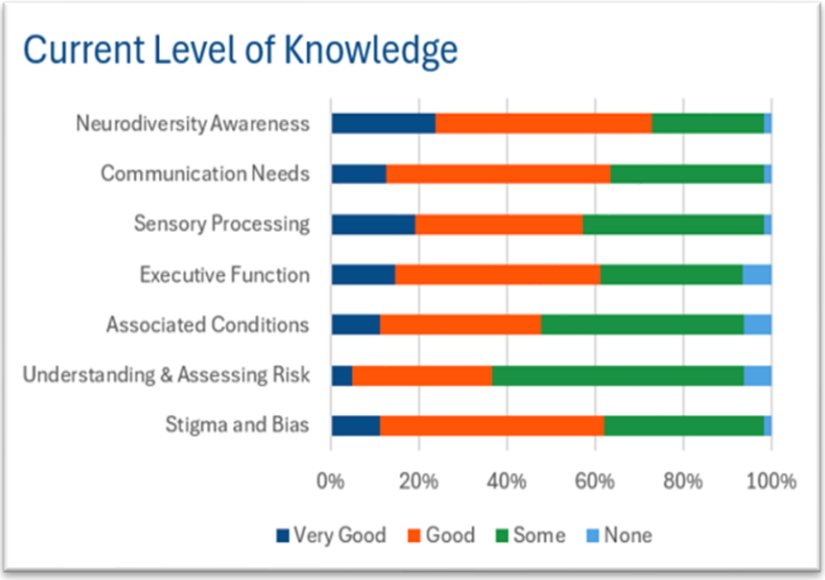
Figure 10h shows clearly that staff want training around neurodiversity as a priority. 92% of respondents felt that managers should ensure this is available. Over 70% of participants also felt that supporting staff working with neurodivergent service users and supporting neurodivergent staff were priorities.

Figure 10h

'Other' responses included embedding general support to staff around mental health, listening to and learning from neurodivergent staff and ensuring any necessary physical adaptations are made. Finally, staff were asked if there was anything else that would help them to access training and support, or to put their learning into practice. Responses included:

- development of neurodivergent support roles.
- an awareness of recognised / accredited good quality training, so as not to waste time.
- more funding and the availability of more specific (not basic) training.
- more support from Team Leaders, Supervisors and Managers.

Section 3 – Skills and Confidence



Participants were asked to rate their current skills and confidence in working with neurodivergent service users against framework. Results can be seen in figures 10i and 10j. Unsurprisingly, more staff felt they had knowledge and confidence at a basic level than at a more advanced level. They generally felt confident in their basic knowledge of neurodivergence, in recognising traits and understanding common characteristics. However, far less participants felt knowledgeable

Figure 10i

and confident with understanding and assessing risk. This knowledge will be linked with a deeper understanding of communication needs, sensory processing and executive function, along with an understanding of associated mental health issues and other conditions. Overall, most staff felt confident or very confident in most areas but still asked for more in-depth training. Comparing the confidence of staff with the experience of service users there does seem to be a dissonance.

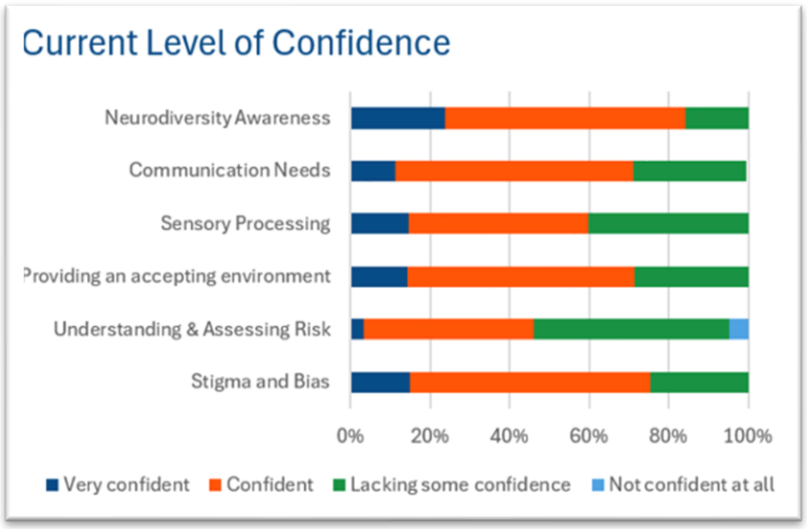


Figure 10j

Whilst over 70% of all staff felt confident or very confident in working with the communication needs of neurodivergent people in crisis, less than 30% of adults and just over 30% of young people felt that these needs were met most or a lot of the time.

Other areas for training

Participants were asked if there were any other specific areas they feel they would benefit from training in. The two most common answers were:

ii. the intersection of Autism and Eating Disorders, particularly Avoidant/Restrictive Food Intake Disorder (ARFID)

iii. the intersection of neurodivergence and LGBTQ+ within young people, particularly regarding gender.

Several participants asked for a greater understanding of the impact of issues, such as of mental health, the menopause and chronic stress, on neurodivergent people. One-off suggestions included communication tools, understanding dyslexia and dyspraxia, positive behaviour support plans, supporting neurodivergent young people with a sense of identity and engaging with young people who spend social time online. One participant asked for training around neurodivergence and cultural differences which offers practical advice.

Anything else that would help your service meet the needs of neurodivergent people?

This final question was a cover all and most people reinforced views that have already been expressed. One person said that '*Having a workspace where we could host families and young people*.' Would make a difference. The other recurring themes were **communication aids and funding.**

Section 4 – Assessment of Risk

Participants were asked the following open question:

In your experience, what specific risks can be involved when working with neurodivergent service users in crisis?

Assessment of risk will routinely look at risk of harm to the user, staff or others in attendance. Risk of harm to others was raised by some parents as an indicator of crisis, but not generally amongst adults. Guidelines on Best Practice Managing Risk[14] within crisis services (2007) emphasises a strength-based, positive risk management approach carried out in collaboration with the service user and their carer (if appropriate). It recommends that general **risk management training is repeated every 3 years.**

Looking at risk management in this way, it is clear that a **knowledge and awareness of the experiences of neurodivergent individuals alongside an understanding of the social model of disability,** will **enable a more accurate assessment and management of risk** for this demographic. Research into improving care for suicidality in autistic young people[15][16] emphasises the need for staff training to avoid miscommunication and misreading of young people's emotional presentation. In Cervantes et al (2025) a young person is quoted as saying "*She didn't really understand my thoughts. Maybe she wasn't trained in autism, maybe I wasn't expressing myself. I felt like she wasn't listening to me on purpose - needless to say, I felt frustrated...*" A common theme that emerges in the feedback below and which emphasises the need for staff to receive training on differences in neurodivergent brain functioning and how to respond appropriately.

The responses to this question on risk have therefore been analysed within the SPACE framework and presented alongside good practice which should aid in the mitigation of risk.

Sensory Need

Inaccessible environments which overstimulate or prevent individuals in crisis from finding a calm, accepting space where they can de-escalate may well increase the risk of harmful situations. These could include emotional or violent outbursts causing harm to self or others, shutdown, the need to self-harm, reinforcing an individual's lack of self-worth or increased internal distress. In the worst-case scenario, this could lead to service users being excluded from services and no longer able to access the support they need, or feeling services are not suitable for them. With young people it could increase the risk of absconding. By nature of the fact that neurodivergent people live with high levels of distress and stimulation much of the time, something which may seem trivial to a neurotypical person could lead a neurodivergent person to escalate to a point where they may be at risk of harm.

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[14] Best Practice Managing Risk Cover

[15] Cervantes, P. E., Palinkas, L. A., Conlon, G. R., Richards-Rachlin, S., Sullivan, K. A., Baroni, A., & Horwitz, S. M. (2025). Improving emergency department care for suicidality in autism: Perspectives from autistic youth, caregivers, and clinicians. *Journal of autism and developmental disorders*, *55*(8), 2820-2833.

[16] Cervantes, P.E., Li, A., Sullivan, K.A. *et al.* Assessing and Managing Suicide Risk in Autistic Youth: Findings from a Clinician Survey in a Paediatric Psychiatric Emergency Setting. *J Autism Dev Disord* **53**, 1755–1763 (2023). https://doi.org/10.1007/s10803-022-05448-8

Predictability

Services which do not offer enough information about what will happen and clearly explain the process to individuals cause increased distress to those who are neurodivergent. Any individual who has experienced trauma and is in mental health crisis will not find it easy to build trust and rapport, a key ingredient in enabling recovery. Those who are neurodivergent have usually experienced ongoing trauma due to their neurodivergence on top of any childhood trauma and find it even more difficult to build trust. The risk of disengagement is high if services do not provide a predictable and reliable service. Re-engagement is then more difficult due to the negative experience and re-traumatisation that has occurred.

Acceptance

Services are much more able to provide a predictable and appropriate service if they have background information on the service user and their up-to-date safety plan. This enables services to provide bespoke support and ensure that an appropriate plan is put in place. It is important for services to consider co-occurring conditions, intersections of identity e.g. LGBTQ+, cultural diversity, gender diversity and whether the provision is an accepting environment. A lack of understanding of these intersecting factors will undoubtedly cause a higher risk of escalation or disengagement. Neurodivergent people mask a lot of the time, and this causes extra stress which can again lead to avoidable dysregulation.

Children and young people are growing to understand the world around them constantly. For neurodivergent children and young people this is even more challenging. They and / or their family members may have lack of knowledge around risk, environmental triggers, preferred communication styles and processing ability. For some children (and even some adults) keeping themselves safe requires constant supervision from an adult. This can be exhausting, and a lack of professional support can lead to risk when parents / carers are no longer able to cope. Family members talk about being at breaking point and in need of support when none is available. Staff talk about the need for more support for families.

Communication

Whilst most staff feel confident to communicate with neurodivergent users, most neurodivergent users feel that their communication needs are not well met. A consequence of this is undoubtedly that services are not meeting the needs of neurodivergent users as well as they could. Communication failure is likely to lead to a number of potential outcomes including frustration, shutdown, disengagement and a recurrence of the same situation with no real change achieved. Some comments from staff in reply to this question stated rigid thinking, difficulty with negotiating and an inability to self soothe posing increased risks. Reframing this, an understanding of why the young person might need to think this way and the issues that rigid thinking might cause, combined with creative communication techniques or games and an understanding that the process may take longer would potentially help to alleviate this risk. **A lack of mutual understanding and empathy could lead to a poor assessment of suicide risk** making this a crucial area of training in order to provide equality of care to neurodivergent users.

Empathy and Skills

The questionnaire used this section of the SPACE framework to look at the training and skills staff need in order to be understanding of and empathetic to neurodivergent service users in crisis. Without an understanding of how neurodivergence affects people's ability to function in the way the neurotypical world expects, services will be unable to meet need and in turn unable to mitigate associated risk. Some of the differences highlighted by participants in this section included:

- service users not being able to implement their own safety plan or usual support offered by staff due to a range of factors
- self-neglect and lack of understanding of risky behaviour
- neurodivergent individuals often not being aware of increasing mental health difficulties until crisis point has been reached
- Pathological Demand Avoidance (PDA) and how it affects young people
- loneliness and self-isolation
- interoception and the inability to sense when physical needs are not being met

The knowledge and understanding gained from the training recommended in this report are essential for reducing the risks identified above.

Figure 10k

88% of staff felt that training on understanding the processing differences of neurodivergent brains and being given strategies and tools to ensure these are well met, was important to managing risk. Training on adapting communication styles and providing / using different communication aids was requested by over 80% of staff.

Whilst these were the top two requests, all of the training topics, relating to the SPACE framework were seen as important by at least 70% of participants. This clearly backs up the narrative above that risk is much higher if staff are not appropriately trained. However, there is no particular training that will just address risk management. Any risks specific to neurodivergent people in crisis, will be best managed by understanding and responding appropriately to their needs.

4. Focus groups with staff

The final section of research was conducted with two main groups of staff working with people in mental health crisis and one additional staff team working with young people. Firstly, those working in commissioned crisis alternatives and secondly those working in Keyworker services with neurodivergent young people. The staff team was from a young people's mental wellbeing service.

Section 1 – Focus Groups with Crisis Alternative Staff

Focus groups were held with staff from a crisis alternative service in each of the four ICB areas as follows:

a. South Yorkshire – Doncaster Safe Space – staff working with ages 16+
b. West Yorkshire – Touchstone Here for You – staff working with ages 16+
c. North Yorkshire – Hull & East Yorkshire Mind – staff working with children and young people
d. North East and North Cumbria – Everyturn Newcastle – staff working with ages 18+

Numbers attending the focus groups ranged from 2 to 7 and 3 out of the 4 groups were held virtually, with Newcastle staff attending in person. All groups were asked the same questions, but able to explore areas further if they wished.

Demographics

A total of 20 staff members took part in the focus groups. Age, gender and ethnicity were not asked, so cannot be verified. However, it is worth noting that the cohort was heavily female and heavily white. From observation only, there was only one male participant and no ethnically diverse participants. Considering the feedback from ethnically and culturally diverse communities that seeing 'people like them' is important, this is significant. Additionally, the lack of male participation in the research appears to be reflected by the lack of male staff involvement.

Staff participating were all white and very predominantly female.

Every focus group did, however, have at least one member, mostly more, who identified as neurodivergent.

Focus Group Responses

1. Current Service Provision

Groups were asked how well they felt their service currently met the needs of neurodivergent users and what adaptations they used if any. In summary:

i. All services prided themselves on being **person centred** and in taking time to listen to people's needs and how they would like to access their support
ii. Services felt that **having neurodivergent staff** and staff with experience or working with neurodivergent relatives or friends was very helpful and expertise was generally available.
iii. One service felt that doing a lot of work over **the telephone made it hard** for people to communicate and read body language. They also felt their drop-in service, which doubled as a public café, could be an **overstimulating environment**
iv. Two services talked about **building relationships** and breaking the ice by playing games or doing activities with or alongside people.

v. The service working with young people was **given information** on them before they arrived which **enabled them to prepare** and be aware if specific resources were required.

vi. **Consistency and long termism** were raised as important features which often weren't available in crisis alternative provision.

vii. The young people's service also talked about the benefits of **incorporating a trusted person** and about the need to **understand parent's reactions** and be able to work with them. Many parents of neurodivergent children and young people are neurodivergent themselves, although this may be undiagnosed, which can affect their reactions.

viii. One service mentioned **using text messaging** if people were non-verbal.

2. Current Training

The focus groups were asked what, if any, training they had had around neurodivergence and the differing needs of neurodivergent people in crisis.

i. Some individuals had done the Oliver McGowan training and did not rate it highly.

ii. Two groups had had training delivered by local groups working with neurodivergent people. This was generally good, but not as in depth as staff would like.

iii. Staff in one service had had no training on neurodivergence

3. Awareness of issues affecting neurodivergent people.

Staff were asked about their levels of awareness of the following issues affecting neurodivergent people with the results summarised below.

i. Sensory issues, including proprioception, interoception and vestibular senses
Generally, staff were aware that neurodivergent people may have different sensory needs and that they may be overstimulated by their senses. Some were aware that this included eating and was linked to ARFID as well as sight, sound, smell and touch. There was a lesser understanding of pleasure seeking and under stimulation linked to sensory issues.

The knowledge of proprioception, interoception and vestibular senses was extremely limited with one or two staff who had done more individual training being aware of these.

All teams would welcome training in this area and felt it was extremely important, particularly when they learnt how this can cause neurodivergent people to be less aware of physical needs.

ii. **Alexithymia** - difficulty recognising expressing and describing emotions
The vast majority of staff had not heard of this term, however, knowledge that neurodivergent people may have difficulties recognising and expressing their emotions was slightly more prevalent. One staff team had no idea about this but felt it made a lot of sense from their experience. One neurodivergent person emphasised how important they felt this was and teams generally wanted training around how to support people with this.

iii. **Spoon Theory** – A theory that helps track energy and prevent burnout
Young Experts by Experience had specifically asked for this to be in the research as they felt it was extremely helpful for them. At least one person on 3 of the 4 teams had some knowledge of this theory, but most staff were not aware of it. When explained there was a resounding agreement on its use. Staff felt it should be widely available as a tool.

iv. **Processing and communication difficulties**
All teams had a knowledge that neurodivergent people may had difficulties with communication, particularly when in crisis. However, there was an overwhelming agreement that they needed training on practical tools that they could use in their settings.

v. **Executive function differences**
There was much less knowledge and understanding of executive function and how this differs in a neurodivergent brain. Some people were aware that neurodivergent people might struggle with numerical scales or filling in forms, but not why or how they could help. The main knowledge was amongst those who were neurodivergent themselves. Everyone agreed that practical examples of how to support people in this area are key.

Most staff were **excited about the prospect of training in these areas** and felt that it would really improve their ability to work well and support neurodivergent individuals. However, there were one or two who felt that, as long as you got to know the person and how they liked to do things, there was no need for more training.

4. Level of training wanted

Staff were asked what level of training they felt it was important for them to have access to around supporting neurodivergent individuals. 3 of the four teams felt that they should be offered the highest level of training. Reasons included:

I. We get a high percent of people who are neurodivergent using our service
II. Knowledge enables people to work better, and you don't know what you don't know.
III. It is very possible someone in crisis might present as non-verbal
IV. We need an in depth understanding accompanied by practical tools and ways to support neurodivergent people

The fourth team felt it needed to be delivered at all levels and to more than just delivery staff. They felt it was important for receptionists and doctors as well as support workers. Different staff would need different levels of training.

Finally, Oliver McGowan training was mentioned and felt it was too clinical and didn't give enough practical tools. It was not felt appropriate for the voluntary sector.

5. Preferred training delivery type

Staff in the focus groups were asked how they learnt best and what types of training they preferred. The main points are summarised below.

- **Lived Experience** - The point that was agreed on by all teams was the need for training to involve people with lived experience, both in its production and delivery. They felt this was more informed, more memorable and of more practical help.
- **Face-to-face** – The most favoured delivery type was face-to-face. There were some requests such as not to include role plays and to keep things dynamic to avoid boredom. Small group work was mentioned as generally being beneficial as it enabled people to learn from each other as well as the trainer.
- **Different learning types** – Individuals talked about how they learn differently and the importance of allowing for that. One felt they learnt by doing and not in a classroom, another from watching short videos that worked for their attention span. One person said they got too distracted in a 'classroom' environment.

- **Same material different formats** – One team felt it would be important to present the same material in different formats as people learn in different ways and some have access issues, so a mix of in person and online was required.
- **Shared across organisations –** Several staff felt it would be beneficial to share training with other organisations. They felt it would be more interesting and enable networking. It might also enable a critical mass for training in smaller towns or more rural areas.

6. Barriers to accessing training

The next question was about the barriers teams or individuals encountered in accessing training. The main two were money to pay for it and time to attend it. These are expanded on below with any other barriers.

- **Money to pay for training –** this was seen as the main barrier. Budgets were being cut and managers felt that money had to be prioritised to keep services open rather than paying for training or using staff time to attend it (even if it was free). Suggestions were that **services should clearly identify the need for this in their proposals** and that **commissioners** need to see the importance of it and dedicate money or a training offer to the voluntary sector in the same way that they would the statutory sector.
- **Time to attend training –** some staff saw this as a separate issue to money. In one team, staff were employed to cover two roles and felt that juggling these left no space to fit in training even if it was available. They felt that the organisation needed to prioritise time for their training and include it in their timetable.
- **Identifying good quality training –** one team commented that there was a lot of training available, but it was difficult to know which of this was high quality and appropriate for their roles. As money is tight it is important to invest in the right training.
- **Training not being appropriate** – some staff felt that the training required of volunteers was not always appropriate. They felt there was far too many modules of 'irrelevant' material if people are just using their lived experience to listen to others.
- **Travel, particularly in rural areas –** one person pointed out that they might need to get 3 trains and a bus to a particular venue if they didn't drive which could take 4 hours. In these situations, it would be important to consider online training or multidisciplinary training delivered more locally.

7. Support to implement learning

The focus groups were asked what support they received and / or found useful to put their learning into practice. The answers to this question varied from team to team and some staff felt more supported than others. The two main types of support appeared to be supervision and debriefs or check-outs at the end of a day or session. In summary:

- Two of the four teams mentioned **supervision** being an important part of their support. They were able to take cases for discussion and reflect on these. One team felt that supervision was not as regular as it should be due to pressures of work.
- All teams mentioned **discussing cases amongst the team**, usually as part of a **debrief** or check-out. Depending on how staff worked together and the nature of the service these varied but were always seen as very important.
- Formal team or **staff meetings** were used by one service to discuss difficult cases. These were every 4-6 weeks.
- One team had **group clinical supervision** with a psychologist once a month

8. Assessing risk

Staff were asked if they felt there were specific risks associated with neurodivergent users and how they assess and mitigate against these. There were some themes that came up several times and other issues that were specific to certain settings. In summary:

- **Sudden escalation** – There was a consensus that with neurodivergent people, particularly children and young people, behaviour or crisis might escalate more quickly when triggered than that of a neurotypical person. An example of this was that a young person could go from being completely calm to banging their head against a wall. One service working with a group of neurodivergent young people felt that, with so many differing needs, staff must be aware that one person's behaviour can trigger a crisis in someone else.
- **Unsuitable support** – There was a recognition within some teams that environment and unsuitable support could increase risk, and that training would help to reduce this. Struggles with communication, lack of understanding and unpredictability of a service would all potentially contribute to escalating a person's crisis. The move to adult services was also identified as a risk factor as it was not felt that adult services were necessarily appropriate for a vulnerable 18-year-old.
- **Alexithymia –** one person felt that the difficulty neurodivergent people had identifying their feelings might cause them to be less able to explain what they needed and be a risk factor.
- **Neurodivergent Meltdowns –** A neurodivergent participant felt that it was not always easy to separate a mental health crisis form a meltdown and it was important not to make a meltdown worse for someone.
- **Self-Harm** – Self harm was raised as being more prevalent amongst neurodivergent young people and the need for awareness of this, particularly if individuals felt they needed to escalate this in times of distress.
- **Person centred risk-assessing –** one team felt that the risks were no different, as everyone had different triggers and rates of escalation. They felt everyone should be risk-assessed individually with triggers identified at an early stage and shared within the team.
- **Environmental risk –** One team felt vulnerable in their setting, but this was not specifically around working with neurodivergent clients. They felt that, with the building being used as a café and anyone being able to walk in, just having 3 female staff caused them concern.

9. Anything else – need for training of clinicians

Finally, the focus groups were given space to bring up anything else they thought might be relevant. One team felt very strongly that **clinicians needed more training**, particularly around autism. They named several concerns:

- Clinicians and systems claiming that young people's mental health problems are due to their neurodiversity and therefore not in need of any therapy or treatment.
- The refusal to allow a safe and trusted person to accompany a young adult to an appointment or to have an input when the adult wants them to.
- Clinicians not recognising that young people not knowing how they want supporting can be down to their neurodivergence and not being difficult. One staff member said her 13-year-old autistic daughter had been refused help because she couldn't articulate what help she wanted.

Section 2 – Focus Groups with Keyworkers and @ Home Barnsley

Keyworker services provide support to autistic or learning-disabled young people and their families at risk of being admitted to hospital. To receive Keyworker support a child or young person must be on the Dynamic Support Register (DSR). Each area within the North East and Yorkshire region has slightly different criteria to access their keyworker services, but all of them provide support to children and young people up to the age of 25 at risk of admission to hospital. The following four groups of keyworkers were consulted:

- West Yorkshire Keyworker Service delivered by Barnardo's
- South Yorkshire Keyworker Service delivered by South Yorkshire Integrated Care Partnership
- Keyworkers for the southern half of the North East and North Cumbria region delivered by Daisychain
- Keyworkers for the northern half of the North East and North Cumbria region delivered by Skills for People

As well as Keyworkers, a focus group was held with the staff of a Youth Mental Health Project for young people in Barnsley. This group works with any young people struggling with their mental health, but the majority of young people are neurodivergent. Many of the issues they raised were similar. A separate account can be found in Appendix 9, but the main points are included here. All groups were met face-to-face and asked the same questions which they debated in small groups and then fed back. Notes were made on flip charts which have been summarised below pulling out common themes.

Demographics

37 keyworkers were involved within the 4 groups showing that services were very keen to support the research. The **majority were white females**, but demographics were not kept, so no analysis can be made. One young man who had had a keyworker himself commented that he had needed a man but been given a middle-aged woman to whom he couldn't relate. 8 mainly white British, female staff from Barnsley participated.

Focus Group Responses

1. Understanding Mental Health Crisis

One team listed a range of mental health crisis presentations, but three of the teams also came up with a similar definition of what they thought a mental health crisis was for the people they worked with. A combined summary of this would be:

> *Crisis occurs when resilience levels / coping strategies are outweighed by the demands / stressors of life and affect the young person's ability to function.*

There was a recognition that crisis means different things for everyone, but that it affects the whole family and causes immense suffering. It was also agreed that crisis was not always visible and that shutdowns, meltdowns and masking behaviours were often overlooked. The Barnsley Project felt that the medical model of crisis support often does not feel comfortable for young people and can be difficult to access if neurodivergent due to an overload of information. They said that many young people accessed them as it was easy to do so.

2. Unique Role of Keyworkers

The focus groups were asked how the keyworker service is unique in meeting the needs of Autistic young people and preventing crisis or supporting them through it? The same themes came through from every service, including the Youth Work Project in Barnsley and can be summarised as:

- **Person-centred and flexible**: Keyworkers emphasise working *with* young people and families, not *for* them, respecting their autonomy and preferences.
- **Holistic and relational**: They build trust over time, support transitions, and often serve as the only consistent presence across services.
- **Non-clinical and voluntary**: Their approach is consent based, non-threatening, non-transactional, and not bound by rigid systems or time limits.
- **Advocacy and system navigation**: Keyworkers challenge systems, identify gaps, and help families navigate complex service landscapes.
- **Whole family approach**: Recognising and working with the needs of the whole family, in turn also benefits the young person.
- **When set in a service such as Daisy Chain** there are many additional wrap-around services that can be offered.
- **No diagnosis** was required for the **Barnsley project,** and young people could **self-refer.**

3. Essential Skills for Keyworkers and Youth Workers

As the keyworkers and youth workers are working with neurodivergent children and young people daily, they are well positioned to know the skill needed to do the job well. There were a wide range of skills cited by the five teams, but general agreement that these included:

- **Being caring, compassionate and non-judgemental**: The teams felt that a values-based recruitment process was crucial.
- **Relationship building skills,** including empathy, listening, communication and patience. Establishing a professional, trusting relationship is a crucial part of the role, enabling the young person to engage freely.
- **The confidence and ability to advocate** on behalf of the family and challenge decisions**.**
- **Creativity and adaptability**: Keyworkers often need to think outside the box to meet individual needs.
- **Trauma-informed and culturally competent**: Understanding trauma and diversity is crucial.
- **Team learning and lived experience (particularly of neurodivergence)**: Peer learning, reflective practice, and diverse backgrounds enrich the team's effectiveness.
- **Local knowledge**: of services, systems and processes.
- **Keeping support real and fun** to maintain engagement

A list of training recommended by Keyworkers to strengthen and compliment these skills can be found in Appendix 9.

4. Barriers to accessing support

Teams were asked what barriers young people and families encounter, whilst trying to access support for their mental health. These were significant and fell into several themes as outlined below.

- **Rigid criteria and thresholds**: Many young people don't "fit the box" and are excluded from several services. Or they may be on a pathway that doesn't consider their autism; however, they can only be on one pathway. Young people can be 'too complex' for mainstream services but not meet specific criteria for any one pathway. Services are all diagnosis led rather than looking at the needs of the young person.
- **Lack of understanding and adjustments**: Many NHS and clinical services have very poor knowledge or understanding of neurodivergence. Professionals often misinterpret behaviours or fail to make reasonable accommodations. Young people will be discharged inappropriately for not engaging when the services are not accommodating their neurodivergence. Services may also add to the young person's trauma or crisis due to inappropriate environments or processes.
- **Long waiting lists and poor transitions**: Long waiting lists mean that people reach crisis before they get the service which might have prevented it. The wait for diagnosis is several years in most places and access to services is often limited without this. Delays and poor handovers between services (e.g., child to adult) exacerbate crises. In some regions, people are not getting onto DSR until too late for the crisis to be averted.
- **Cliff edge of reaching 18**: The transition to adulthood is all done at the same time. Placements may be breaking down at the same point as CAMHS ends their involvement and education is in flux or benefits stop to families.
- **Parental challenges**: Parents often lack knowledge, feel blamed, or are not taken seriously. They might play issues down due to fear of admission or social care involvement. Parent mental health as well as that of other family members may impact resilience and parenting styles. Often families don't get help until they hit crisis point.
- **Diagnostic overshadowing:** everything is put down to the young person's autism and comorbid conditions are overlooked. With the lack of services and long waiting lists, this can be used as an excuse to pass a young person over as someone else's responsibility.
- **Time limitations and lack of appropriate services:** Often when a young person eventually accesses the service they require, it is limited to a certain number of sessions, or a period, that is not sufficient for them as a neurodivergent individual. It is known that there are not enough services to meet the mental health needs of young people today and services are running to rigid criteria to see as many people as possible. There are very few step-down services if a young person is discharged from more intensive support. In most areas there is no post-diagnosis support for anyone receiving a diagnosis of autism or ADHD. Parents are just left to get on with it until crisis hits.
- **Services not being client led:** So many services do not even involve young people in their design and are delivered wholly inappropriately.
- **Judgment and stigma:** young people often feel belittled by parents, carers and professionals

5. Ideal Service

The 5 teams were asked what an ideal service would look like that would:

> Provide community-based support for neurodivergent young people (or adults) who may not meet the criteria for the Keyworker service but are in or approaching crisis.

All teams came up with similar key elements which are summarised below. Interestingly, much of what the Keyworker services asked for was delivered by the Barnsley Mental Wellbeing Project. The service would need to be:

Accessible and inclusive:

- Low threshold with no diagnosis required
- Well-advertised across all services and social media savvy
- Drop in options available
- Open referral
- Take a positive risk management approach
- Offer services in person, online, on the phone and home visits
- Potentially a hub and spoke model (depending on area / region)
- Offer a wide range of adaptations and communication methods

Person centred and trauma informed

- Staff having all the essential skills for keyworkers (point 2, page 38)
- Good support for staff – wellbeing / therapy available.
- Supportive communicative team, supportive managers, trauma informed culture
- Young people and families are listened to, heard and understood
- Quality checked by Experts by Experience
- Enabling and empowering

Safe, sensory-friendly environments:

- Non-clinical, welcoming spaces that reduce stress.

Offer crisis prevention and step-down support:

- Services that engage before, during, and after crisis.
- Staffed by a range of professionals from different backgrounds, e.g. youth work, mental health, social work, addiction.
- Able to manage complex cases and comorbidities
- In partnership with CAMHS, Keyworkers and voluntary sector

Informed by lived experience:

- Offering peer support for 16–25-year-olds
- Staff with lived experience
- Creating family networks and support

Flexible and responsive: Services that adapt to individual needs and are not time limited.

- An inclusion team that advises on how to engage different communities
- Holistic family appropriate service and support
- Networked with all local providers and referring / hand holding to these

Offering a residential element:

- Intensive intervention away from home
- Offer respite for families
- Preventing Tier 4 admission
- Stepdown from 136 or ward
- This residential element along with a purpose-built building were requested by one project.

SUMMARY OF RESEARCH OUTCOMES

a. Summary of care needed by neurodivergent people

The research drew out four themes, all of which fit under a master theme of:

'Support that feels accessible for me'

- 'Offering me a safe space I can access'
- 'Communicating with me in ways that I can understand'
- 'Seeing me for 'me' and treating me holistically'
- 'Involving me in a process in which I can feel safe'

These themes represent the way in which environment, communication, holistic care and predictability within support pathways are essential to provide adequate crisis care. Allowing neurodivergent individuals to feel seen within support pathways and to feel safe within the services they are accessing will enable services to better provide both interventions and preventative measures for crisis. This includes **incorporating a variety of communication methods** and **ensuring the individual is aware of and involved in the process and pathway of their care**. Support provided needs to be **holistic** in terms of both the individual's **intersecting needs** and presentations and expanding care to **include the individual's wider support network**. There is a need for services to be flexible in their approaches, to **develop thorough understanding of neurodiversity and subsequently demonstrate appropriate changes in service delivery to meet the needs of neurodivergent individuals.**

Neurodivergent people told us through questionnaires and focus groups that **feeling understood and accepted** was **the** most important aspect of any care they received. On average 93% indicated that this was very important, rising to 98% when including 'Important' responses.

These themes were echoed by members of minoritised communities. They felt that an **understanding of their culture and/or issues** that they face including stigma within and outside of the community was crucial to them feeling that support was accessible to them. In general, people from minority community groups accessed crisis alternative services far less than their more majority mainstream peers. Reasons given for not attending were that **support was not accessible for them**.

b. Details of what that looks like

It is possible to summarise the responses from the research into practical steps under each heading. Quotes from individuals to back up these steps can be found in Appendix 10.

i. 'Offering me a safe space I can access'

The space and service need to be / have:

a. A quiet physically accessible place with adaptations and accessories to meet sensory needs

b. A space without judgement that reflects diversity so that I feel accepted and feel that people will understand me (staff and posters / images)

c. A space located somewhere I can access safely, taking into account cultural needs and stigma.

d. A psychologically informed environment that is not clinical

e. Well-advertised with clear information so that I know it is suited to my needs (and caters for neurodivergence)

f. Different ways to access it, not just by telephone; ideally, I can just drop in.

g. Support to get there if I have no technology, money or mobility needs (e.g. care leavers, visually impaired)

h. Somewhere that allows me to visit before I am in crisis

Additionally, for children and young people it needs to be / have:

i. A space that is available before, during and after crisis

j. Somewhere for family to wait and ideally get support separately

ii. 'Communicating with me in ways that I can understand'

This means:

a. Offering a range of communication methods, even if I am verbal

b. Using simple language that is clear and unambiguous. Don't use jargon.

c. Having trained interpreters and people who speak my language

d. Understanding that I am not being rude if I cannot communicate as you expect

e. Helping me to identify how I feel, if I would like that

f. Giving me time and space as I may not feel able to talk immediately

g. Offering me information and strategies in picture format as well as writing.

iii. 'Seeing me for 'me' and treating me holistically'

This means:

a. Listening to me and taking me seriously, not making assumptions

b. Offering me support for what I have come for and avoiding diagnostic overshadowing

c. Understanding the factors that might be affecting me as a neurodivergent individual

d. Including my 'trusted other' if I ask you to, or if I can't verbalise it but they know me, and listening to them

e. Ensuring my physical needs are being met when I am in crisis (offering food and drink in a different space)

f. Respecting my choice of name and pronouns

g. Understanding that my family and external circumstances may need to be taken into account. Recognise what is going on for me and empathise.

h. Referring me to other places but not expecting I can just access that alone?

i. Giving me the opportunity to meet peers who are experiencing the same issues and get support from / give back to them

Additionally, for parents and carers of children and young people it needs to be / have:

j. Listening to my child but also giving me space to talk to you without them present and listening to me.

iv. 'Involving me in a process in which I can feel safe'

This means

a. Asking me my access needs at the start in a clear and open way and offering options
b. Giving me clear and precise information about what is going to happen next
c. Reading any background information (e.g. hospital passport) so I don't have to repeat myself and relive trauma
d. Giving me the option of information backed up in writing
e. Giving me plenty of time to process information and ask questions (supporting me with questions I might like to ask). Taking regular breaks
f. Reassuring me that I am in the right place
g. Keeping the same team involved and building a trusting relationship
h. Telling me who you are and what your role is – (Wearing a name badge I can see)
i. Keeping to the timescales you have told me about

WORKFORCE DEVELOPMENT NEEDS

a) Summary of Findings

Relating directly to the need to feel understood and accepted, **neurodivergent people** felt that it was important for all staff to have more than just a basic understanding of neurodivergence and the social model of disability. They felt that **staff required** a deeper understanding of **processing and communication needs, masking and meltdowns and trauma in neurodivergent people.**

The Core Capabilities Framework for Supporting Autistic people[17] was commissioned as one of the key objectives for workforce development in delivering the Autism Strategy, overseen by the Department of Health & Social Care (DHSC). **It clearly states that training should be provided to health care professionals delivering support to autistic people**. It gives guidance on the levels of training to be undertaken for staff within different roles. Within talking therapies, studies have shown that a therapist's confidence to make useful adaptations for autistic people was not associated with their years of practice or how many adaptations they made **but was dependent on how much training they received.**[18] This is likely to be the same for crisis alternative staff.

The research identified that most staff only receive training around neurodivergence through online modules and at a basic introductory level. In direct contradiction of this, and in line with the guidance in the Core Competency Framework, most staff felt that they needed face-to-face training at an advanced level. Many individual staff and some teams felt that being person centred and tailoring support to each individual went a long way to meeting the needs of those who are neurodivergent. However, generally staff felt that they would be able to **deliver a better service if they had access to training.**

[17] Autism-Capabilities-Framework-Oct-2019.pdf

[18] Cooper, K., Loades, ME., Russell, AJ. Adapting psychological therapies for autism - Therapist experience, skills and confidence. Res Autism Spectr Disord. 2018 Jan 1;45:43-50. doi: 10.1016/j.rasd.2017.11.002. PMID: 30245739; PMCID: PMC6150418

There was a clear discrepancy between staff feeling that their person-centred approach was meeting the needs of neurodivergent clients well, and the views of neurodivergent clients who didn't feel understood. This discrepancy is backed up by the theory of double empathy[19] now commonly understood within the social model of autism. In addition, many neurodivergent people expressed finding it hard to ask for adaptations or to express that they didn't understand or needed more time, as they would have to do this too often, and generally like to please people. These factors, along with stigma and the need to fit in, contribute to masking, a way of life for most neurodivergent people, making it difficult for staff to realise that they are not meeting their client's needs.

Staff and neurodivergent services users clearly identified the need for staff to receive focused advanced level training on understanding neurodivergence and supporting neurodivergent people in crisis. This would include **sensory**, **processing and communication needs, alexithymia, masking, overwhelm and trauma** in neurodivergent people. It would also cover **assessing risk and trauma-informed practice**. Most staff favoured face-to-face training including trainers with lived experience, although the practicalities of this in rural areas were raised. They wanted the training to provide **practical applications** of theory as well as **case studies and examples**.

The support or otherwise of management received mixed results, but whilst 81% of respondents received managerial supervision, only around half of staff had access to reflective practice. In terms of solidifying learning, discussing and reflecting on support given was generally perceived as crucial. Delivery staff wanted **managers to be trained in neurodivergence** to be able to support them in their work and for them to support neurodivergent staff.

Members of ethnically and culturally diverse communities also requested **training and awareness raising on mental health and neurodiversity** for their communities. They wanted staff teams in crisis alternatives to be more diverse and to have an understanding of their culture and /or issues facing them. LGBTQ+ young people wanted to feel accepted and understood, this requires staff to be trained in the unique needs of those who are LGBTQ+ and neurodivergent. Workforce development needs include an **awareness of culturally competent care** and an understanding of cultures both accessing and not currently feeling able to access services.

Research indicates that, when developing training with learning outcomes below it should:

a) be co-produced and delivered by people with lived experience
b) ideally be delivered face-to-face. (Unless travel is prohibitive)
c) be at an advanced level (Tier 2-3 in Core Capabilities Framework) giving a detailed understanding of neurodivergence and co-morbidities
d) include practical tools that can be used with clients.
e) cover sensory processing, executive function, communication, alexithymia, masking, overwhelm, trauma informed practice and stigma and bias.
f) offer specialist training to staff around eating disorders and pathological demand avoidance where required.
g) explore the unique needs of those) who are LGBTQ+ and neurodivergent

[19] Milton, D. (2012) On the Ontological Status of Autism: the 'Double Empathy Problem'. Disability and Society. Vol. 27(6): 883-887.

h) address cultural competence and run alongside awareness and understanding of local communities

b) Suggested Learning Outcomes

The research outcomes on pages 41-43 were used to create the following learning outcomes. These were then used to develop the pilot training outlined below.

Suggested Learning Outcomes

By the end of the training, you will be able to:

1. Provide a space that is both accessible to, and safe for, neurodivergent people in mental health crisis.
    i. Understand sensory processing differences and why environment is crucial in creating a safe space
    ii. Know the practical adjustments that should be made available and be able to implement these

2. Communicate appropriately and flexibly with neurodivergent people using a variety of methods
    i. Understand contributing factors to communication issues including the 'double empathy' problem, alexithymia and sensory processing, and the disconnect that often occurs leaving people feeling misunderstood.
    ii. Have and be able to use a range of tools to communicate effectively with neurodivergent people with varied communication needs

3. Involve neurodivergent people in crisis, in processes in which they feel safe.
    i. Understand executive function differences and how they might impact neurodivergent people
    ii. Be able to create appropriate information, processes and resources for your service that will support neurodivergent people in feeling safe.
    iii. Understand how to manage and mitigate risk for neurodivergent people in crisis

4. Understand the varied needs of neurodivergent people in crisis and offer them appropriate support, treating them holistically.
    i. Be able to listen carefully to what neurodivergent people are saying and detect inconsistencies, helping them to unmask.
    ii. Recognise and understand masking and meltdowns in neurodivergent people and be able to offer appropriate support.
    iii. Understand the impact of trauma for neurodivergent people and the complexities of growing up in a neurotypical world.
    iv. Be able to recognise and use a range of neurodivergent friendly / adapted tools to support people to manage their mental health.

c) Pilot Training

The pilot training, delivered as part of this commissioned project, had a limited budget and a limited delivery time. It was delivered to Touchstone Crisis Alternative Staff who work with people aged 16+. Due to the limited time and the mainly adult service users, the training did not cover points f)-h) (more specialist areas) on pages 44-45. This should be considered in devising future training and calculating the time and resources required for delivery.

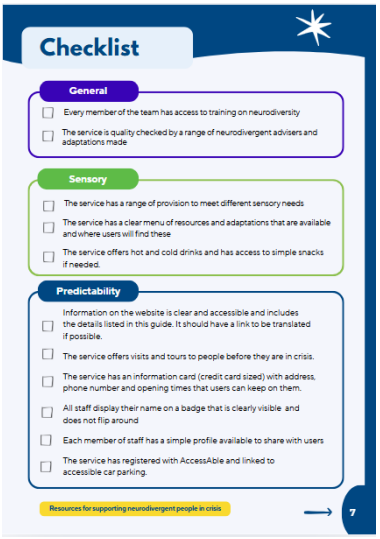
Key points about delivery were as follows

- The training was delivered face-to-face over 7 hours, in 2 x 3.5-hour sessions.
- It was co-produced and delivered by trainers with lived experience
- It covered the Learning Outcomes listed above
- It was accompanied by a resource pack, co-produced with experts by experience with learning from the research. This resource pack included practical tools to use with clients
- The training gave opportunity for participants to explore the resource pack as well as learn at an advanced level about autism and ADHD.
- The training was evaluated through before and after questionnaires and results can be found in Appendix 11.
- After the training people rated their knowledge of neurodivergence as good or very good in 97% of responses.
- Before the training 23% of staff said they felt able to support neurodivergent people in crisis well and 13% very well. After the training this increased to 51% feeling they could do it well and 45% very well.

Recommendations:

- That training identified through this research is fully funded and offered to all staff working in crisis alternative settings.
- That the Resource Pack is given as part of the training to all crisis alternative settings
- That reflective practice is expected as part of any service delivering crisis support and those providing it are also trained in neurodivergence.

Crisis Resource Pack produced with Experts by Experience



ADDITIONAL DISCUSSION AND RECOMMENDATIONS

The research clearly indicates a need for the workforce to be more aware of the specific needs of those who are neurodivergent; a need which can partially be met through the provision of training and resources.

However, there were barriers to access identified that cannot necessarily be addressed solely through workforce development. This was particularly the case for people from marginalised groups including those from ethnically and culturally diverse communities, young people, care leavers and those with sensory impairments. Whilst the main aim of the research was to identify appropriate training, additional barriers have been identified along with recommendations of actions to tackle many of these.

This discussion will identify **key additional themes and issues** arising from the results and make recommendations for action where appropriate. Section A will cover general themes, whilst section B will cover themes relating to children and young people specifically.

Section A – General Themes

1. Listening, Hearing and Taking Action

Neurodivergent people expressed not feeling listened to much of the time. Some of the reasons for this were given, including:

1. Individuals feeling they weren't given the time they needed to explain
2. Feeling misunderstood (because they are different to the person they talked to)
3. Feeling patronised or looked down on by people (often due to stigma or stereotypes)
4. Not feeling respected for their views – Particularly by doctors by whom they often felt dismissed
5. Parents feeling their views weren't important as professionals would not ask or include them
6. Experience of mental health services (particularly CAMHS) not understanding neurodivergence

Highlighting the importance of this, the single question in the questionnaire which got the highest percentage (93%) of *'very important'* responses was:

'***How important is it to feel heard and understood?***'

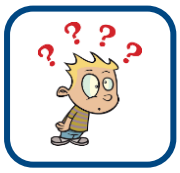
Although the research asked about Crisis Alternative provision, it was clear from individual responses that many people do not recognise or separate different types of provision. They may have been answering the questions about an NHS crisis team rather than a VCSE crisis alternative. Numerous local studies[2021] indicate that the voluntary sector fares better at this than its clinical counterparts, but the **need for staff in all sectors to improve their empathy and understanding by being trained in supporting neurodivergent clients is evident**.

Recommendation: All staff in any mental health services receive training on being **person-centred and trauma informed** as well as an appropriate level of training on neurodivergence.

[20] Leeds Health and Care Partnership. Insight Report: mental health crisis services, September 2024

[21] Common Room. Mental health crisis: Hearing from young people about their experiences. July 2017

2. The Definition and Language of Crisis



Despite diverse views of what a 'crisis' is and how it is defined, there was a general agreement that this varies for each individual. A helpful definition was summed up in a keyworker focus group as:

> *"Crisis occurs when resilience levels / coping strategies are outweighed by the demands / stressors of life and affect the young person's ability to function"*

This may include suicidality, psychosis or emotional overwhelm, but however it presents it is not the individual's norm and affects their ability to function. However, services do define the level of 'crisis' that they will deal with. Some services are 'low risk' and encourage people to drop in so that they don't reach the point of becoming suicidal. If they have a plan for suicide, they will be directed elsewhere. Other services triage and only accept medium to high-risk individuals. However, all use the same word 'crisis' and are described as 'crisis alternatives'. This can be extremely confusing to people who are then very unclear whether they are suited to a service. The language of mental health and particularly of crisis also creates a barrier to many communities.

> *"The word crisis is very scary for people. They would worry about who is going to get involved, what it might mean and whether they will be labelled."*

Recommendation: For services / commissioners to consider the language they use to describe services and to be sure they are clear about what **level of presentation** they are there to support.

3. Timely and Accessible Support

a) Many of the barriers that people told us they face are about access to support in a timely manner. Whilst crisis alternative services generally focus on providing 'out of hours' support, the ideal service provision was clearly one that could be accessed **24 hours a day 7 days a week**. This was particularly the case for children and young people who felt that they needed prior experience of the service they would attend in crisis, so that specific service would need to be available whenever the crisis occurred. Parents and carers felt that they needed access to a professional during the crisis, not 24 hours later, which was generally their experience. People also told us that **if they had timely access to regular mental health services when their crisis was building, they would need crisis services less.**

To be accessible services need to be **located close to public transport links** and in the local community. The ideal would be for services to be **co-located** so that travelling around to multiple appointments was not necessary. Fewer venues to become familiar with reduces anxiety as well as transport costs and time. Neurodivergent individuals talked a lot about the energy that social interactions use and having to attend three different locations in one day may not actually be viable for them, even if physically possible.

Recommendation: When commissioning services, consider the location of the service and the benefits of multiple agencies being co-located, as well as opening times.

b) To be truly accessible people told us that services needed to be **contactable via multiple methods of communication**, a fact backed up by previous studies[22], including the option to drop-in and see someone face-to-face. As a minimum this would include contact via text or email as well as by telephone, but ideally through as many routes as possible. Support should also be offered as flexibly as possible so that individuals who cannot attend a venue or use the telephone can still access support online or virtually. Many neurodivergent people told us they find using the telephone particularly difficult.

Recommendation: To ensure all services have multiple ways for individuals to make contact or be referred. Telephone contact should NOT be the only form of initial communication or the only way that support is offered.

c) Finally, services need to be **well advertised** clearly stating **who they are for** and **what support they offer.** These adverts need to be inclusive and in targeted community languages. They need to be in multiple places, both virtually and physically. For the younger generation, QR codes on lampposts and the use of social media are key, as well as schools and colleges. For older people flyers and posters in frequented areas are also important. The back of toilet doors are ideal places for people to privately gain information. Some neurodivergent people told us that they had been excluded from mental health services due to their diagnosis. They would not therefore consider attending mental health provision unless it specifically stated it was for them. As well as public advertisements, networking with other professionals and community leaders is also key to making services accessible. Recommendations by word of mouth are often more trusted than those from an advert.

Recommendation: To ensure all bids include a budget for publicity, including translation costs if necessary and that services are promoted within current systems and networks as well as in public spaces (Physical and Virtual).

4. Intersectionality and Crisis Alternative Services

Through focus groups and interviews, the impact of poor mental health, intersecting with other factors that may impact people's experience of life or life chances, was highlighted. Individuals who identified numerous barriers to accessing support for their mental health included people who were refugees, care leavers, members of the LGBTQ+ community or of ethnically and culturally diverse communities. A representative of the Gypsy and Traveller community explained that people have so many stressors and issues in their lives that they don't have the time to prioritise their mental health, and if they did, they would not know who they could turn to or trust. This was a theme that was echoed by all the marginalised communities engaged in the research. Prejudice and oppression were extra hurdles that people from these groups had to deal with, adding to their challenges. The points worth reiterating here are:

- The predominant Eurocentric language and concept of mental health immediately alienate some communities. Alienation and lack of trust can mean that crisis services are not accessed until too late. This can result in people's first contact being via the criminal justice system or use of the Mental Health Act.

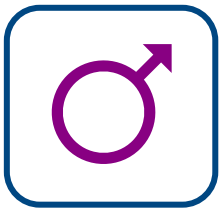
[22] Doherty, Alison Jayne, et al. "Barriers and facilitators to primary health care for people with intellectual disabilities and/or autism: an integrative review." *BJGP open* 4.3 (2020).

- Publicity is not available in the ways people are asking for it - in the right places and the right languages. The result is a lack of awareness of available services.
- The stigma associated with mental health issues can prevent people from accessing mainstream services due to where they are and how they are accessed.
- Poor experiences of services, often due to a lack of cultural understanding, perpetuates the lack of trust.

Recommendations:

I. Invest in mental health and neurodiversity awareness raising within diverse communities
II. Fund more minority groups directly and trust them to know how to approach the mental health of their communities.
III. Invest in 'outreach' to those who, due to multiple and complex needs, may not be able to access crisis services. For example, care leavers or asylum seekers.
IV. Ensure that translation of materials and funding of interpreters are included in proposals
V. Provide crisis staff with cultural awareness training specific to cultures present in local areas ensuring that services are culturally competent.

5. Men's Mental Health



Young men told us that it was very hard for them to reach out for help due to stereotypes such as 'men need to be strong' and 'having mental health issues is seen as weak'. Men are more likely to die by suicide than women and the North East region has a higher-than-average suicide rate (22.2 per 100,000 compared with a national average of 15.8 per 100,000[23]). The facts that so few men were engaged in the research, and feedback from focus groups was that men found it hard to ask for help, raise the need for further discussion.

The Suicide Prevention in England Strategy (2023)[24] highlights the need to target interventions at priority groups, including children and young people, middle-aged men and autistic people, amongst others. Studies conducted by Harmless[25][26] indicated that men often didn't know where to turn for support with 80% of men welcoming more in-person outreach in male dominated spaces. Other barriers identified included services being difficult to access, the stigma associated with asking for help and a lack of understanding of professionals. Signposting rather than referring was also seen as a barrier as this involved men having to ask for help twice. Additionally, research by the Samaritans[27] on suicide in middle aged men from less well-off backgrounds, concluded that men rarely encounter services before reaching crisis point. However, they would prefer to engage with services that frame their support around human contact or goal orientated activity. A quote from a male expert by experience in a Harmless case study expresses this clearly:

"The thought of going to a healthcare setting to sit in a room with one other person and talk about emotions is pretty horrific."

[23] Office for National Statistics, "Suicides in England and Wales", September 2022: https://bit.ly/3Sl0ZcL

[24] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK

[25] A-consultation-aimed-at-understanding-the-needs-of-males-in-suicide-crisis-A-Case-Study-Part-1.pdf

[26] A-Case-Study-on-Community-Interventions-Collaborative-Efforts-to-Target-Men-for-Suicide-Prevention.pdf

[27] *Samaritans_-_out_of_sight_out_of_mind_2020.pdf*

Most of the crisis alternative services included in this research are framed as offering help and support which the Samaritan's report concluded was limited in two ways:

> *"Firstly, this was perceived as implying that there was something 'wrong' with the men that needed to be 'fixed'. Secondly, the men spoke of the stigma they felt around asking for support, which meant that men found it much harder to engage with help-seeking services." (Samaritans Out of Sight, Out of Mind, 2020)*

The mental health field is dominated by women in most spaces. One male Expert by Experience, involved with this research, talked about feeling marginalised as a man in the EbE community. He was often the only male voice and felt that he was not listened to in the same way as women.

The suicide prevention strategy[2] recognises the need to fund VCSE services engaging men, and research is currently taking place within our region to look at the role of non-mental health specific interventions on young men's mental health[28]. Services commissioned to provide crisis alternative provision may benefit from looking at alternative methods of outreach and delivery to men.

Recommendations

I. That further research is undertaken specifically with men from a wide demographic to establish the type of crisis support that works for them
II. To consider commissioning different models of crisis support other than those based around talking

6. Managing Risk

As part of the research, staff were asked if they felt there were specific risks when supporting neurodivergent individuals. Good practice in risk management involves a strength's based, positive approach carried out in collaboration with the service However, analysis of risk factors raised, supported the fact that a lack of knowledge or training around autism in a neurotypical world could exacerbate these. Staff felt that budgets were being cut to the voluntary sector, whilst at the same time, they were being asked to hold a higher level of risk. It was some staff's experience that training and supervision would be cut back to maintain frontline services. This was felt to have a negative impact on the management of risk.

It is recognised that an understanding of neurodivergence, particularly processing, communication and sensory differences will contribute directly to lowering risk for neurodivergent individuals. In order to provide an equitable service where risk (particularly risk of suicide) is managed well for all users, training in the above areas is essential.

Recommendations:

I. That neurodiversity training, as recommended in this report is seen as an integral part of risk management in crisis alternative services.
II. That mandatory risk management training is completed by all staff every 3 years

[28] *Research spotlight: Young men, mental health and community services - NIHR School for Public Health Research*

Section B – Themes for Children and Young People's Provision

7. Lack of Services for Children and Young People (CYP)

Whilst responses were received from a high percentage of staff working with children and young people, the majority of these were not from crisis alternative provision. Across the whole region, at the time of the research, 33 adult services were identified, but only 9 that worked with children and young people under 16, with 7 of these in West Yorkshire (a further service was planned in NENC). Four services only accepted referrals from restricted professionals, leaving only five open access provisions as follows:

- Safe Zone in Leeds, offering two evenings a week, face-to-face
- Night Owls, a phone-based service covering West Yorkshire and now commissioned to deliver the 111 service.
- Teen Connect – a Leeds phone-based service from 3.30-8.30pm every day
- Safe Spaces Bradford which works from ages 7-adult.
- The fifth is open to any young person who attends hospital in Calderdale & Huddersfield.

However, when asked what type of provision young people would like to access, they described an **informal, crisis alternative service which they could access before, during and after crisis**. Research by the BMC in 2024[29] identified the core characteristics of high-quality services as rapid access, learning self-care skills, individualised support, clear information, compassionate and competent staff and aftercare planning. This research was not focussed on supporting neurodivergent young people but still came up with the same core qualities.

Parents and carers of younger children highlighted the lack of services, saying provision for primary school aged children did not exist. 74% of parents and carers said that it was difficult or impossible to access support in a crisis. Parents and carers wanted to stay with their child or young person during a crisis but to be able to access professional support to help them manage it. The other most repeated requests from parents and carers were a face-to-face appointment when they needed it and tools to help them manage a crisis. Most felt that none of this support was available.

Key workers, and those working as specialists with neurodivergent young people, were clear that there was not enough provision for those who fell outside of their remit. They felt that support was needed sooner, in a preventative capacity, as well as identifying a need for step down provision, both of which could be part of a 'wrap around' service. They felt that a lack of respite services also contributed to avoidable crises. Other key learning points from the Key Worker model included the need for services to be person / family centred and flexible and for staff to have an in-depth understanding of neurodivergence and PDA (Pathological Demand Avoidance)

The research with young people also engaged 'early intervention' services that were not commissioned as crisis alternatives. However, these services are also dealing with individuals when they reach crisis and are regarded highly by young people, many of whom will not engage with CAMHS or statutory services.

[29] Service design for children and young people with common mental health problems: literature review, service mapping and collective case study

Recommendations:

I. To recognise the need **for more voluntary sector crisis alternative provision for children and young people.** To use the findings from this report to identify best practice in this.

II. To recognise the importance of **including** youth wellbeing services, that may not be commissioned crisis alternatives, in the training resulting from the research.

III. To ensure statutory services and youth wellbeing services are working together to support young people through crisis.

8. LGBTQ+ Young People and Neurodivergence

Research suggests that autistic individuals report increased homosexuality, bisexuality, and asexuality, and decreased heterosexuality.[30][31]The numbers of young people identifying as neurodivergent and LGBTQ+ in this study[32] backs up this research and emphasises the need for tailored support for this group of vulnerable young people. Those who are neurodivergent and those who identify as LGBTQ+ are subject to higher rates of mental ill health and to discrimination and poorer health care. It is important to ensure that those working in crisis services are aware of these factors and able to provide tailored support.

Recommendation: To include awareness raising and training on the specific needs of those who are neurodivergent and LGBTQ+

9. The Needs of Parents & Carers

It was clear from the research that parents and carers do not feel listened to and in many cases feel burned out and abandoned. They overwhelmingly felt that **a named professional they could contact, and accessible advice** when they began to spot signs of escalation was most important to them, but that advice invariably came too late if at all.

Not only did they recognise the lack of support for CYP, but felt that, when they did get an appointment with a mental health service, they were generally not listened to or taken seriously. Many felt blamed and felt seen as 'part of the problem' as opposed to being part of the support. Research shows that caregivers of autistic children are at a substantially increased risk of poorer mental health and psychological well-being compared to the general population[33]. It is important to be aware that parents themselves may be struggling. As neurodivergence is often genetic, it may be that parents are dealing with more than one neurodivergent child and may be neurodivergent themselves. Appropriately supporting parents will positively affect the CYP. Sometimes this will

[30] George R, Stokes MA. Sexual orientation in autism spectrum disorder. Autism Res. 2018;11:133–41. https://doi.org/10.1002/aur.1892.

[31] Weir E, Allison C, Baron-Cohen S. The sexual health, orientation, and activity of autistic adolescents and adults. Autism Res. 2021;14:2342–54. https://doi.org/10.1002/aur.2604.

[32] 87% of young people who attended two focus groups for LGBTQ+ young people identified as neurodivergent.

[33] Werner, S., & Shulman, C. (2013). Subjective well-being among family caregivers of individuals with developmental disabilities: The role of affiliate stigma and psychosocial moderating variables. *Research in developmental disabilities*, *34*(11), 4103-4114.

involve educating parents about the significance of their actions and help them to understand the child or young person's perspective. At least two significant differences were identified in the report.

- Firstly, parents and carers are more likely to want to stay at home and get advice whilst the CYP would generally prefer to go somewhere else for support. CYP told us they often need their parents to help them recognise they are in crisis, but they also need space to recover fully.
- Secondly, CYP feel that using their correct name and pronoun is very important, whereas parents rated this much less so. As adolescence is a crucial time of identity formation, young people need to feel affirmed in their search. Ignoring their preferred terms can severely impact their mental health.

It is important to recognise that parents and carers are unlikely to be deliberately sabotaging the recovery of the CYP and are likely to be struggling with these issues themselves. Supporting them in a way that understands and educates is a vital part of supporting the CYP.

Recommendation: To fund services which provide support to both CYP and their parents /carers but realise that this may need to be done separately at times.

10. Transition Between Services / Support for 16–24-Year-Olds

A repeated theme from young people and those who work with them was the lack of support for young people in the transition from child to adult services. The need to prepare a young person for the change in support when they reach 18, and for an adequate 'induction' into adult services appears to be discussed infinitely. CAMHS and adult services generally have policies and pathways in place. However, these policies and pathways do not recognise that an **18-year-old is still in need of more support than a fully developed adult**. Despite all the academic knowledge[34][35] on brain development and risk of onset of mental illness in late teens and early twenties, very little support is focussed on this age group. At 18, all services change; education, social care, the justice system and the mental health system to name a few. Young people with complex needs may lose several trusted adults in one go and have no parent or carer by their side**. Neurodivergent young people particularly emphasised not feeling ready to access adult support and in being completely abandoned when they reached 18**. Amongst parents and carers completing the questionnaire, 39% were supporting someone between the ages of 18 and 24, reiterating the need for extra support for this group. Recent research into disabled young people and transitions in North East England and Scotland[36] echoed the need for extra support when young people are estranged from their families.

The one crisis alternative service in the area targeted at 16–25-year-olds (Better You in Doncaster) is mostly accessed by neurodivergent young people and is described below as an example of good practice.

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[34] Arain M, Haque M, Johal L, Mathur P, Nel W, Rais A, Sandhu R, Sharma S. Maturation of the adolescent brain. Neuropsychiatry Dis Treat. 2013;9:449-61. doi: 10.2147/NDT.S39776. Epub 2013 Apr 3. PMID: 23579318; PMCID: PMC3621648.

[35] Giedd, J. N., Blumenthal, J., Jeffries, N. O., Castellanos, F. X., Liu, H., Zijdenbos, A., ... & Rapoport, J. L. (1999). Brain development during childhood and adolescence: a longitudinal MRI study. *Nature neuroscience*, *2*(10), 861-863.

[36] Disability and Youth Transitions | Explore Youth Transitions

A recent piece of research by Will Mason[37] at the University of Sheffield explored the contributions of the voluntary sector to the mental health of young men in marginalised communities. They talked with young men using a gym in Sheffield and a boxing club in Newcastle. Around 65% of the young men using the service in a multi-racial community in Sheffield were in their late teens of early twenties and felt they had nowhere else to go for support.

Recommendations:

I. To fund services which actively support young people between the ages of 16 and 25 at risk of experiencing crisis to prevent them from reaching that point.

II. To provide crisis alternative services aimed specifically at 16–25-year-olds, such as Better You. (See case study on page A67.)

GOOD PRACTICE EXAMPLES

There were many examples of good practice amongst the projects contributing to this research. The examples below have been chosen for their success in successfully supporting neurodivergent people. They have been divided into two sections.

Section 1 will refer to services that have some particular element that is unusual and meeting an otherwise unmet need. They will have a brief description and a link to their website.

The examples in **section 2** are more in depth and showcase the way that services have worked together with partners, or with complimentary internal provision to deliver a holistic and neurodivergent friendly service.

Section 1

a. Provision for ethnically and culturally diverse communities

- **Dial House @ Touchstone**[38]**.**

Based in Leeds, this service delivered by Leeds Survivor Led Crisis Services, delivers a Crisis Alternative service specifically for people from Black and Minority Ethnic backgrounds. Service users say they value it very much as they can see there are other 'people like me' struggling.

"Dial House @ Touchstone has been a lifeline for me, I have been coming here for 10 years. The staff here are amazing"

- **Roshni Ghar**[39]

Based in Bradford, Roshni Ghar is a mental health and wellbeing charity that provides culturally appropriate and responsive services, aimed predominantly at South Asian community. It provides acute crisis services and is rated very highly by its users.

- **Afrikindness**[40]

A children's charity, based in Leeds, Afrikindness aims to connect children to their community and inspire them to be kind. It runs a community awareness and training campaign to bridge the

[37] *Research spotlight: Young men, mental health and community services - NIHR School for Public Health Research*

[38] Leeds Survivor-Led Crisis Service » Dial House @Touchstone

[39] Professional Referral - Roshni Ghar

[40] https://afrikindness.org/our-services/parent-neurodiversity-training/#

gap in autism awareness and improve response to diagnosis and support within the Black and minority communities. They recently ran a groundbreaking conference on this subject, striving to break down barriers within and between communities.

- **Leeds GATE**[41]

Leeds GATE offers support to Gypsy and Traveller Communities in Leeds and across West Yorkshire. They recognise the stigma around mental health and the mistrust of statutory services by their communities. They offer services where people are, rather than expecting them to access provision where they may feel unwelcome or uncomfortable.

b. Provision for Young People

- **Chilypep - Home**[42]

This service, based in Barnsley is part of the wider Chilypep charity. It provides tailored support to young people struggling with their mental health and will support them through crisis. Although it does not receive any financial support as a provider of crisis services, it is where young people turn. The project contributed to our focus groups where the young people emphasised the importance of its work.

- **Safe Zone**[43] **by Leeds Survivor Led Crisis Service**

Safe Zone is a free, on-the-night face-to-face mental health crisis support service for **11–17-year-olds** and their **parents/carers.** It is well used and one of the very few services providing face to face crisis support in a non-clinical environment. This is just what young people are asking for. Further details of this service which could be replicated across the country can be found in Appendix 12

- **Safe Space – Sheffield**

Safe Space was a commissioned crisis service for 16–17-year-olds in Sheffield, taking referrals from a range of agencies, for up to 72 hours to de-escalate young people in crisis. It had positive outcomes and was highly regarded by professionals' young people and parents who had used it. It was not recommissioned due to funding issues but provided an excellent model for such a service if it could be on a larger scale / for a larger age range. An evaluation can be found here.

c. Provision for Men

- **Andys man Club**[44]

This well-known peer-led service delivers support to men-by-men across much of the country and is well represented in our region. Men say the hardest step is getting across the threshold and breaking down the stigma of men and mental health is both required for and a part of this service.

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[41] Mental Health | Leeds GATE

[42] HOME - Barnsley - Chilypep

[43] Leeds Survivor-Led Crisis Service » Safe Zone

[44] ANDYSMANCLUB - It's Okay To Talk

d. Provision for the Deaf Community

- **Deaf Connect[45] by Leeds Survivor Led Crisis Service**

Deaf connect provides a much-needed service to an underserved community. It is the only service found in the region supporting deaf people in mental health crisis. This is an area that requires further research, along with support for visually impaired and other disabled people.

Section 2

Neurodivergent people asked for services that understood their processing and communication needs. These tended to be strongest in services who either gave longer term support to individuals referred to them in crisis, or where partnership working enabled individuals to gain continued and holistic support. These services will be described below with in depth case studies provided in Appendix 12.

Case Study 1

Service Name: People Focussed Group (PFG)

Provides for: Crisis Alternative and ongoing support

Place: Doncaster- based in Intake (near the city Centre)

Partnerships with: NHS (RDaSH), South Yorkshire Police and Yorkshire Ambulance Services

Website: peoplefocused.org.uk

Summary

PFG is a Peer Support Charity running three main services, **the Wellness Centre**, **Safe Space Crisis Alternative Service** and **Better You**, a service working with young people referred during a crisis, most of whom are neurodivergent. The Wellness Centre is the heart of the community and everyone attending is encouraged to give back as part of the receiving and healing process. The three services complement each other, working together to give people the opportunity not just to come through crisis but to build on their recovery and contribute to the recovery of others.

Case Study 2

Service Name: Everyturn – **Together in a Crisis (TiaC)**

Provides for: Crisis Alternative

Place: Several places across the North East.

Partnerships with: Everyturn has internal crisis hub services and external partnerships.

Website: Everyturn Mental Health

Summary

This service launched as a pilot in Newcastle in 2017 after NHS crisis teams observed that many individuals presenting in crisis had non-clinical needs contributing to their deteriorating mental health. The TiaC model addresses this recurring “revolving door” pattern by offering 12 sessions of support, once a week, to address practical issues such as housing, finance, relationship breakdown, drug and alcohol problems or social isolation. This service now runs alongside newly launched Safe

[45] Leeds Survivor-Led Crisis Service » Deaf Connect

Havens in 3 locations and on its own in a further 3. The service uses the nationally recognised 14-point WEMWBS[46]score with **89.2%** of service users showing an **improvement** in their score at the end of the 12 weeks.

Case Study 3

Partnerships between the following Services in Hull:

- Hull and East Yorkshire (HEY) Mind[47]
- Welcome House (Asylum Seeker Support)[48]
- The Peel Project (Support for people from ethnically and culturally diverse communities)[49]
- Matthews Hub (Support for neurodivergent adults)[50]
- The Warren Youth Project[51]

The striking thing on visiting HEY Mind was how well connected they were to other organisations in the local community and how these organisations worked together to improve the outcomes of a wide range of individuals in mental health crisis.

Below are some examples of work that is happening between these organisations.

- HEY Mind have a stall and representative at Welcome House every week
- HEY Mind work closely with the Peel Project for referrals, and in providing outreach to enable a better understanding of mental health and to break down barriers.
- HEY Mind and Matthews Hub have a close working partnership referring clients to each other
- Referrals occur regularly between The Warren Youth Project, Matthews Hub and HEY Mind and the organisations know each other well.
- The Warren Youth Project offers counselling for young people and HEY Mind refers young people there.
- Matthews Hub has begun outreach with the Peel Project and Welcome House to raise awareness of neurodivergence.
- Both the Peel Project and Welcome House are very aware of the need for mental health support for their members and are proactive in awareness raising.

Appendix 12 has the following more detailed case studies:

3a) The work of Welcome House supported by HEY Mind

3b) A young person supported across The Warren Youth Project and Matthews Hub.

[46] The Warwick and Edinburgh Mental Wellbeing Score: WEMWBS

[47] Hull and East Yorkshire Mind - We are Hull & East Yorkshire Mind, the mental health charity

[48] Home - Welcome House

[49] Homepage - The Peel Project

[50] Matthew's Hub | Autism & ADHD Support in Hull & East Yorkshire

[51] The Warren Youth Project | A place for young people

LIMITATIONS OF RESEARCH

As with any piece of research there will be factors that limit the accuracy and scope of the findings and limitations which need to be considered. These are listed below:

1. **Men and people from ethnically and culturally diverse communities were underrepresented** in the questionnaires. Men made up only 18% of respondents. Although statistically the percentage of respondents from ethnically and culturally diverse groups matches the make-up of the region, the small numbers of respondents do not enable a real understanding of the needs of these communities. To address this to some degree, focus groups and interviews were targeted at people from diverse communities.

   To mitigate against bias and check findings with these groups, the first draft of the report / results was shared with charities working with neurodivergent men and an African community group working in mental health. The following responses were received:

   From the CEO of Afrikindness:

   > *"The report clearly captures the realities families face, and the perspectives of parents are particularly well articulated. I was pleased to see that themes around trust — and the lack of trust many communities feel towards services — were acknowledged and reflected in the findings. Also, stigma, digital exclusion, barriers to accessing support and training needs are key factors mentioned as well. These are important factors influencing engagement and help-seeking behaviour, and it is helpful that the report recognises this.*
   >
   > *A major issue we have been trying to address is the misconception around mental health - especially the confusion around what it is... also religious and cultural beliefs are currently barriers. There is a need for awareness in hard-to-reach communities to address these challenges."*

   From the CEO of Leeds Autism Services

   > *"While men were underrepresented in the study, I do not feel that a relatively low proportion of men taking part is likely to skew the outcomes; the experiences of the men we support who have accessed crisis alternative services appear to be reflected in the conclusions of the study overall, and the barriers identified in the report are reflective of those shared with us by the men our organisation supports. It's really positive to see the things we hear from our beneficiaries being reflected in some proper research"*

   Further research on the voices of men, and particularly Black men, should be considered. Two studies[52] [53] were ongoing at the same time as this, one looking at the attitudes of Black men to mental health, and the other researching the role of the voluntary sector in improving the mental health of young men, particularly those from marginalised communities. Feedback from the former suggested reasons why the involvement of men, particularly Black men was lower than that of women.

[52] COLIS 2025 - 12th International Conference on Conceptions of Library and Information Science: Adjunct Proceedings - Doctoral Workshop pp 70-72

[53] Research spotlight: Young men, mental health and community services - NIHR School for Public Health Research

These included:

- men not always wanting to be labelled by a diagnosis. African / Caribbean men would often not identify with being neurodivergent or having mental health issues even if they did.
- men feeling a pressure to be the 'provider' and so being more likely to participate in research where they are compensated for their time.
- as mentioned previously, the Eurocentric language of crisis and mental health would have discouraged many people
- as a white woman conducted the research, this will have made it more difficult to reach these groups. It may have been good to recruit volunteers from other backgrounds to have been involved.
- African and Caribbean people feel that community is a big part of who they are. The best way to engage people is within community groups and working closely with grass roots organisations. This was part of the method, but more time was required to build relationships and trust. The female researcher was given more access to groups of women.
- knowing that statistically more men, particularly Black men, are brought to the attention of mental health services through the criminal justice system, it may have been helpful to engage with services within this system.

Learning from these points will allow future research to be more inclusive.

2. The SPACE Framework and its potential influence on results

The first aim of the research was to *establish specific needs* of neurodivergent people. To create a questionnaire that asked appropriate questions, the researcher worked with experts by experience who identified a particular published theoretical framework. Two points are worth noting:

- This framework was autism based, meaning it was not as appropriate for people with ADHD, and this had to be considered when building the questionnaire. Experts by Experience with ADHD were included in this process and although some made comments about the framework being autism focussed, most found it still enabled them to include issues they faced. Many of these were around processing.
- As the questions were built around the SPACE elements (Sensory, Predictability, Acceptance, Communication and Empathy) it could be felt to have influenced the resulting themes which do broadly overlap with these. Although the thematic analysis was not conducted under these headings, participants made comments under each heading which in turn will influence the themes of these comments.

Basing the research on a framework that is rooted in a theoretical understanding of autism clearly has benefits, but it will be important to ask if this has limited the results in any way. Involving neurodivergent experts by experience in reviewing the results would be one way of mitigating against this to some extent. The areas for training presented to staff in the questionnaire were also based around the same framework. However, there was space for staff to come up with areas they felt were important in addition to this and topics such as PDA and ARFID were raised separately. It is therefore less likely that these have been limited by the SPACE framework

3. **A lack of budget for involving Experts by Experience**, meant that work could only be done with pre-formed groups who were externally funded. This, along with a large region and time limitations meant that involvement was from only one ICB area. A special thanks must go to Sheffield ICB, Rethink Mental Health and Chilypep in Sheffield for working in partnership with Touchstone on this.
4. **Questionnaires were only available in English** as research into costs of translation found it unachievable. Although access to translators were offered, this is not as complete an offer and there was not time to build relationships and trust for this to take place.
5. **Not all areas of the region were equally represented**. There was a lack of focus group involvement in North Cumbria and North Lincolnshire despite attempts at this.
6. **There were no responses from anyone over the age of 65**. This is not surprising as the rise in awareness and diagnosis of autism and ADHD is a newer phenomenon with very few people over 65 identifying as neurodivergent. However, it is a limitation of the study.
7. As explained in the results, **not all responses were about VCSE crisis alternatives**, leading to an inaccurate picture of people's experiences of these. However, this does not negate the outcome in terms of training required, backed up by focus group discussions with groups of crisis alternative staff. It does show that the **learning is relevant across more than just the VCSE sector.**

SUMMARY AND CONCLUSION

The research project clearly identified the need for crisis alternative services to engage their staff in workforce development programmes which include training, familiarisation with appropriate resources and understanding the needs of the communities they are there to serve, particularly marginalised groups.

The main recommendations of this report are divided into two sections.

1. Those directly related to the workforce development needs to meet the needs of neurodivergent people in crisis
2. Those which are broader reaching, but vital to ensure that everyone can access crisis support, particularly those from more marginalised or vulnerable groups.

Section 1 – Workforce Development Needs

To meet the needs of neurodivergent people in crisis, staff working in crisis services should:

a. Attend advanced level training which covers the learning outcomes covered in section b of workforce development needs
b. Have access to tried and tested resources and be familiar with / trained to use them. The resource pack accompanying this report contains many of these.
c. Involve neurodivergent people in quality checking the service, including the environment and processes / procedures.
d. Be trained in person centred care and trauma informed practice which should be embedded in the whole organisation

e. Engage in reflective practice with supervisors also trained in and experienced in working with neurodivergent people.
f. Be culturally competent, understanding the needs of the ethnically and culturally diverse groups in their community.
g. Attend training or awareness raising on the unique needs of the neurodivergent LGBTQ+ community.

Section 2 – Wider Reaching Research Implications

i. Supporting Neurodivergent Young People in Crisis

Whilst the scope of the project included all ages, and a significant number of young people were involved in the research; there was not enough time to develop bespoke training and resources for children and young people with their unique needs in mind. This is a piece of work which needs to be developed.

The research did, however, highlight several issues around supporting children and young people and make recommendations for addressing these. These include:

a. **The lack of commissioned crisis alternative** services specifically for children and young people. When asked, this is the type of provision young people wanted to attend, but it was generally not available. Commissioners must look at successful models such as Safe Zone in Leeds and Safe Space (formerly in Sheffield) and commission more of these services in the voluntary sector.
b. Neurodivergent young people find it hard to recognise when they are approaching crisis and are unlikely to go somewhere new when they are experiencing it. **They want services they can attend before, during and after crisis** who will 'hand hold' and support them offering safety and familiarity. Many voluntary sector organisations already play this role but are not recognised for this or equipped to deal with young people in crisis. This is further area for development.
c. Many crisis alternative services offer support to those aged 16+, but few young people under the age of 20 access them. Staff have not necessarily been trained to work with young people as they are only a fraction of their users, and they are seen and treated as 'mini adults'. It is widely recognised that neurodivergent young people are emotionally less developed than their neurotypical peers and parents / carers note the need for their continued support well into their child's adulthood. **The need for bespoke services supporting young people aged 16-24,** particularly those without parent / carer support was repeated regularly in the research. Better You, a project for 16–24-year-olds in Doncaster is an excellent example of this.

ii. The Need TO LISTEN and to provide Timely and Accessible Support

Neurodivergent people expressed not feeling listened to much of the time. This message was even stronger from young people and their parents and carers. They often felt misunderstood, patronised,

dismissed and excluded from decisions. This is backed up in studies[54][55] where the views of those using mental health services are sought. In a report on service user feedback by Common Room (Leeds) participants report:

"*There isn't enough listening going on - we've been saying things for ages and nothing changes*"

This was echoed time and time again in the research. The importance of feeling heard and understood stood out in the questionnaire responses. This research has listened to the voices of neurodivergent people and staff who work with them, and the results need to be listened to and acted upon. Nothing will change if staff are not trained to understand neurodivergence and implement their learning within their setting. To make provision accessible people said:

a. For all neurodivergent people, **having a range of ways to access a service** is vital, particularly as many services are telephone dependent which can be very difficult for this group. Crisis services opening 24/7 and being co-located with other provision was generally favoured. A reliance on technology to access services can also exclude members of particular groups such as care leavers or asylum seekers.
b. **Language, transport costs, stigma, lack of cultural awareness, lack of appropriate publicity and Eurocentric language** around mental health were all cited as **barriers** to accessing support. Commissioners should provide funding for these barriers to be tackled and make it a condition of the funding.

Telephones are not the preferred method of communication for most neurodivergent people and are inaccessible for many

iii. The Need to Cater for Diversity and understand Intersectionality

Through focus groups and interviews, the impact of poor mental health, intersecting with other factors that may impact people's experience of life or life chances, was highlighted. Individuals who identified numerous barriers to accessing support for their mental health included people who were refugees, care leavers, members of the LGBTQ+ community or of ethnically and culturally diverse communities. Most services agreed that these groups were underrepresented in their provision.

a. Supporting awareness raising of mental health and neurodivergence amongst ethnically and culturally diverse communities needs to be a priority.
b. Commissioning more culturally and ethnically diverse organisations to deliver crisis alternatives will help with issues of trust and fear.
c. All provision should be culturally competent, gender affirming and reaching out to those on the margins.
d. Staff should be trained in understanding the particular needs of those who are LGBTQ+ and neurodivergent

[54] Consultation report on the experiences of Children and Young People who were admitted to Acute Paediatric wards due to mental health issues. Humber & N. Yorks Health & care Partnership

[55] Service User Feedback from Emerge Users – Leeds by Common Room

Inclusive Crisis Alternatives

Appendices

APPENDIX 1 – GLOSSARY

NHSE	National Health Service England. The body that leads the NHS in England.
VCSE	The Voluntary, Community and Social Enterprise sector
ICB	Integrated Care Board – body that plans and funds NHS services in a geographical area.
Neurodiversity	refers to the natural diversity in human brains
Neurodivergent	is the term for when someone's brain processes, learns, and/or behaves differently from what is considered "typical". Some neurodivergent conditions include autism, ADHD, dyslexia, dyspraxia (also called developmental coordination disorder, or DCD) and dyscalculia
ADHD	Attention Deficit and Hyperactivity Disorder
CYP	Children and Young People
GP	General Practitioner in a National Health Service Practice
A & E	Accident and Emergency Department of an NHS hospital
Learning Difficulty	a type of special educational need which affect areas of learning (includes dyslexia and dyscalculia)
Learning Disability	a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.
Mental Health Crisis	when a person's coping strategies are outweighed by their stressors, affecting their ability to function - can include significant emotional distress, suicide attempts and/or self-harm, acute change in mental state.
Crisis Services:	defined by the ability to respond urgently to those in a mental health crisis.
Crisis Workforce:	those working in a setting which provides care or support to those experiencing mental health crisis & their families.
Crisis Alternatives:	alternative to an emergency department, health-based place of safety or inpatient admission, usually defined as safe space, sanctuaries, crisis house or crisis café
North East and Yorkshire (NEY):	The NHSE region covering North, South and West Yorkshire, Humberside, North East England and North Cumbria.
Expert by Experience (EbE)	Someone who has lived experience of being neurodivergent and using mental health or social care services and / or caring for someone who is neurodivergent and uses those services.
CAMHS	Child and Adolescent Mental Health Services provided by the NHS
CMHT	Community Mental Health Team providing NHS services in the community
LDA	Learning disability and autism services, usually provided by the NHS
LGBTQ+	An acronym commonly used to describe people who are lesbian, gay, bi, trans, queer, questioning and ace.

APPENDIX 2 – RESEARCH METHOD

Design

This research employs a convergent mixed methods approach to identify the specific needs of neurodivergent people in crisis and the training required for staff to be able to meet these needs.

It combines surveys of mental health crisis staff and neurodivergent people and carers, with focus groups and interviews with a range of stakeholders from diverse backgrounds. This multi-faceted approach aims to include the voices of often marginalised groups to gain a comprehensive understanding of the issues facing a wide range of potential service users.

Both qualitative and quantitative data was collected simultaneously and compared to produce integrated insights. It consists of:

- the views of neurodivergent people and their parents/carers from a wide range of backgrounds on their needs when in crisis.
- the views of the crisis workforce on what they need to deliver excellent services to neurodivergent people
- case studies of existing services to look at how they are currently meeting the needs of neurodivergent people from different backgrounds and how they could improve.
- the views of minority groups of people who may need to use mental health crisis services
- data from other reports / findings on mental health support for neurodivergent people

Co-production

The questionnaires were co-produced with neurodivergent experts by experience (adults[56] and young people[57]) and staff[58] working in crisis alternative provision.

There were four separate questionnaires which can be found by clicking on each individually.

- Adult Questionnaire
- Child and Young Person Questionnaire
- Parent and Carer Questionnaire
- Staff Questionnaire

Data Collection Methods

The research used the following mixed methods of data collection:

- Quantitative and qualitative data collected using questionnaires open to staff, neurodivergent people and their carers
- Focus groups conducted with communities who are not accessing current provision
- Interviews with individuals who work with neurodivergent people or those from diverse / marginalised groups
- Case studies of different crisis services to identify good practice
- Reviewing local, regional and national reports and research

[56] Experts by Experience recruited by Rethink Sheffield

[57] Members of the Chilypep STAMP group, Sheffield

[58] Staff from Touchstone's Here for You Service, Leeds and Kirklees

Appendix 2 – Research Method

Timescale

Data was collected through the months of April, May and June 2025.

Identification of Participants

The research used voluntary response sampling. Participants were invited to take part in the study if they met the following criteria:

They lived or worked in the North East and Yorkshire Region of NHS England **and** fulfilled one or more of the criteria below:

- They were neurodivergent or had a learning difficulty and used or may need to use mental health crisis services
- They were a parent or carer of a neurodivergent person who may need to use mental health crisis services
- They worked as a member of staff in a Crisis Alternative setting

Questionnaires were distributed in the following ways:

5. A link circulated by email to:
   - all crisis alternative services who had been identified and agreed to take part
   - any identified service working with neurodivergent groups or individuals
   - all contacts in NHSE Learning Disability Autism services or other interested departments
   - any VCSE infrastructure organisations who circulate newsletters and may reach eligible participants
   - any identified services working with minority groups
   - any other contacts who have displayed an interest
6. An advert and link posted on the Touchstone website and social media

Focus Groups and interviews were chosen to:

- Reflect diverse groups of marginalised communities
- Include people of different ages including children and young people
- As far as possible, reflect different geographical areas across the region.
- Include people who are neurodivergent or have learning difficulties

All groups were recruited proactively by the researcher, but some individuals responded to adverts in emails and on social media.

All focus groups and interviews will use a semi structured interview process. This involves asking all groups the same questions, although follow on questions may be used if the initial ones do not promote a response. The Focus Group and Interview Questions can be found in the links below.

- Focus Group Questions
- Interview Questions

Case Studies were chosen to:

- Show different models of crisis alternative provision
- Showcase examples of good practice
- Highlight issues identified in the research
- Include services from at least one Place in each ICB area

APPENDIX 3 – DETAILED PARTICIPANT BREAKDOWN

A total of **410** individuals contributed to the research in the following ways:

d) Questionnaires

272 Completed responses were received from:

- 101 neurodivergent adults over the age of 18
- 67 neurodivergent children and young people up to the age of 25
- 41 parents and carers of children and young people aged up to 25
- 63 crisis alternative staff

e) Focus Groups and interviews with neurodivergent people or those from minoritised communities

59 individual service users or potential service users were involved in focus groups or interviews. These were made up of:

- A focus group of 4 young people from Sheffield who were, or had been, **homeless**
- Two focus groups of young people from the **LGBTQ+ community**, one from Sheffield and one from Barnsley involving 17 young people
- Focus groups involving a further 10 **young people** from a mental health project in Barnsley
- A focus group of 4 **young people from a crisis mental health provision** in Doncaster
- A focus group of 4 **care leavers** from Hull
- A focus group of 4 **Muslim women** from a befriending group in Hull
- A focus group of 3 **service users from a crisis alternative service** in Leeds specifically for members of ethnically and culturally diverse communities, all of whom had experienced being sectioned.
- 2 interviews with individual **refugees** who had experience of **seeking asylum,** one from Sheffield and one from Hull.
- Interviews with 5 individual **users of crisis alternative provision**, 4 from Doncaster and 1 from Newcastle
- An interview with a **partially sighted autistic** young person from Leeds
- Interviews with 2 users from a **VCSE service for neurodivergent people** in Hull. One of whom had used extensive crisis services, another who had spent time as an inpatient.
- An interview with a neurodivergent **user of a youth project** in Hull who was also a young **trans man and a carer.**
- An interview with a **neurodivergent youth representative** who is an international student from Bangladesh
- An interview with an autistic man from Leeds of African and Caribbean descent

f) Interviews with Stakeholders from minoritised communities

Information was also gathered through interviews with 15 stakeholders working with minoritised communities. This was particularly important for groups with language barriers or a mistrust of researchers. Stakeholder Interviews were held with:

- Two deaf staff from **the Deaf Connect Service** in Leeds using a sign language translator
- Two staff, **one blind,** from BID services supporting visually and hearing-impaired service users

- Two staff from Welcome House, Hull, working with **asylum seekers**
- Two staff from Leeds Gate, working with **Gypsy and Traveller communities**
- The CEO of a service working with **South Asian Women**
- A member of the **Race Equality Service** in Bradford
- The CEO of a service working with people who **self-harm**
- Two staff members from a service supporting **Sikh Elders**
- Two staff members from a **young people's mental health project** in Sheffield

g) Focus groups with crisis alternative staff

Focus groups were held with 64 staff working in different contexts across adult and children and young people's services. These focussed on the skills they used (particularly for Keyworkers) as well as their existing training and training they felt was necessary. These were made up of

- Four groups of staff (totalling 20 individuals) working in **crisis alternative services,** one in each ICB area across the region.
- Four teams of **Keyworkers** (totalling 36 individuals) supporting autistic young people and those with a learning disability at risk of hospital admission from across the region
- One staff team (totalling 8 individuals) of a **young people's mental health project** in Barnsley

h) Visits and Case Studies

One Place was selected in each area in which to conduct more focussed research and to identify good practice. The four areas were Doncaster in South Yorkshire, Bradford in West Yorkshire, Hull in Humber and North Yorkshire and Newcastle in NENC. The focus on each area varied as follows:

- Doncaster – the delivery of an excellent community-based crisis alternative and the integration of this with NHS services
- Bradford – the issues with delivering services to ethnically diverse groups
- Hull – the benefits of a range of voluntary sector services working closely together to provide wrap around support
- Newcastle – the delivery of a variety of crisis services by one large voluntary sector organisation.

Each service was visited and many of them provided interviews or focus groups with service users or staff. Some have been written up as examples of good practice.

APPENDIX 4 – AUDIT OF CRISIS ALTERNATIVE SERVICES

NHS England North East and Yorkshire Region

Table of Contents	Page

Introduction

This audit was carried out by Touchstone as part of the Inclusive Crisis Alternatives Research[59], commissioned by NHS England. It aimed to locate all the commissioned crisis alternative services in the region to:

- Build a picture of the services available across the region
- Invite all the services to be involved in the research
- Locate and share good practice

A list of the services in each area can be found at the end of the report.

This document gives a summary of services across the region breaking them down into age range and type of service as of January 2024.

[59] Inclusive Crisis Alternatives - Touchstone

Crisis Provision Summary

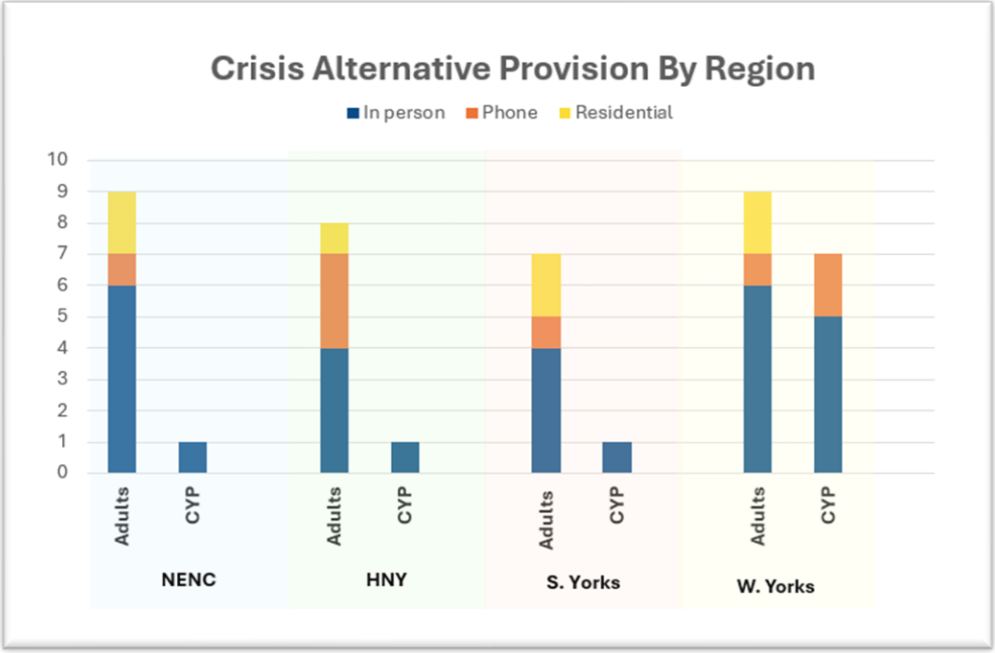


Figure 1

Forty-three services were identified across the region with a reasonable distribution of adult services in each area. However, there were areas that were underserved, particularly more rural areas. The striking feature is the lack of services for children and young people in all areas apart from West Yorkshire.

In fact, when the audit took place, there were only two services where young people could drop in for support without a professional referral and both were in West Yorkshire. The service for young people in NENC was in North Cumbria and had not started when the audit took place.

Ages Served by Crisis Alternative Provision

Splitting services into those for adults and those for children and young people was not straightforward as many services crossed the traditional age boundaries. For this audit we have used the following definitions.

a. Services defined for adults will generally be 16+ or 18+. Although16- and 17-year-olds are classed as young people, staff in these services are not generally trained to work with young people and in most cases only see a very small number of them.

b. Services for Children and Young People (CYP) will be assumed to work with those under the age of 18 unless specifically stated.

c. There is one service that does 7 + and another 13+ through to adults these are classed as all age and included in both the adult and the CYP audit figures.

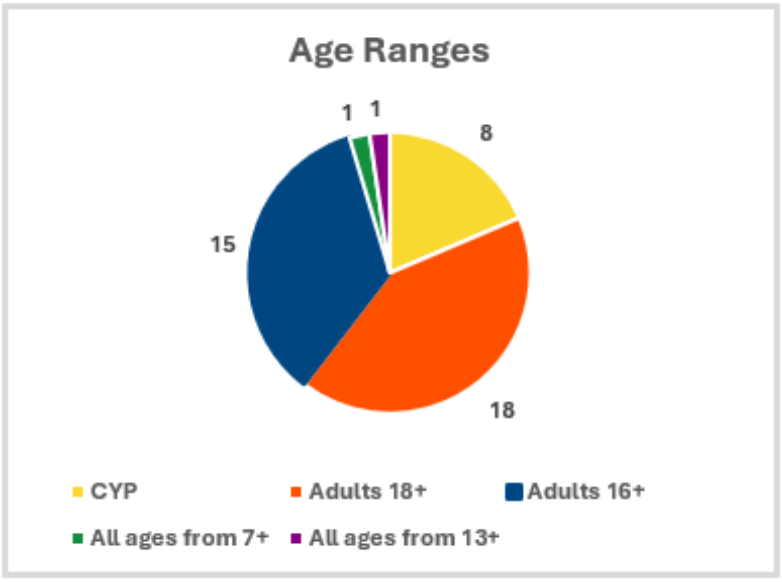


Figure 2

Types of Provision

Services were categorised according to their delivery style. Some physical hubs still did most of their support over the phone and many required people to call in before attending. The pie chart below shows the number of services across the region:

a. Having a physical Hub where people can come to meet either 1:1 or in a social space when they are feeling overwhelmed / in a crisis.

b. Delivering phone support to individuals at a point of crisis

c. Offering a residential stay. These Crisis Houses all had referral pathways involving statutory mental health teams.

d. Supporting people who attend Accident and Emergency departments in a crisis

e. Other services:
   - an overnight service for young people as part of CAMHS crisis pathway
   - a service for young women of South Asian heritage offering crisis counselling sessions

f. Other 1:1 services offering a model of 1:1 crisis support over a longer period

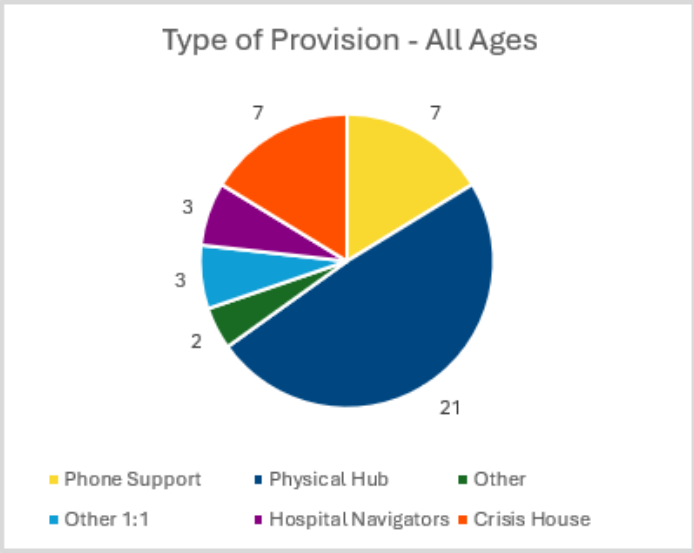


Figure 3

Figure 1 give a visual record of the different types of provision across all ages. This is then split into children and young people's services (Figure 2) and adult services (Figure 3).

There are currently no residential services for CYP.

HEY Mind offers an overnight space, but this is not a bed and is part of the CAMHS pathway.

There was a crisis house for 16- & 17-year-olds in Sheffield, but this closed in 2024, despite successful outcomes.

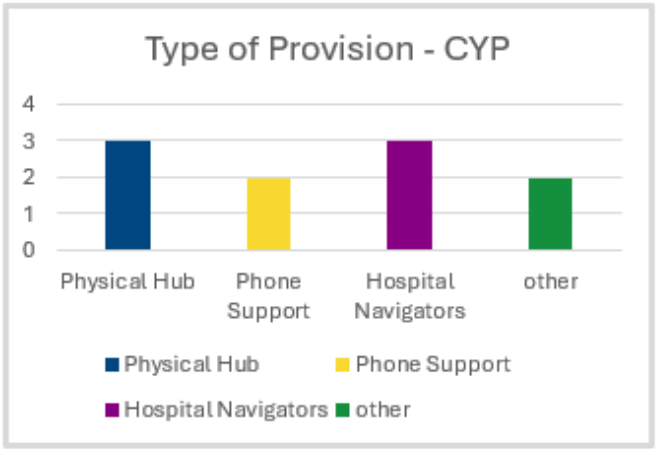


Figure 4

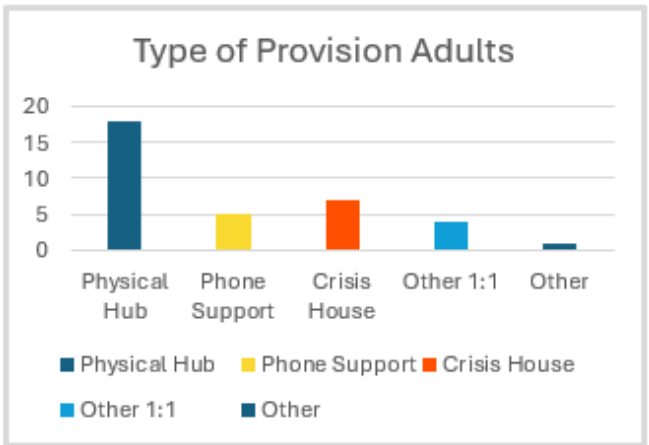


Figure 5

Referral Routes

Most of the crisis alternative provision accepted referrals by anyone, with phone services generally being self-referral. However, there were **4 young people's services and 3 adult services which require professional referral**, usually through the statutory Mental Health Team. In some of these areas (e.g. Hull), there is no open access alternative in-person support.

All Crisis Houses insist on referrals through the local Crisis Mental Health Teams.

Access Routes

a) Children and Young people

There are **no services for young people where a person in crisis can just turn up** without making an appointment. There are two phonelines, both in West Yorkshire where young people can call and 111 has now been rolled out nationally but was not included in this audit.

b) Adults

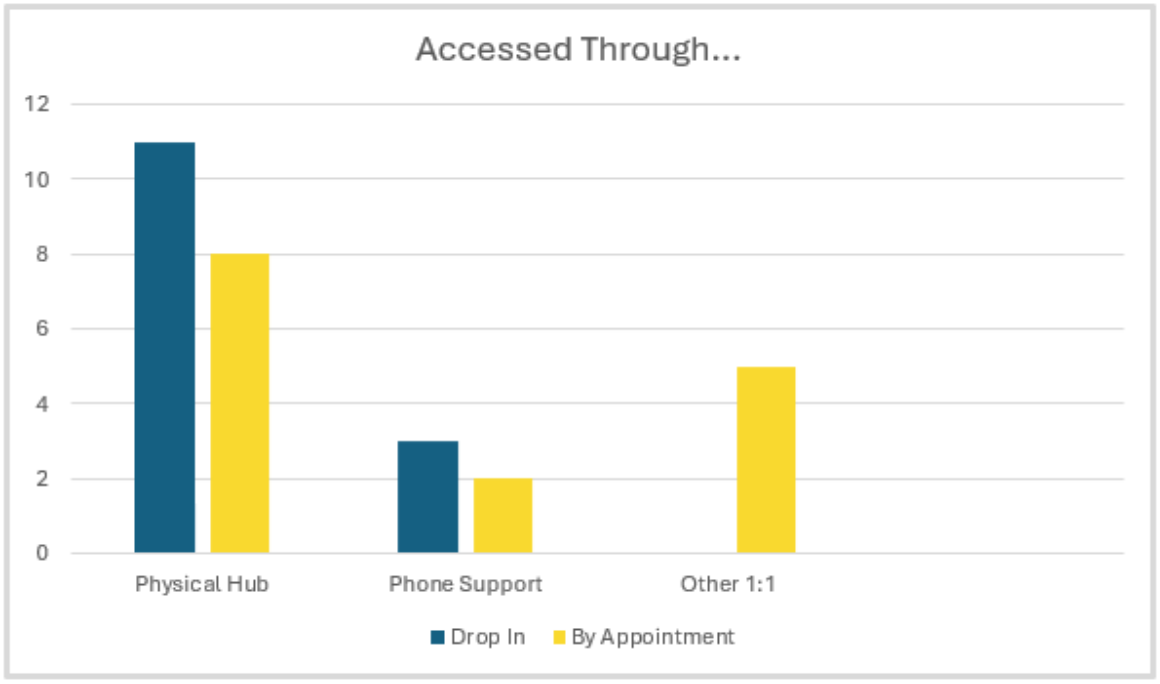


Figure 6

Adults have more access to 'drop in' services, but these are generally regional. The 'Hubs' in South Yorkshire and The North East and North Cumbria generally allow people to drop-in whereas those in West Yorkshire and North Yorkshire require an appointment.

Crisis Support Platforms

This question looked at what different platforms services offered to provide support. Whilst services might primarily offer face-to-face support for example, they may also offer support by text or phone if this is preferred.

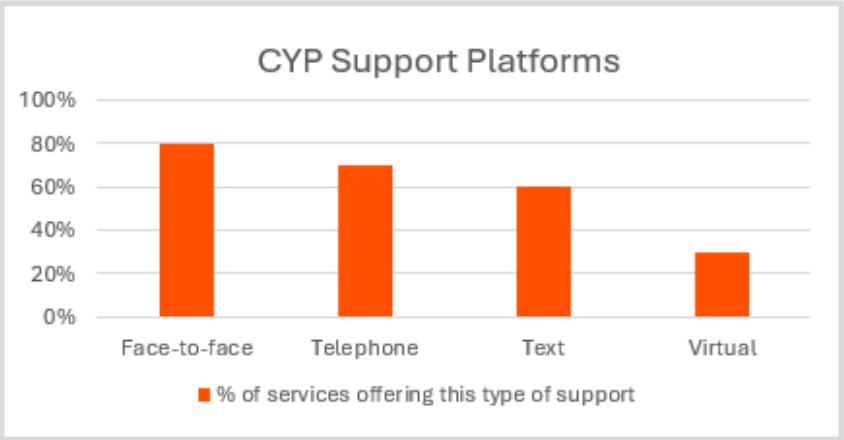


Figure 7

Children's crisis alternative services are more likely to offer text support than adults, perhaps in recognition that CYP often don't want to speak on the phone. However, Figure 7 shows that telephone support is still offered by more services than texting or virtual support.

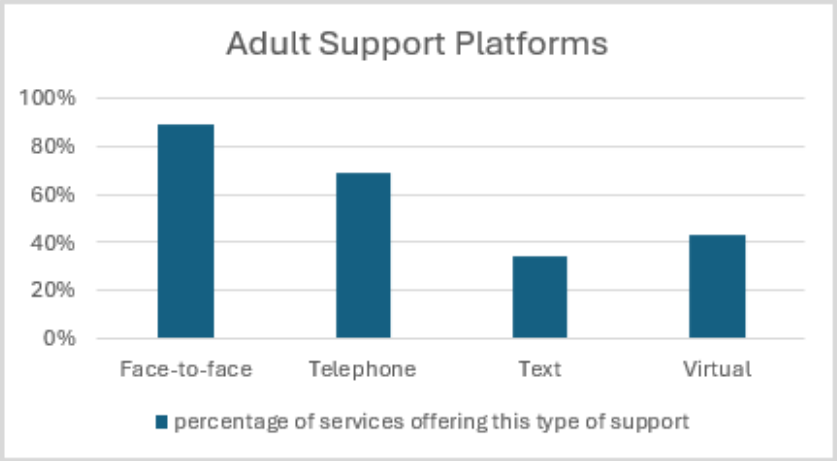


Figure 8

89% of adult crisis alternative services across the region offer face-to-face support. Some of these require an initial telephone discussion and others do most of their support over the phone but will offer face-to-face if the person requiring support pushes for it.

Length and type of support offered

This section looked at how long the support was offered for and what the areas or types of support given. This might be listening, coping strategies, group, social or practical support.

a) Children and Young people

On the night support – This is given by 6 of the 10 provisions, two of which are telephone support. In all these cases, there is no limit to the number of times a person can return, but the support is given at the time of crisis. The Cumbria provision had not started and the other three face-to-face support alternatives in Leeds, Bradford and Hull would try to provide consistency if the young person returned. Safe Zone in Leeds does encourage young people to return if they feel it would benefit them.

Longer term support – Longer term support is given by the three hospital navigator services and the crisis counselling service for young Asian women. The duration differs across services, with a degree of flexibility typically built in. On average, support is provided for approximately 6–12 weeks.

Type of support – The support given to children and young people is generally to listen in crisis and offer coping strategies. Some services also offer support to parents, either intentionally asking,

or in response to a request. One service then integrates young people into social groups. Hospital navigator services generally offer more practical support if required (perhaps engaging with issues such as education or housing).

b) Adults

On the night support – The majority of physical hubs (16/18) and all the phone helplines offer on the night support where people can return as often as they like, but each crisis is seen as separate. The number of 'regular' attenders varies, but most physical hubs have a number of these.

Longer term support – Two hubs offer longer term support. One in West Yorkshire has a day time walk in service which can be longer term and an on the night evening service. The other in Cumbria offers 8 sessions of support.

The projects categorised as 'other' or 'other 1:1' all provide a different model of support which is longer term.

- County Durham had a model called '**Distress Brief Intervention'** (DBI) which is commissioned all over Scotland. It involves up to 14 days intensive phone support.
- Everyturn, delivers a model called Together in a Crisis across 6 Local Authorities. This offers around 12 weeks of 1:1 sessions supporting people with anything practical that is affecting their mental health and contributing to crisis.
- The crisis support for South Asian women provides up to 8 1:1 sessions and then further group support
- In Doncaster there are two services providing longer term support and all agencies work very well together. The first works with High Intensity Users of A&E, giving them unlimited support, but integrating them into the community to reduce their use of A&E. The second Safe Space offers up to 8 sessions of support by phone or in person and offers people longer term support through their integrated Wellbeing Hub. They also run Better You, long term support along youth work lines for 16–25-year-olds who have experienced a mental health crisis.

Crisis Houses - Most crisis houses provide support only for the duration of a person's stay, which typically ranges from three to seven nights, often with a review after the first three nights. One service in the North East allows stays of up to three weeks; however, they have access to mental health nurses and are therefore able to support individuals who require medication reviews. As well as 1:1 and social support, many crisis houses offered practical support to address issues affecting their crisis.

One service routinely contacts people after discharge to check on their wellbeing and offer any further support. Several services reported that they had previously provided outreach but were unable to continue due to funding constraints.

Opening Hours / Availability

a) Children and Young People

The audit clearly showed minimal provision for CYP via crisis alternatives. The limited opening hours show that even this little amount of provision is restricted.

Of the two **phonelines**, one is only open for 4.5 hours a day after school, the other is 24/7 but is now the 111 option for CYP in West Yorkshire.

Of the **two operating hubs**, one is open every day from 3-9pm, it takes young people within its overall service at other times. The second is only able to open twice a week from 4-10pm. Both are in West Yorkshire

The **overnight provision** linked to CAMHS operates from 8pm-8am 7 days a week.

The navigator services and the counselling appointments are not open as such, they are planned around referrals.

b) Adults

Adult **Hubs** are generally open more frequently, with 14/18 services opening 7 days a week. Most of these open at some point in the afternoon and run until between 10pm and midnight. Three hubs only open for 5 days a week due to funding limitations, although one of these, in Leeds, opens specifically for ethnically and culturally diverse groups on the remaining two nights.

Of the 5 **phonelines**, only one is 24/7, run by Hull and East Yorkshire Mind. The others all operate from some point in the afternoon until 11pm or midnight. All are open 365 days a year.

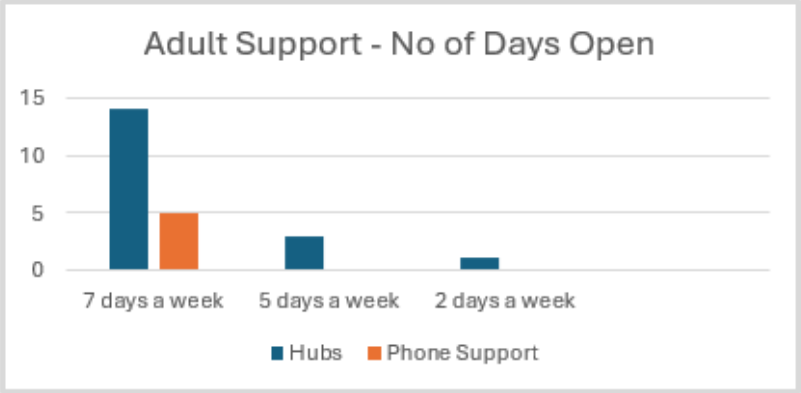


Figure 9

The '**other'** services all operate on an appointment basis, most of which take place during the working day. Safe Space in Doncaster is open from 2pm-2am every day of the week and gives appointments during those times after receiving a referral.

Service Uptake

a) Children and Young People

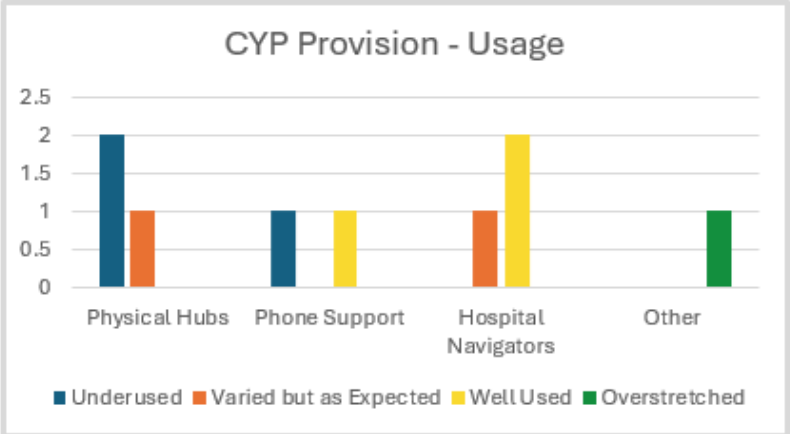


Figure 10

It would appear from Figures 9 and 10 that some crisis alternative provision for CYP is not as well suited to the need as that for adults. There are three provisions that are underused. One is a phone line for CYP in Leeds. However, West Yorkshire also has a 24-hour county-wide phone line with excellent take up and a good reputation. The second is the overnight provision in Hull which is

dependent on referrals from CAMHS. The last one is a provision in Bradford that covers all ages from 7 upwards.

Safe Zone in Leeds is moving from ‘as expected’ to ‘very well used’ after strengthening pathways from CAMHS and A&E and beginning to build a reputation by word of mouth. The well-established hospital navigator services are ‘well used’ with a newly started one in Wakefield being ‘as expected’. As can be seen with the adults, services offering appointments for ongoing support are better used than the one-off services.

b) Adults

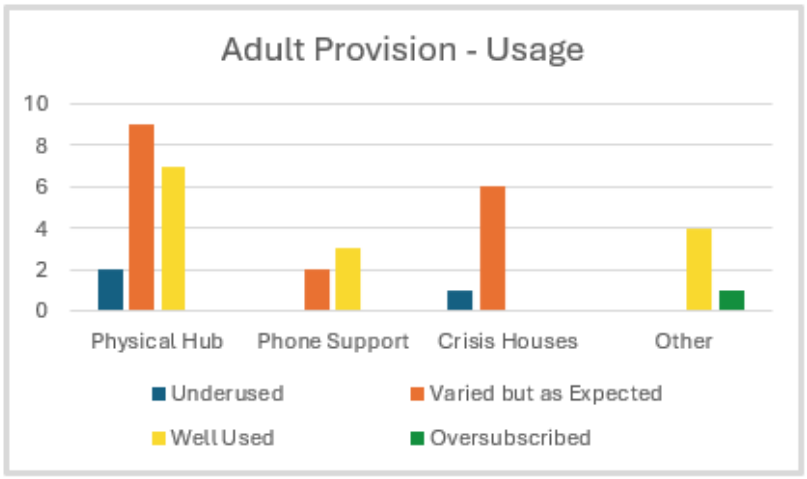


Figure 10 shows that, where crisis alternative provision is an option for adults, it is generally well used. Crises are not predictable and the limited opening hours of services means that not everyone will experience the need for the service when it is open. Services generally choose to open at the times shown to be busiest locally and outside of the normal working week, when other help is easier to obtain.

Figure 11

Where services are underused, this may be due to them being new and not well known or not being tied into the appropriate networks. All the services providing ongoing support for more than a single session are well used or oversubscribed.

Diversity and Inclusion

Services were asked to give an overview of how they felt the people using their services reflected the diversity of their local community. These were qualitative estimates and not taken (in most cases) from any data. The graphs below show that there is plenty of work to be done to ensure that people from **ethnically and culturally diverse communities** feel able to access these crisis alternative services. They also show how **young adults**, although accepted in adult services, are often not using them.

a) Children and Young People

The groups most identified as not attending CYP crisis alternative services were those from ethnically and culturally diverse communities. Generally, services saw a higher number of young women than young men, but this was only stark in two cases. One telephone line reported that neurodivergent people generally avoided the phone and would text other places or find in person support.

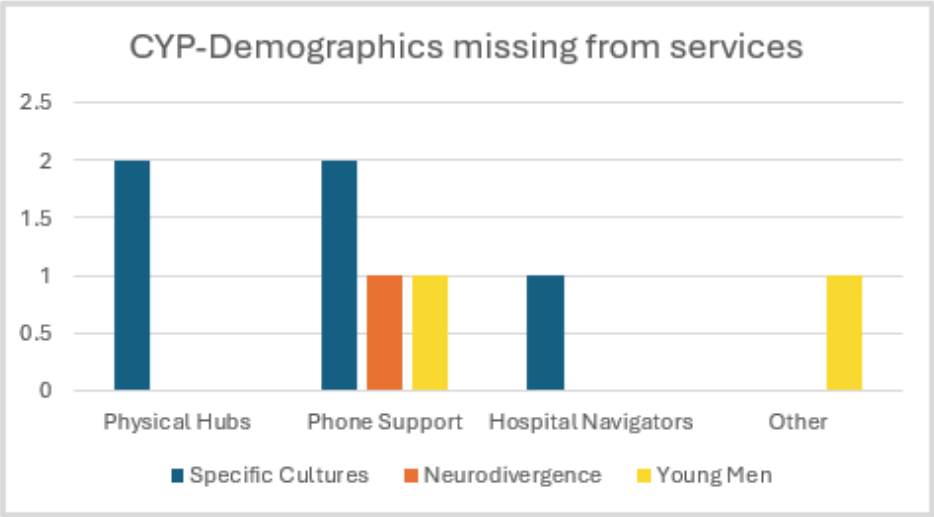


Figure 12

b) Adults

Adult groups reported a lack of people from diverse cultures in 61% of physical hubs and 71% of crisis houses. As crisis house referrals are gatekept by the NHS Crisis Mental Health Teams, the question lies with them as to why this might be. Physical hubs and crisis houses also report significantly fewer 16–20-year-olds (or 18–20-year-olds), than they would expect. One crisis house felt that they didn't see many neurodivergent people, but that may be down to a lack of diagnosis and recognition.

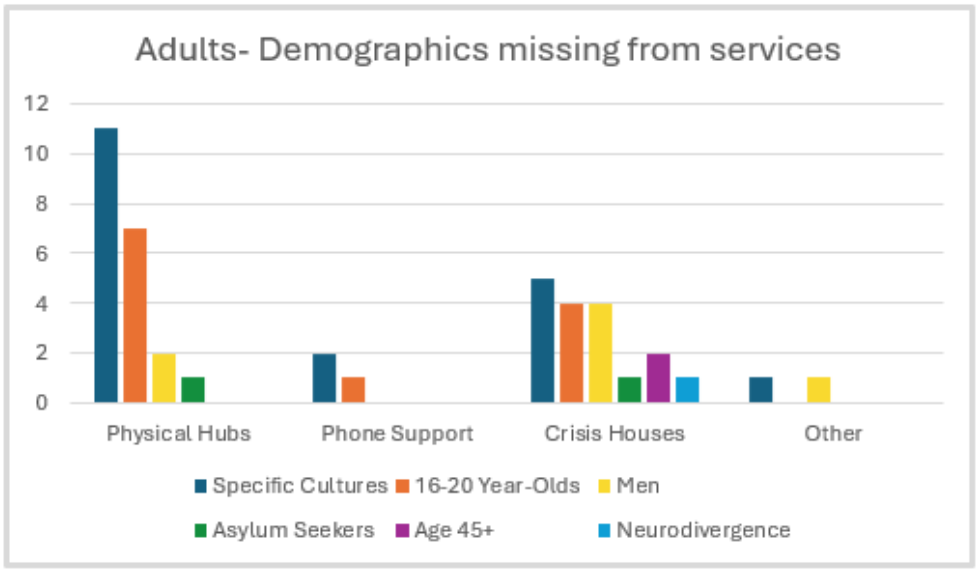


Figure 13

List of Services Included in Audit

Area	Place	Type	Age range	Run by
S. Yorks	Sheffield	Physical Hub	Adults 16+	Mental Health Matters
	Sheffield	Crisis House	Adults 18+	Rethink
	Doncaster	Other 1:1	Adults 16+	People Focussed Group
	Doncaster	Other 1:1 (HIU)	Adults 18+	Doncaster Mind
	Doncaster	Crisis House	Adults 16+	Rethink
	Rotherham	Physical Hub	Adults 18+	Mental Health Matters
	Rotherham	Hospital Navigators	CYP	Voluntary Action Rotherham
	Barnsley	Physical Hub	Adults 18+	Mental Health Matters
W. Yorks	Leeds	Physical Hub	CYP	Leeds Survivor Led Crisis Services
	Leeds	Phone Support	CYP to 17	Leeds Survivor Led Crisis Services
	Leeds	Physical Hub (BME)	Adults 16+	Leeds Survivor Led Crisis Services
	Leeds	Physical Hub	Adults 16+	Leeds Survivor Led Crisis Services
	Leeds	Physical Hub	Adults 16+	Touchstone
	Leeds	Phone Support (Deaf)	Adults 18+	Leeds Survivor Led Crisis Services
	Leeds	Crisis House	Adults 18+	Leeds Survivor led Crisis Services
	Wakefield	Physical Hub	Adults 16+	Touchstone
	Wakefield	Hospital Navigators	CYP	Touchstone
	Batley	Crisis House	Adults 18+	Community Links
	Dewsbury	Physical Hub	Adults 16+	Touchstone
	Halifax	Physical Hub	Adults 16+	Healthy Minds Calderdale
	Calderdale	Hospital Navigators	CYP	NHS Calderdale & Huddersfield
	Bradford & Keighley	Physical Hub	All ages7+	Bradford Mind & Cellar Trust
	Keighley	Other	All ages 13+	Roshni Ghar
	W. Yorks	Phone Support	CYP to 19	Leeds Survivor Led Crisis Services

Appendix 4 – Crisis Service Audit

Area	Place	Type	Age range	Run by
N. Yorks & Humberside	Hull + wider	Physical Hub	Adults 18+	Hull & East Yorks (HEY) Mind
	Hull	Other- Safe Space	CYP	Hull & East Yorks Mind
	Hull + wider	Phone Support	Adults 18+	Hull & East Yorks Mind
	Hull	Phone Support		HEY Mind with Police
	Scarborough & York	Physical Hub	Adults 16+	Scarborough Survivors
	York & Selby	Physical Hub	Adults 16+	Mental Health Matters
	Scunthorpe	Phone Support	Adults 16+	North Links Mind
	Grimsby	Physical Hub	Adults 18+	Navigo
	Grimsby	Crisis House	Adults 18+	Rethink
North East & North Cumbria	Newcastle	Physical Hub	Adults 18+	Everyturn
	Ashington	Physical Hub	Adults 18+	Everyturn
	Co. Durham	Other 1:1	Adults 16+	Everyturn
	Across NE	Other 1:1	Adults18+	Everyturn
	Gateshead	Crisis House	Adults 18+	Everyturn
	Carlisle	Physical Hub	Adults 18+	Carlisle and Eden Mind
	Workington	Physical Hub	Adults 18+	Waythrough
	Whitehaven	Crisis House	Adults 18+	Waythrough
	Cumbria Wide	Phone Support	Adults 18+	Carlisle and Eden Mind
	Rural Cumbria	Physical Hubs*	CYP	Carlisle and Eden Mind

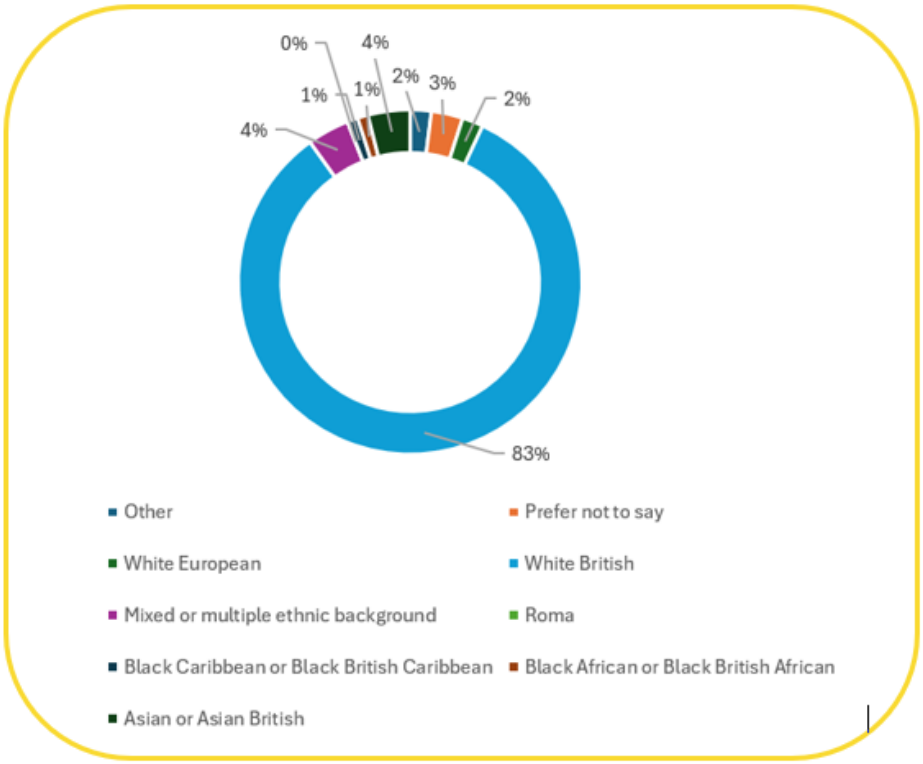
*This provision had not started at the time of audit.

APPENDIX 5 – QUESTIONNAIRES FROM NEURODIVERGENT PEOPLE

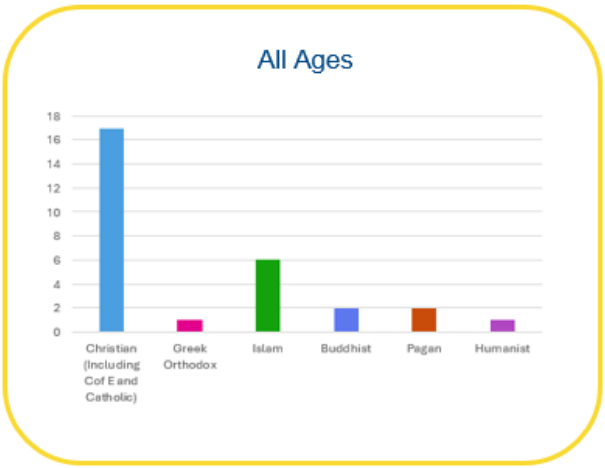
Additional Demographic Charts

Ethnicity, Religion and first language

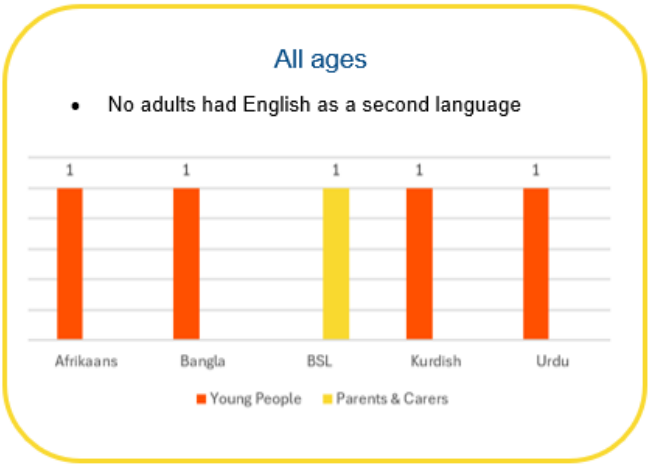
Ethnicity – All ages



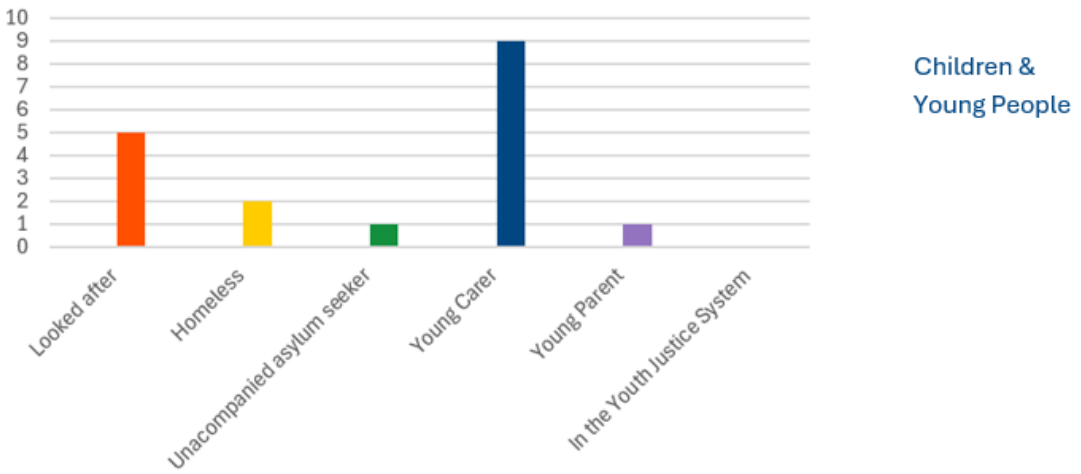
Religion



If English is not your first language what is?



Please tell us if you are currently or have experienced being one of the following:



Services Preferred by Children & Young People and Parents & Carers

27 parents & carers answered a follow-on question about what other kind of support they would want. These included:

- asking for a face-to-face appointment with someone who had professional expertise and the ability to relate to their child or young person. Examples included CAMHS, GP, and professionals trained in autism (6)
- wanting a named person who could be contacted to get support (5)
- feeling that there was no support available and if there was it was confusing to find, particularly if they were autistic themselves (4)
- someone to visit them in their home whilst the crisis is occurring (4)
- using friends and family for support (3)

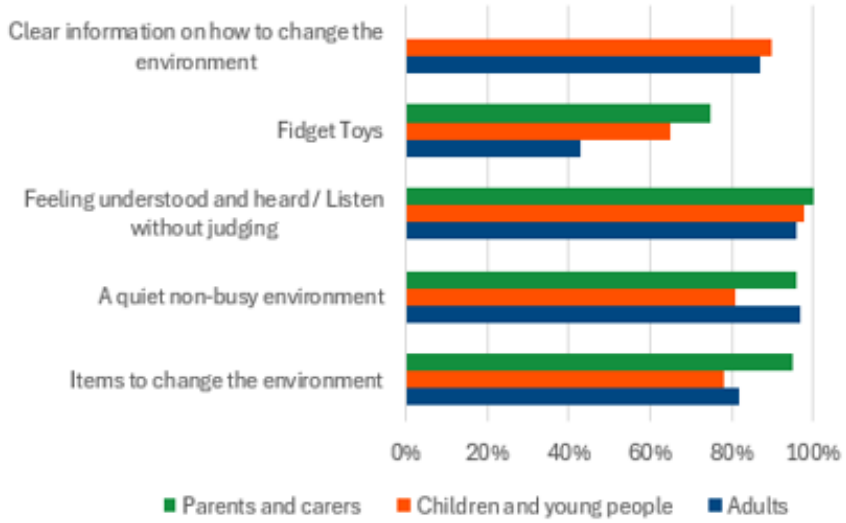
supporting the individual themselves but asking for training in tools that they can use when a crisis arises (including safety planning done in advance) (3)

Additional Charts from SPACE Questions:

Section 2: Sensory Need

How important are the following to make you feel comfortable and prevent you from experiencing sensory overload?

Responses across all participants

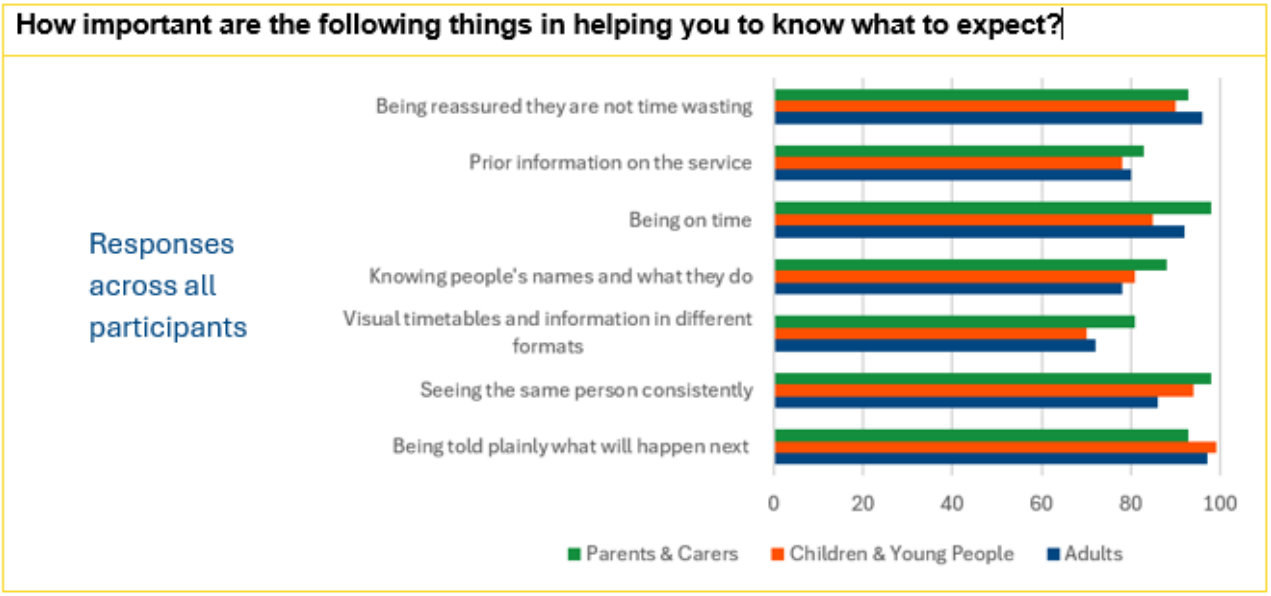


Additional adult responses

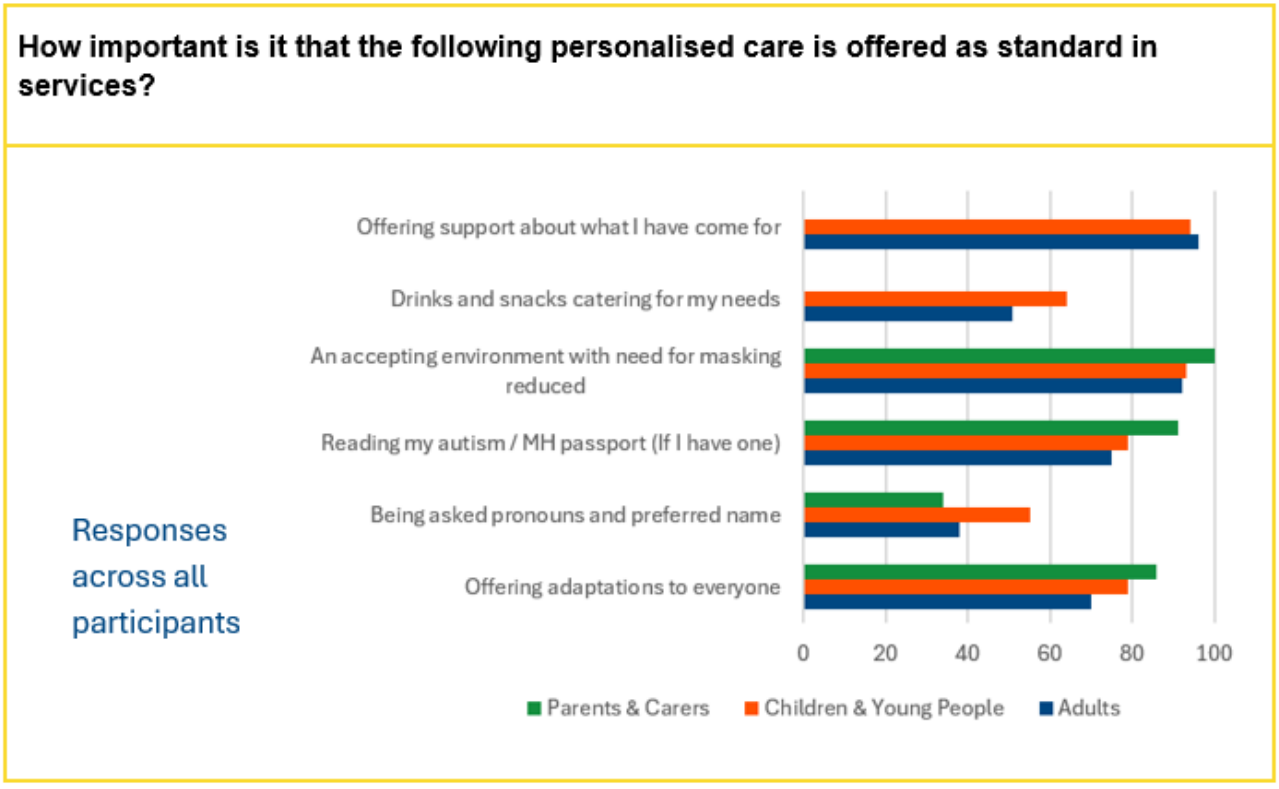
Additional child & young person responses

Additional parent & carer responses

Section 3. Predictability



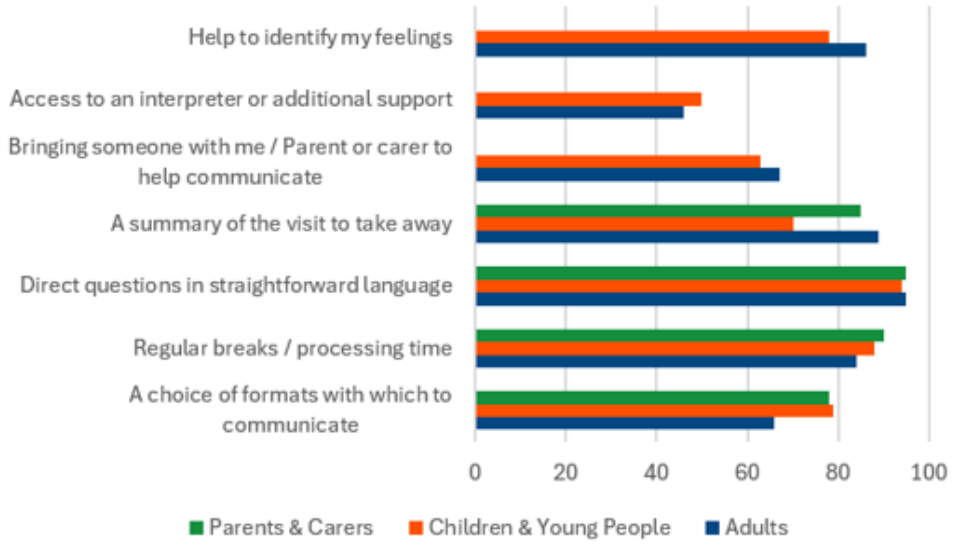
Section 4. Acceptance



Section 5. Communication

How important are the following aspects of communication in a *crisis alternative service*?

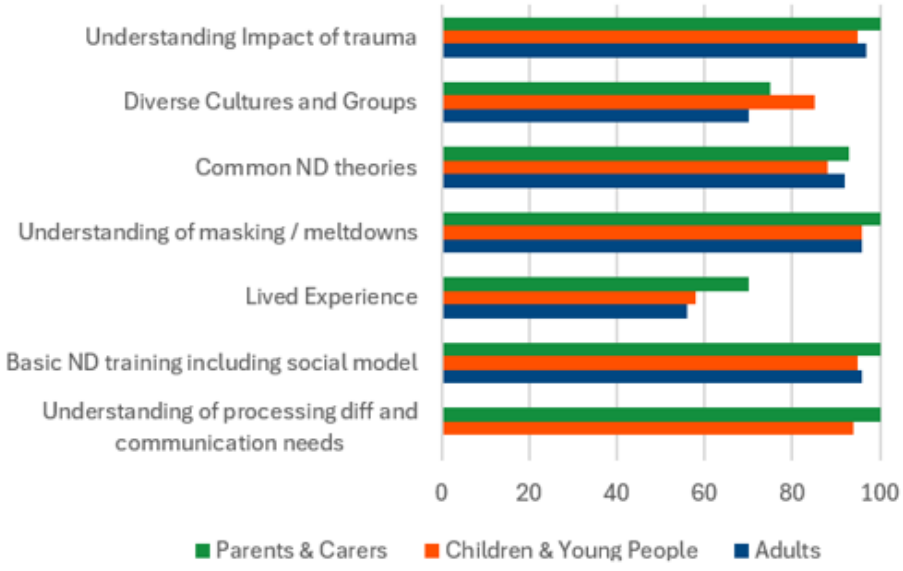
Responses across all participants



Section 6. Empathy and Training Needs

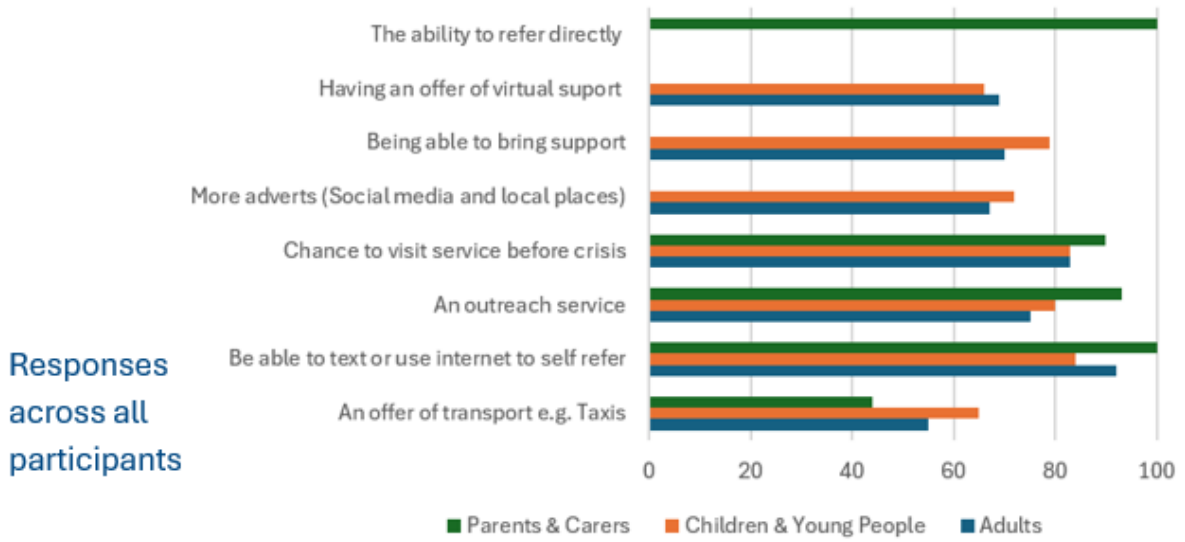
How important is it for staff to have the following skills or experience?

Responses across all participants



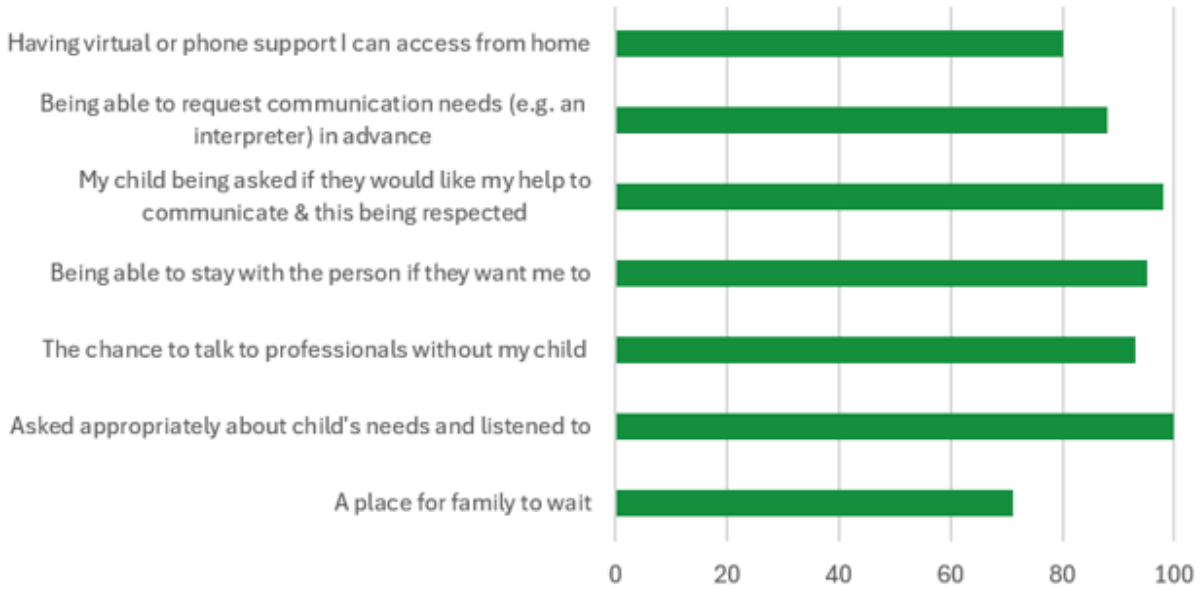
Section 7. Access

How important are the following things to enable you to use a *crisis alternative service*?



Section 8. Support for Parents & Carers

When you access crisis services in the community sector for the person you support, how important are the following for you and your family?



How significant would the following provision be in supporting you to keep the person in crisis safe and reduce the likelihood of ongoing crisis?

Parent and Carer Responses

Individual Responses from Parents and Carers on their support needs.

Please tell us of any other way you would prefer to get support for the person who is in crisis
I do not know of any support available I don't find A&E helpful or knowledgeable enough to help in the appropriate way without exasperating situations of crisis making matters worse
Have a contact that we can email and phone with a timely response
Being able to do non person will help with anxiety but also having the in-person support but being more supportive and not thinking medication is the best route to help them it's not
De-escalate the situation first and use the knowledge I already know in other ways you could do a resource course on how parents can and should help their child in need when in crisis
In the hospital but not A&E
CAMHS
Someone to come out to where they are. I would not be able to coax them into a hospital or other setting
A children's safe space to attend that is not clinical
They need to be able to connect with someone they can trust, talk to and be heard at such times ideally skilled in autism such as with psychology or counselling background choice should be available as to whether this is in video call or in person or otherwise, so they have some control and sense of trust/safety from the outset
Help from someone visiting my daughter at home.
At the first instance, I would be there and keep them safe. Then I would get help from a mental health professional. I have had very bad experiences with CAHMS and the NHS. I have only ever been able to use private mental health care.
Support them myself with tools I have learned
Being able to call a specialist number and speak to someone who can listen and support myself as well as give advice about how to support my child.

Have a named professional/expert ay GP practice (with good availability)
Face To Face examination. I would attend A&E as a very last resort if no other avenues were able to help.
My AuDHD daughter has a PDA profile, and if I ask questions or try to offer support, she sees it as a threat to her autonomy, and it fires up her fight and flight response. She would be much more likely to speak to someone she deems a professional, but the professional would need to have an understanding of PDA and allow my daughter to appear to have autonomy and also realising although is intellectually bright her emotional intelligence is below her peers. They would need to use the correct language and appropriate for her age and not get her heckles up by asking her by asking about 'special interests'. The person would need be aware of literalness and ask 'what medication you are prescribed' not 'what medication do you take' as the latter would miss out any prescription that was not admitted orally. Whilst respecting confidentiality, the professional should try and clarify things with the parent, as things are lost in translation. Say 'tell me about your day' rather than asking how the person is - as the latter may just confuse if you do not know how you are feeling.
Someone that could come to the house and see you face to face to avoid waiting in A&E or being unable to concentrate on phone calls when already dealing with a crisis.
Friends who understand my son
There is no support in Doncaster as CAMHS, and crisis team deemed not there simply and if they are most of staff are being paid to do Uni courses for her higher pay and no staff there helping kids
School offer support as well as other services we have access to
Friends and family
CAMHS and doctor
Having a written safety plan that has been written with myself the person it's for and a professional's input
Support from family
It's not that I wouldn't want to be able to access these means of support, it's that in the past we've been told none of these avenues are available to us. There ARE no means of support because my son is still of primary school age "too young" and his neurodiversity, although he's medicated for it, is deemed "insufficient" for us to access support.
For persons identified as high risk it would be nice to have a specified person to contact in crisis rather than just call the crisis line
Call crisis team
In the last I have been on the way to A&E then called 111 for crisis advice and was told not to go to A&E even though she was actively harming so now I don't know what to do (I'm autistic)
Access to someone coming in to the home as my child can be anxious, I can't get anywhere and previous phone support is no good.

APPENDIX 6 – DETAIL OF SERVICE USER FOCUS GROUPS

i. Young People

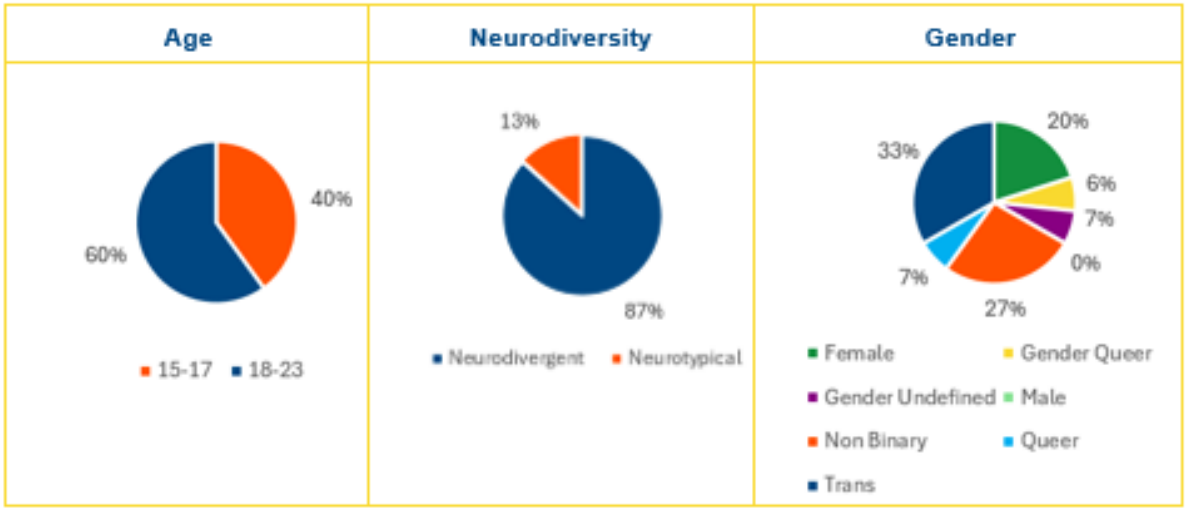
Section 1 – LGBTQ+ Focus Groups

Two separate groups were held, with young people specifically from LGBTQ+ communities.

- A group of 5 young people from a Sheffield based voluntary sector group for LGBTQ+ young people
- A group of 10 young people from a mental Young People's mental health project in Barnsley. This specific group was for those identifying as LGBTQ+.

The group of 5 took place as one large discussion, the group of 10 split into 3 smaller groups and recorded their thoughts on flip chart paper before all coming back together to share responses.

Demographics



The demographics of these groups are very interesting, particularly taken with the demographics of the questionnaires from neurodivergent users.

Neurodivergence: The two groups were specifically for young people who identified as LGBTQ+. They were not specifically for neurodivergent young people, and they were open to anyone of any gender. However, we can see that 87% (13/15) young people described themselves as neurodivergent, and most, although not all, were diagnosed. There is therefore a clear connection between young people who are neurodivergent and identify as LGBTQ+.

Gender: In terms of gender, there were no cis-gender men in these groups, which again echoes the lack of cis-gender men completing the questionnaire. We know statistically that there are more young people (under the age of 25) than older people who identify as LGB (lesbian, gay or bi). According to the ONS in 2022, 10.6% of young women identified as lesbian or bi-sexual and 7.9% of young men as gay or bi-sexual. Even considering the slightly higher percentage of LGB young women, there are still a significant number of cis-gendered LGB men who are missing from this research and potentially from accessing support. 80% of the young people identified as non-cis-gendered.

Responses

1. Understanding Mental Health Crisis

The groups were asked about their understanding of a mental health crisis. The participants described crisis as different for everyone but often including:

- **Emotional overwhelm** including dissociation, numbness, devastation, spiralling.
- **Physical and behavioural signs including** staying in bed, hygiene struggles, self-harm, recklessness' being destructive.
- **Loss of motivation and self-worth** and feeling like a burden to others
- **Difficulty recognising when they are in crisis**, especially among neurodivergent individuals.

2. Stigma and Stereotypes

The young people were asked if there was any stigma attached to mental health in their community and if so, how this affected them. 100% of participants agreed that they faced stigma. They felt that this contributed to difficulties in being taken seriously and getting the help they needed. Comments included:

- Mental health is seen as a "women's issue" and men must 'man up'
- Dismissal of trans and neurodivergent identities.
- Not being "suicidal enough" to qualify for help.
- Dismissal from older people who don't understand mental health. Young people reported as being continuously told to '*get over it'* and that they '*had it much better than previous generations.'*
- Young people being dismissed as attention seeking by adults (including professionals).

3. Access to services

The next question asked how easy it was to get support when they were heading towards crisis or at crisis point. It also asked the young people if they knew what services existed and how to find them. Young people felt it was generally very difficult to find help when they were at crisis point for several reasons including:

- **Bad experiences of services**
    - CAMHS, hospitals, and helplines were often described as unhelpful or traumatic.
    - *'I called 111 in a crisis and was told they were busy and would call me back, but they didn't'*
    - *'999 feels very dramatic and they are usually busy. They put me on the line with a nurse who was really unhelpful. I was also put on wrong ward'*
    - GPs described as dismissive or by one YP *'my GP hates me'*
- **Schools were seen as indifferent or ineffective.** One young person said *'In year 9 I was really struggling but my parent's ignored me, so I reached out to school, and they just told my parent who didn't believe in mental health'*
- **Lack of Publicity / Awareness** Young people didn't know about alternative services (apart from the groups they attended regularly which were low level support). They felt schools should have much more information and services should be advertised.

- **Young people in crisis not knowing what they needed** and being dependent on adults who felt unsupported, didn't know what to do, or downplayed the issue.

4. Other barriers

Young people were asked if there were any other barriers and they said:

- Long waiting lists and poor service quality.
- Needing parental involvement when parents weren't around or supportive
- Lack of support for 16–18-year-olds and issues when transferring services One YP said that when you transfer from children's to adult hospital environments *'it suddenly feels like neurodivergent people don't exist'.*
- **Communication challenges**:
    - A lot of neurodivergent young people found phone-based services inaccessible.
    - They felt there were a lack of alternative contact methods (e.g., text, email, chat).

5. Young People's Needs in Crisis

Young people were then asked what they needed when they were in a mental health crisis and what would build their trust in services. Responses can be summarised as follows:

Young people want:

- **Relatable, younger staff** who listen to them and understand their experiences.
- **Non-clinical, welcoming environments**.
- **Diverse representation** in staff (gender, race, neurotype, sexuality).
- **Holistic support** that doesn't dismiss or redirect based on identity.
- **Clear, accessible information** about services before crisis hits.
- **Parents who listen** or if not someone else to recognise when I need help
- **Predictability and consistency-** knowing what will happen next and when

6. Ideal Crisis Support

Finally, the young people were asked to imagine what their ideal crisis service would be like and there was clear agreement across all groups with the main points being:

- **Sensory-friendly spaces**: quiet rooms, rage rooms, sensory rooms, adjustable lighting.
- **Creative and playful elements**: gardens, outdoor space, places to "be a child again".
- **Multiple communication options**: walk-in, text, email, chat, phone, video.
- **Age-specific support**: tailored approaches for different age ranges. (important to have a space for their age group as older adults more judgemental)
- **Peer and lived experience involvement**.
- **Support before crisis**, not just during, so they felt able to access it
- **Real-life coping tools**: distraction, grounding, emotional regulation, practical help.

7. Final Recurring themes

- **Intersectionality matters**: being trans, neurodivergent, disabled, or from a minority group, compounds barriers.
- **Young people feel dismissed and misunderstood** by adults and professionals.
- **The LGBTQ+ groups they attend are a trusted source of support**, but more services like them are needed.
- **Friends and family are a crucial form of support.** When that is lacking there is a big gap. This particularly applies to those in the 16-24 age group.
- **Young people aged find services very disjointed.** One young person said that 16- and 17-year-olds. exist in a "limbo" or "Wild West" state between children's and adults' services

Section 2 – Focus Groups with care leavers and homeless young people.

One focus group took place with 4 Peer Educators from a Sheffield charity who were or had been homeless. A second group took place with 5 Care Leavers from Hull who attended a voice and influence group. Both groups had experienced prejudice, involvement with other statutory agencies and lack of parental support. They will be looked at together to keep the report manageable.

Demographics

Peer educators:

- 4 young women aged 18,19, 24 and 25.
- All white British
- All 4 diagnosed with ADHD
- 1 diagnosed autistic

Care leavers:

- 5 young people aged 19-24
- All White British
- 1 young woman, 4 young men
- Mix of neurodiversity
- 1 visually impaired

Responses

1. Understanding Mental Health Crisis

These groups did not focus in the same way on what a mental health crisis meant. The care leavers wanted to talk immediately about how they felt let down, with one member of the staff summing up how everyone seemed to feel below:

> *'What comes to mind is waiting lists, not being able to get hold of the crisis team, services not working in the way they should for care leavers, a 2 month wait if care leavers are referred for assessment, then a 2–12-week process which can just end up with the young person on another waiting list.'*

Most of the peer educators felt that although they had mental health issues, they had not experienced a crisis. One young person (19) said she went to her GP when she was in crisis, and he offered her 3 days of sleeping tablets or a year of anti-depressants which she didn't want. Another time she was referred to Talking Therapies but was told she was too complex for them due to her Post Traumatic Stress Disorder (PTSD) from abuse but didn't signpost her anywhere else. CAMHS discharged her at 18 with no further support despite her living in a hostel and just leaving an abusive relationship. She felt very let down.

2. Stigma and Stereotypes

The young people raised the following:

- Feeling judged and unwanted due to their ADHD and seemingly 'rude' behaviour
- Worried about getting support for their mental health in case it affected any future children
- Stigma about being a care leaver. One young person felt the view was *'most care leavers go to jail'* and others echoed the sense that they can't do anything right or won't amount to anything.
- It is assumed that care leavers will have poor mental health, so it is not always taken seriously
- There is stigma in having a disability
- There need to be more adverts about men's mental health as there is stigma around that and men find it very hard to reach out

3. Access to services

The overwhelming view was that it was not at all easy to access services in a crisis. Experiences included:

- Not being able to get an appointment with the GP when in crisis
- Crisis team not getting back to them (2 young people)
- Not wanting to go to A&E as it would be a long wait in a difficult environment
- Not knowing where else to go (Young People didn't know about local crisis alternatives)

4. Other barriers

- Having to phone in is very difficult for neurodivergent people, particularly if the line is engaged, they must choose options or hold
- Neurodivergent people often worry about wasting other people's time so if services are busy, they may not call back
- Digital exclusion. Often care leavers don't have a phone or data. Many young people may have no money at the end of the month even if they do have a phone. (Usually pay as you go)
- Getting to a service if it is not local. Again, money is an issue if transport is required
- The care leavers felt stigma was a real barrier
- Care leavers often have no one to turn to when others would go to their parents. They may find it harder to access services without support

5. Young People's Needs in Crisis

- For men to feel it is OK to ask for help (tackling stigma)
- An immediate response available 24/7 with someone giving you actions & somewhere to go
- Somewhere local you can just turn up without an appointment
- Someone to talk to who will really listen to you so you feel validated and cared for
- Multidisciplinary care that actually deals with multiple needs including the practical things

6. Overcoming Barriers / Ideal Crisis Support

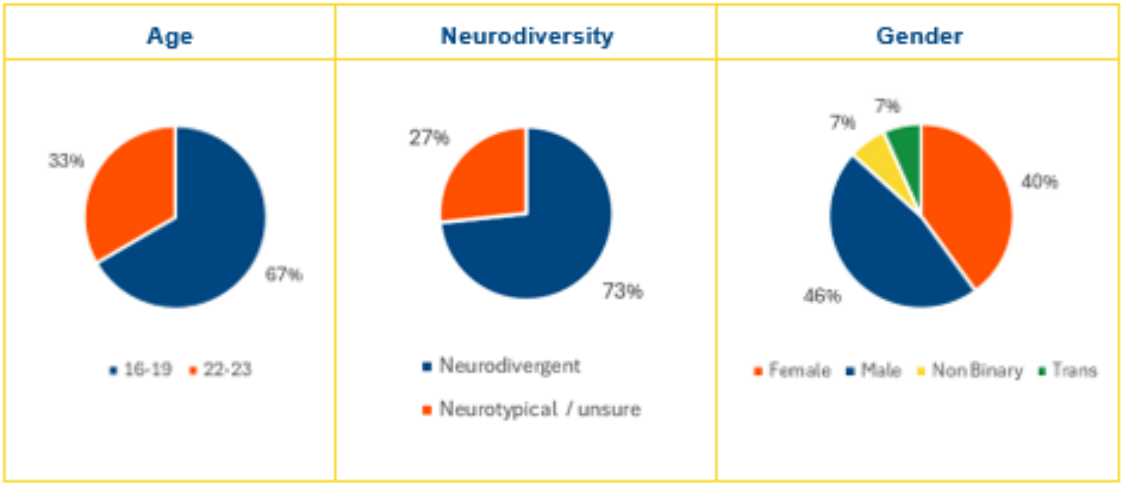
Due to the different settings, these groups were not asked to design their ideal service, but some of their ideas would fit into this picture. They felt the following would help to overcome barriers;

- Services that you can stay with and where you get treatment within a decent time
- A variety of ways to contact the service including text or online
- Having a relationship with one person or a team of people
- Help before crisis point – sometimes just a person to chat to
- Free bus passes for care leavers or free taxis to get there
- An App that works offline if you don't have data and can direct you to the nearest crisis service.
- Put clear information online including a step-by-step process that people can follow so they will know exactly what will happen when and how. Include a video of the service with staff pictures and names
- Make sure staff are trained well, attend refresher course and are looked after well
- Advertise services well including;
    - on bus stops and train stations in big places where people can see them and places where young people go (bowling alleys, cinemas, advice centres etc)
    - a strong social media presence, particularly on Tik Tok
    - Stickers on Lampposts or the back of toilet doors (even just a QR code)

Section 3 – Focus Groups of young people attending mental health support groups

The final focus groups with young people were undertaken with a generic group of young people attending a low-level mental health support project in Barnsley and a funded crisis alternative project for 16–25-year-olds in Doncaster.

Demographics



Unlike the young people in Section 2 who were attending a group related to their experiences, these young people were attending the groups actively seeking support for their mental health. The fact that at least 73% identified as neurodivergent is significant, aligning with statistics that show

neurodivergent individuals are more likely to struggle with mental health problems than their neurotypical peers. Despite this not being a group for LGBTQ+ individuals, 14% were non cis gender.

Responses

1. Understanding Mental Health Crisis

Young people described crisis as:

- **Emotional and physical distress**: panic attacks, suicidal ideation, self-harm, anxiety, isolation, psychosis, really low mood.
- **Behavioural changes**: risky behaviour, substance abuse, neglect, erratic moods.
- **Difficulty recognising or articulating crisis**, especially when overwhelmed.

2. Stigma and Stereotypes

Both groups reported:

- **Stigma from adults and peers**, including:
  - It's harder for men to have mental health and to get help
  - Accusations of attention-seeking.
  - Dismissal based on gender, sexuality, or neurodivergence.
  - It causes me to mask which can later cause meltdown
- **Romanticisation or trivialisation** of mental health issues.
- **Lack of belief or understanding**, especially from older generations -being told to "get a grip" or "calm down".

3. Access to services

Again, most young people felt it was not at all easy to access services in a crisis. They raised:

- **Difficulty reaching services** (e.g., calls not answered, long waits).
- **Lack of drop-in options** and over-reliance on phone-based contact.
- **Not knowing what services exist** or how to access them.
- **Not being able to communicate clearly**

4. Other Barriers

Similarly to previous groups, the young people cited the following as barriers to reaching out for support

- **Fear of judgment** or being misunderstood.
- **Feeling unsafe or unwelcome in clinical settings**.
- **Not wanting to be a burden**
- **Not knowing when they were in crisis** and no one to help them identify this
- **Bad experiences of services,** particularly 111 and A&E

5. Young People's Need in Crisis

- **Face-to-face support with someone to listen**—ideally not family or friends.
- **Distractions and coping strategies**.
- **Safe, informal spaces** with sensory-friendly environments.
- **Support from relatable, younger staff** and people with lived experience.
- **Clear, person-centred communication** without jargon or pressure.
- **An understanding** that it's not easy for everyone to 'just talk' and takes time
- **Having things offered** instead of having to ask for them

6. **Ideal Crisis Support**

Both groups envisioned:

- **Drop-in access** without appointments.
- **Quiet, peaceful spaces** with outdoor areas.
- **Sensory rooms and rage rooms**.
- **Diverse staff** (age, background, neurotype) who know me and can give me a kick if I need it.
- **Support before, during, and after crisis** where you know exactly what will happen when
- **Separate provision for different age ranges** (e.g., 13–17 and 18–25).
- **Non-clinical, welcoming environments** with snacks, music, and activities.
- **Somewhere with no stigma** where I don't feel the need to mask
- **Somewhere to stay overnight** that is non-clinical and gives you space from continuous stressors

"The ideal crisis provision would offer real-life coping mechanisms (healthy), distraction techniques, real advice / help to resolve the issue, not just self-care tips, there would be a mix of formal (professional) and informal support which makes you feel more comfortable."

"It would have a good diversity of staff, racially, neurologically and sexually etc, as this helps people feel more comfortable and able to access it. It needs to think about intersectionality and not just refer to other services based on LGBTQ+ or other 'diagnosis' (It needs to be holistic). It would also have younger staff.

ii. Adults

Section 1: Focus groups with adults from Ethnically and Culturally Diverse Communities

Two focus groups were carried out with adults from ethnically and culturally diverse communities, one at a befriending group for Muslim Women in Hull, and another at a crisis alternative provision specifically for ethnically and culturally diverse communities in Leeds.

Demographics

Befriending Group:

- 5 women
- All South Asian Muslims
- Aged 45-65
- Neurodiversity unknown

Crisis Alternative:

- 2 men and 2 women aged 25-45
- 2 of Asian Heritage
- 2 of African / Caribbean Heritage
- 2 diagnosed with Autism
- 1 recognised a lot of traits during discussion
- 2 men had experienced the criminal justice system

Responses

1. Understanding Mental Health Crisis

1. Both groups associate crisis with **severe emotional distress**, including **depression, anxiety, isolation**, and **suicidal ideation**. There was also an association with being sectioned.
2. There was a shared recognition that **mental health crises are sometimes invisible** and misunderstood by others, especially family.
3. Sometimes it is **hard to recognise you are in crisis** and need others to do so.

2. Stigma and Cultural Barriers

Stigma around mental health was cited as a major barrier by both groups

- Muslim women described **judgment from family and community**, especially around mental illness and neurodivergence.
- The Crisis Alternative participants noted **racial and neurodivergent stigma**, particularly for **Black men**, who are often criminalised rather than supported.
- Cultural expectations (e.g., marriage as a solution to problems) and **lack of understanding of conditions like autism** were highlighted.
- It was also felt that Black/South Asian boys may not choose to be diagnosed as they don't want the stigma. They are already **combatting stigma for their skin colour** and facing enough challenges.

"You can't talk to your family as they don't believe you and think 'you were OK one day, so how can you not be the next?"

"I was nicked 7 times asking for help and didn't get any until eventually the judge said I had a personality disorder and needed help"

"I didn't get the support I needed as a child until I had been done for arson. My neurodivergence was not recognised"

3. Access to services

Both groups expressed **deep feelings of isolation** and difficulty accessing support, apart from at the crisis alternative service.

- Muslim women described **language barriers**, **lack of outreach**, and **not knowing where to go**.
- The crisis alternative users mentioned **mobility issues**, **transport costs**, and **lack of continuity in care** (e.g., being dropped by services).
- Those accessing the crisis alternative said it was 'a lifeline' as the staff listen to them and it helps reduce their loneliness and isolation.

"At crisis point most people can't make decisions for themselves. The intervention is needed before this and that is where services like this are great."

4. Other Barriers

ii. Lack of trust in services and the need for confidentiality was significant for both groups.

iii. Due to stigma, it was not always possible to access services that were visible as 'mental health' or crisis services. Outreach to where women gathered was seen as crucial

iv. A lack of understanding about mental health and neurodiversity in their communities led to people reaching a crisis (and potentially being sectioned) before accessing any help.

5. Overcoming Barriers

Participants were asked what needed to happen to overcome the barriers they faced. The themes from both groups were similar and included

v. Wanting **non-judgemental professionals** and **consistent relationships** with service providers.

vi. More outreach and chances for discussion and education like this (the focus group)

vii. Translation services and providers who speak our language

viii. Culturally competent care – people are afraid, and they need to be reassured

ix. More accessible crisis support, tailored to cultural and neurodivergent needs

x. **Safe, welcoming environments** where people feel seen and heard

xi. **Increased funding** for services and transport

xii. **Peer support** in familiar, culturally sensitive environments

Further comments from service users

I am more comfortable and at ease in a service that caters specifically for Black and Asian people. When I went to another service I felt like the odd one out and was left in a corner on my own. That makes you feel lonelier.

We are often very isolated. We might fall in love or have an arranged marriage and then come to this country knowing no one. It is very hard to find friends, and you don't know who will judge you. You can't share with family.

It must be outsiders as they are easier to talk to, but you need to know and trust them.

We need professionals like you who can help us to talk about things

When I was ill, I didn't leave the house for 3 months and kept the curtains closed. I took an overdose of tablets because I couldn't cope. My friend took me to A&E. It was only my mum coming over from Pakistan and supporting me that eventually helped. She managed to get me out of the house and back talking to people outside." I haven't even told my family now and I don't want them to know. This is the first time I have talked about this.

When you are in hospital you become institutionalised. People tell you when to get up and feed you. They give you drugs and tell you how to lead your life. When you get out it is very difficult to adapt again. The community team dropped me after 3 days and I found that very hard. There should be more support for people coming out of hospital. When I started coming to Dial House that helped me.

APPENDIX 7 – INTERVIEWS WITH NEURODIVERGENT INDIVIDUALS

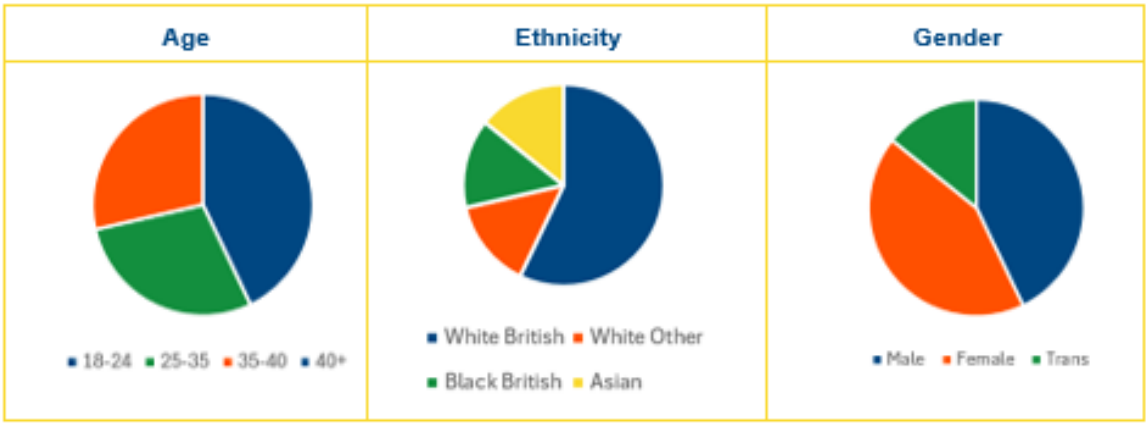
Interviews were conducted with a range of neurodivergent individuals and with stakeholders working with marginalised communities where focus groups were not possible. Some individuals heard about the research and made contact as they felt they wanted to contribute verbally or couldn't do the questionnaire.

The interviews will be summarised here in four sections. Those with neurodivergent individuals, those with groups from BAME communities, those with individual refugees or agencies working with them and those with any others.

Section 1 – Interviews with neurodivergent individuals

Demographic profiles

- Person 1: Whie British autistic woman aged 27 from Newcastle, attends crisis alternative hub
- Person 2: White British autistic woman aged 40 from Hull, attends autism support project
- Person 3: Black British autistic man aged 36 from Leeds, made contact individually
- Person 4: Eastern European autistic trans man with ADHD aged 29 from Sheffield, EbE.
- Person 5: White British autistic male aged 19 from Hull, works at and attends an autism support project
- Person 6: White British partially sighted autistic male aged 21 from Leeds, made contact individually
- Person 7: South Asian autistic female aged 23 from Leeds, foreign student and Youth Ambassador



Whilst the interviews generally covered a better mix of gender and ethnicity than the questionnaires or focus groups, they were limited on age spread. The youngest person was 19 and the oldest 40.

Interview Responses

1. Understanding Mental Health Crisis

There were many similar suggestions of what a mental health crisis might look like to those from the focus groups, but people were keen to get across that a mental health crisis looked different for everyone. Person 4 explained that if she asked for help every time she felt in crisis, then it would be all the time. Her norm was what many people would feel was crisis, so she would only reach out if

she was feeling actively suicidal. At that point she would stay at home and call for help as she would be a danger to herself if she did anything else. Person 3 gave his definition as:

"When someone can't associate with the norms of everyday life. Can't function as they generally would"

and this sentiment was echoed by others. Person 1 explained her autistic overwhelm as:

"I stop processing and can't physically move. It feels like danger is looming and I have to stay in the same position. My brain has paused until the threats have gone."

To her it was more of a temporary state which she knew would pass. However, her description of a mental health crisis was:

"I am more likely to experience crying and know that nothing can help. I might have PTSD images and thoughts from the past and I can't see any way out."

Again, the message that people often don't recognise crisis in themselves until it is too late for them to act, or someone else notices it. Person 7 explained:

"I don't register anything as crisis until it is a life and death situation. That goes back to my culture as mental health doesn't exist, and a mental health crisis is not even real."

2. Stigma and Stereotypes

Without exception, everyone felt there was stigma around being neurodivergent. Person 1 explained that she knew she had traits from about the age of 17 but would not admit it due to the stigma. This prevented her from getting the support she needed. All 3 of the participants from non-white British backgrounds said how mental health and neurodiversity were not even recognised much of the time. If they were to suggest they may have autism or be struggling with their mental health in some communities, they would be dismissed or even ostracised. Person 7 explained her mental health journey as:

"Back home, mental health and neurodiversity don't exist. I have always struggled with my mental health but managed to mask extensively and was not aware of neurodiversity. However, the big change in environment when I came here to study meant I was no longer able to mask, and it all became too much for me – my mental health declined significantly. My doctor suggested I was tested for autism, but my parents refused to help by giving any information about my childhood."

Interestingly, person 5 and person 6 both thought that there was stigma about, and a 'stereotype' of, autism, but that was a good thing. Person 5 could not explain why, but person 6 said:

"I would prefer people assume I was going to go non-verbal in a crisis when I'm not and then find that out."

He did also say that growing up going to a special school shielded him from any stigma and he was not ready for that when he entered the adult world. This was echoed by the young people from the crisis alternative focus group. Person 5 talked about diagnostic overshadowing and that people would see autism and assume everything was due to that. He had had illnesses missed that way.

Person 3 talked much more about the stigma and racism attached to being a Black man. He felt that family, church and running groups all accepted him, but his workplace was racist and had an image of Black men as criminals.

4. Access to services

Individuals were asked how easy they found it to get support when heading towards crisis, or at crisis point.
There were a range of answers depending on their situation and knowledge. Generally, people found it hard to get support unless they had a good relationship with a provider or knowledge of the system. Person 1, who reached crisis point for the first time recently, found it very difficult and had a very negative experience calling 111. She then went to A&E and was directed to the crisis alternative but could not work out how to get there as she was alone and in crisis! When she finally made it, her experience of the crisis alternative was very positive as they gave her space and time to de-escalate before engaging any further. Person 5 felt that as they had been in hospital under section and were with the CMHT it would be easier for them, and they would be taken more seriously. They thought it was harder for people without a serious mental illness. Person 7 felt there was a lot of online and text support, but that they couldn't express themselves that way and they didn't know any other places to go. Person 2, who said at crisis point they couldn't leave the safety of their home, had tried all of the helplines. They found the crisis alternative helpline the best, although it was not always understanding of her neurodivergence. On one occasion when she had sensory overload, they kept insisting she opened the blinds to let in daylight.

v. Other Barriers

Interviewees described a range of barriers that hindered or prevented them from using appropriate services. These can be categorised as:

Fear of judgement

for example, person 2 felt they would need someone to see them at home as they were unsafe to go out at crisis point. However, they would be ashamed of the state of their house due to their crisis and in fear of judgement. Others mentioned not feeling worthy of help or not being deemed sick enough.

Communication and processing

- several people mentioned not liking the telephone. For one person that meant putting of contact until the very last minute.
- 2 people tried text services but found it difficult to express themselves and found they were not given enough time to process and reply before the conversation was ended.
- Person 6 felt frustrated that no one ever read his hospital passport and hated repeating everything.
- Person 1 felt there was a lot of information but all in QR code and writing which was overwhelming. They wanted clear leaflets with pictures to show how things would look.
- Person 4 talked about the need for translation but also that it should not be assumed you want or need a translator just because English is not your first language. Sometimes that was a barrier as people felt they didn't want others in their community to know about their issues.

Lack of knowledge / advertisement

- Person 7 had accessed her GP and university support for crisis, but none of them had mentioned the crisis alternatives which she thought would have been very helpful. Person 6 said they were given no information at school to prepare them for adult life. Person 5 worked with autistic young people and felt there was no awareness of what support was out there.
- Person 6 said that he would need to know that services were autism friendly as his experience was that they weren't. They also felt they needed to know more about what services would be right for them.
- Person 1 wanted clear information in more pictorial forms and a card she could keep in her phone with opening times.

Not being available when needed

At least 3 people felt that services needed to be available whenever crisis hit and that was 24/7. They did not think Accident and emergency filled this need.

Not recognising crisis in time

3 people felt that by the time they recognised they were in crisis it was too late for them to get help alone. They would be unsafe and need someone to spot the signs before it gets to that point.

Transport costs and travel time

The cost of travel and the time taken to get to various services when they were across different sides of the city was raised by person 1, whilst person 5 recognised poverty in Hull and the cost-of-living a as barrier to accessing services. Person 6 said his visual impairment made it very difficult for him to get to services.

iv. Overcoming barriers and creating a great service

The interviewees were asked how they might overcome the barriers they had identified, what their needs were in crisis and how they would like these met. Many of the replies crossed over, so will be summarised together

Clear information and advertising

There was a consensus of views that most people didn't know what services were available and if they were suitable for them. The following suggestions were given to help overcome this:

- Advertise much more in places like in GP surgeries, universities, libraries etc
- Put the opening times and contact number of the service on a business card that you can put in your phone and not lose it. It is hard to remember these, and flyers get lost
- Materials need to be more picture based and use infographics not just lots of words
- Maybe have a map at A&E with directions of how to get there and a picture of the building / entrance so you know where you are going. Also say what it is near (like the university).
- All services should have access to a register of other services they can signpost you to.
- Every service has different thresholds, so it is important that advertising clearly spells out who it is suitable for. One person said off the crisis alternative "I don't trust the Support Hub, they are not there for a crisis, they turn you away if you are ill! It's Ok if you want a warm environment with a cup of tea and have some emotional distress, but nothing more'

Opening hours and access

- Services should be 24 hours and available for drop in
- Separate room at A&E with different protocols (need to communicate timescales, give clear guidelines and information and create a more accessible environment)
- There must be a variety of ways to make contact (not just the phone)
- Services should be based in the same place to make it easier to travel
- Somewhere residential to stay before getting to the point of a section

"A& E would not have been safe for me or others when I was younger and in crisis. Last time I was deep in crisis, I was hidden away in my flat with no phone or contact with the world. If there was somewhere I could just have walked to (A&E didn't cross my mind), this could have been prevented by me knowing it was there".

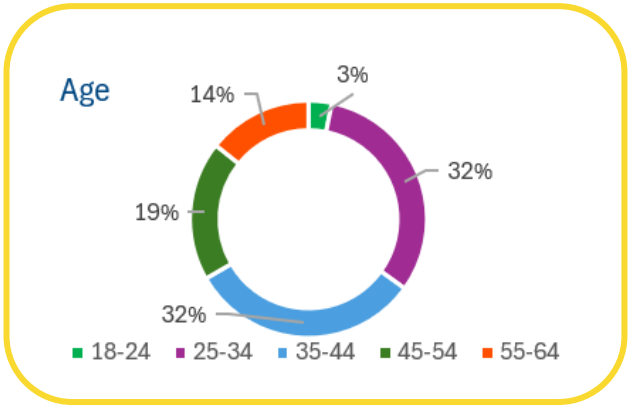
Adapting to neurodivergent needs

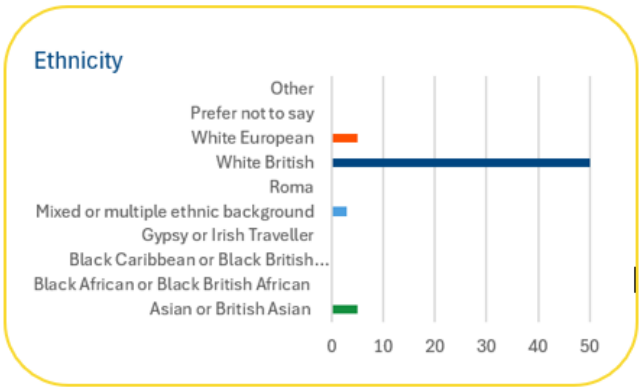
- **Be person centred** – be able to adjust to what each person wants
- Staff should know about Spoon **Theory** and help people to understand it. Perhaps help them to come up with their own infographic that works for them
- Provide **advocacy** if needed.
- Go at the pace the person needs to **process and understand** and recap at the end of the session.
- **Provide resources**. It is important to have ear defenders, fidget toys and blankets available and signs to explain what is free for people to use.

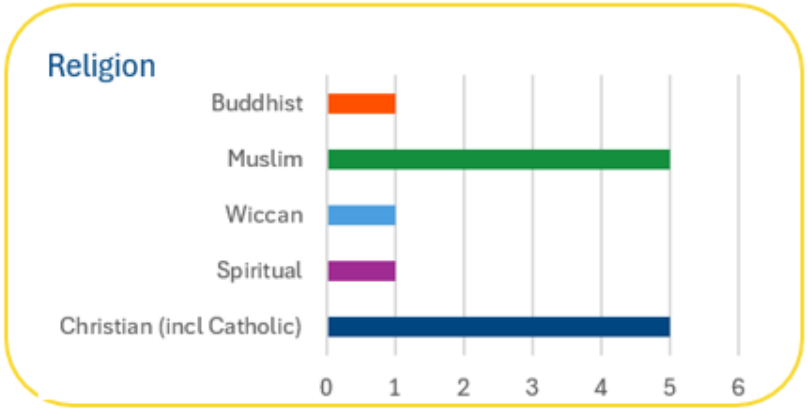
"Together in a Crisis works slower over several weeks which is really good. It is not too much information at once. Also, it doesn't seem like it has a time limit, so I don't feel like I am being rushed out of the door."

APPENDIX 8 – DETAIL OF QUESTIONNAIRES FROM STAFF

Additional Demographic Charts







Preferred Training Delivery Style

Thinking about accessing training in terms of time, travel and venue, along with how you learn best, please rank the following options in order of preference.

APPENDIX 9 – FOCUS GROUPS AND INTERVIEWS WITH STAFF

Section 1- Focus Groups

Detail of Training Recommended by Keyworkers in Focus Groups

The teams were asked what knowledge and / or training had helped them in their role, that they would recommend to others working with neurodivergent young people struggling with their mental health? There was a wide range of training, some of which might be more appropriate for work with young people and some that might be more specific to those at risk of hospital admission. The list below summarises the areas and includes specific providers where these were described as very good.

Neurodivergent-specific training including

- Including PDA (Pathological Demand Avoidance),
- Sensory needs,
- Communication styles and tools to help with this (detailed further below)
- Neurodivergence and comorbidities.
- NEDDE (neurodiversity and eating disorders training)
- Anna Freud National Autism Trainer Programme

Mental health and trauma informed care:

- Mental Health First Aid
- Trauma-informed care and Aces
- FASD (Foetal Alcohol Spectrum Disorder) training
- Sheffield CAMHS Mental Health Training
- Basic OCD training

Safeguarding and behaviour support:

- A variety of safeguarding courses
- Positive behaviour support
- De-escalation and restraint
- Papyrus Asist - Suicide prevention

Law and legislation:

- Human Rights
- The Mental Health Act

Communication: Emphasis on alternative communication methods

- Counselling skills and active listening
- Different types of communication (Including visual, repeating back, understanding 'pleasing' behaviour, using literal language and understanding scales)
- Behaviour as a form of communication
- Makaton
- Tools and approaches

Peer support and reflective practice: Seen as vital for both staff development and service delivery.

Detail of Focus Group with Staff Team of Youth Wellbeing Service

The final focus group was held with the staff team of a youth wellbeing service in South Yorkshire. It consisted of 8 staff members, mostly women, with a range of roles within the project. The questions asked were slightly different again in order to understand how the service benefits young people in crisis.

Focus Group Responses

1. Understanding Mental Health Crisis

The team described how they see young people presenting in crisis and how non-medical support can help.

- Young people often present with suicidal ideation and intent; appear broken, increase use of self-harm, and can engage in risky behaviour, particularly if they are neurodiverse
- Can also present as sleep-deprived, hungry or homeless
- Medical model of crisis support often does not feel comfortable for young people and can be difficult to access if neurodivergent due to an overload of information.
- Young people turn to their service as it is easy to access and gives them time.

2. Support Offered

The service is an early support mental health and emotional wellbeing hub for young people aged between 11 and 25 that provides open access, flexible, early support in a non-judgemental welcoming, safe space. A young person can be involved with HOME at their own pace, for as long as they would like (up to the age of 25) and can choose which elements of the programme they would like to access.

- No diagnosis required
- Young people can self-refer before triage occurs or can be referred by professionals through a triage process
- Everyone offered an initial face-to-face assessment to feel heard
- Although not a crisis service, it can run alongside crisis interventions as young people will not be denied access during crisis

3. Skills and Approach

The following skills and approach were highlighted as critical by the team.

- Relational approach using peer support and youth work – ‘connection before correction’
- Treat people holistically as individuals, tailoring support to each individual whether neurodivergent or not
- Focus on using creative approaches to meet need not diagnosis
- Keeping support real and fun as young people more likely to engage if they enjoy it
- Creating a safe space where no topic is too inappropriate to discuss
- Keeping a consistent approach and continually listening to allow young people to safely open up

4. Training

The staff team in this service have not had any neurodiversity training. They feel like they have a good amount of knowledge from lived experience and working with neurodivergent young people. Most young people who attend the service are neurodivergent. They feel that their understanding of PDA and 'crip time' informs them in order to offer adaptations to the service. They felt that they would welcome good quality, relevant training, but that it was not always easy to find and source this or to fund the training or the staff time to attend.

5. Barriers to support

The team was asked what they thought the barriers to young people accessing support were and these were remarkably similar to those of the key workers above.

- Parental mental health and generational trauma
- Services set up to do one thing rather than utilising a holistic approach
- High thresholds required to access support or must be in crisis
- Judgement and stigma, such as parental misunderstanding or feeling belittled
- Deprivation
- Services not being client led
- Young people being passed around services 'like a tennis ball' and resulting in them being lost in the system
- Stigma around men's mental health
- Young people being dismissed, labelled or categorised

6. Ideal Service

The staff were asked what they would add to their service to make it the ideal crisis service for young people. The points they felt they would include were:

- Have green spaces and own building
- Include a blended practitioner group
- Include therapy dogs and a crisis café
- Could involve residential or supported living options
- Utilise other services to work together and allow for referrals and signposting
- Incorporate clinical supervision and counselling free for staff
- Include a 16-25 age range for support that was not time bound

Section 2- Interviews

Interviews with Stakeholders from Ethnically & Culturally Diverse Communities

Interviews were held with stakeholders who targeted work with community groups from specific cultures. These communities often find mainstream services harder to access and may not have English as their first language. It was not possible to represent all community groups in the time and with the resources available and it must be recognised that each individual speaks of their own experience and not for all underrepresented groups.

Interviews were held with:

- The Chief Executive Officer (CEO) of a charity working with South Asian Women (SA)
- A member of a local Racial Equality Network (REN)
- The CEO of a charity working mainly with families of African descent (A)
- Two team members from a charity working with Gypsy and Traveller Communities (GT)
- Two staff members of a project working with the senior (aged 50+) Sikh community (S)
- An outreach worker from a crisis alternative service in a diverse city (O)

The demographics of those interviewed are not of significance in the same was as with other interview as they are speaking on behalf of their communities. However, the individuals above included men and women across a range of ages.

Interview Responses

1. Understanding Mental Health Crisis

All interviewees felt that there were poor levels of mental health amongst the communities they were a part of.

There was an understanding that 'crisis' was when people reached the state of **not coping** anymore and need immediate help.

> *"People face multiple barriers, including language, poverty, racism, immigration and finding culturally appropriate support. Rather than dealing with low level concerns this then escalates, and people end up in crisis." (SA)*

Unhelpful language- all interviewees agreed that using the term 'mental health crisis' was likely to put people off engaging with a service and that this is not a shared language.

> *"The word crisis is very scary for people. They would worry about who is going to get involved, what it might mean and whether they will be labelled." (SE)*

In some cultures, 'mental health' is confused with 'mental illness and seen as "*people that are crazy wandering the streets or in psychiatric homes." (A)*

> *A lot of people suffer with mental health issues but don't know it. They say there are 'Bad with mi nerves.' They don't understand that it is something you can get help with. (GT)*

2. Stigma and Stereotypes

Mental illness carries stigma and shame amongst all the communities represented here. This does vary and is changing within some groups. The Muslim women in the focus group earlier felt that generally women would be more accepting now, but not men. In interviews with stakeholders (SA), (GT) and (REN) there was a general feeling that attitudes were changing but that there were still a lot of barriers facing people.

There were mixed responses to how communities see neurodivergence. (GT) felt that neurodivergence was more accepted than mental illness and it helped explain things, but accessing support was hard. (SE) also felt that information on neurodivergence was getting out there through films and TV but that much more education was needed. However, (A) felt that within many African communities neurodivergence had even more stigma than mental illness and that education was

desperately lacking and (SA) felt there was very little knowledge or understanding of neurodivergence.

Stigma is really significant. People who access services live on their own. There is so much stigma about accessing stuff if others find out about it. (GT)

In Africa, mentally ill people are often Isolated from communities and treated as 2nd or 3rd class citizens (A)

"One of my neighbours threatened to send his son back to Kenya when someone suggested he may be autistic" (SA)

Religion is a significant aspect of people's lives and what religious leaders believe will be listened to.

You can't talk about mental health in the church – people will leave. It is a taboo. (A)

"Faith is a key core value. We spiritualise a lot of things. We may ask 'Can you curse the demons out of the child'. Pastors who are not mental health specialists and have very little knowledge are the ones being approached by families." (A)

People also feel stigmatised as members of minority communities, experiencing prejudice, racism and poorer services which contributes to heightened stress and poor mental health. This is not just from members of the public but from professionals and services

It seems that people are deemed 'hard to reach' such as Asian men, this is an excuse not to support them. I could walk through the city now and find men who are struggling with their mental health, but professionals are not prepared to do what needs to be done to access these groups who have lost trust in the system. (REN)

The attitude towards Gypsy and Traveller communities is in fact a 'Tolerated form of discrimination'…. All doors impact on their mental wellbeing (such as housing, poverty, physical health and stigma.). People are living with a lack of self-worth due to this. (GT)

3. Barriers to accessing services

There were a range of barriers impacting people's ability to access mainstream services and, it seems, few services that are tailored to the needs of specific communities. As mentioned in the section on stigma, the use of the language 'mental health crisis' immediately prevents large groups of people from either recognising the service is for them, or accessing it due to stigma, even if they did. The common themes were:

Lack of trust

Many people from these communities feel let down by services that have failed to understand or meet their needs in the past. That might be health services specifically, or a general distrust of mainstream services where they have been let down with a plethora of issues including housing, work, benefits, education and more.

The thinking "They don't understand me. How will they help and support me in the way I live" is ingrained from experiences of prejudice & oppression. (GT)

Parents who understand a bit then go to a whole lot of effort to get the support. They don't know the appropriate services, but when they finally reach someone, they are just told 'we don't support you because…' (e.g. right to work in UK?) (A)

Members of the Sikh community will only reach out to people they trust. We are where they are in their spaces and are well known within the community. (SE)

Lack of diversity

A lack of diversity in the workforce of mainstream services leaves people feeling that they are not understood or included.

If they walk into a space and see no one 'like them' amongst the workforce, or even using the service, they will not feel safe (SA)

There is a disproportionate lack of Black and Brown skinned people in leadership within the big organisations and bureaucracies (REN)

Language barriers and lack of service awareness

Language was identified as a barrier in many ways. Either the use of Eurocentric language which alienates and stigmatises, a lack of literacy in some groups and a lack of local community languages or translators in services. The outreach worker was clear that people had asked for physical leaflets in their own language left in discreet places that they frequent. However, there was no money for hard copies, so translated versions were only available online. This excludes anyone who is not digitally literate.

If someone is in crisis, they may be able to say 'help' but possibly nothing more, so could not access any helplines. (SE)

Literacy issues mean people aren't able to read publicity/ know about services (GT)

Language barriers need to be addressed, and an interpreter does not always work. sometimes there is no word in one language that conveys exactly how you feel in another. (SA)

Mental health providers use jargon… One woman had a diagnosis of Bi-polar, but no understanding of what that meant. No-one had sat down and shared with her the different phases of her illness. People don't explain in simple language. (GT)

Venue and opening hours

Interviewees noted that often people don't feel safe venturing outside of their local area / community to access services. This may be from fear generated from within (e.g. stigma) or outside (e.g. lack of trust / prejudice). Not speaking English or being frail limits people's ability to use public transport and when in crisis this may not be at all possible.

Getting somewhere that is not local or known to them would be a challenge (SE)

Men who work don't get help for their mental health at all. The only ones on our caseload were part time. (No holiday pay and no sick pay). (GT)

Transport … and even if this was provided (e.g., by cab), not wanting to be picked up / dropped off at home due to stigma. (GT)

Poverty, Prejudice and Intersectionality

Statistics show that people from ethnically and culturally diverse communities are disproportionally affected by poverty, discrimination, crime, poor housing and many other factors which impact on their wellbeing. Interviewees felt that people struggled with so many issues and had so much to cope with and do on a daily basis that even if they recognised a decline in their mental wellbeing it would not be a priority for them until it became a severe crisis.

People have so much on and so many struggles there is no time to get help with their mental health. (GT)
Refugees and Asylum seekers come to the UK from war torn areas having suffered trauma and abuse and when they get here, they often face language barriers and racism to get help (REN)
Within the UK Black people have to deal with a multitude of issues including racism, poverty, struggling with immigration and navigating the system. They may have issues with their children around special needs and schools. Then if you put a layer of mental health into it, that is just too much. (A)

4. Overcoming barriers and creating an accessible service

In analysing what interviewees said about overcoming barriers, a number of common themes arose. Generally, it was important to have services embedded in the local community with trusted members of the community delivering these, but this was not always the case. Sometimes people did not want their community to know about the issues they were facing. All the points under each heading were raised specifically by at least one of the groups.

Culturally competent, community-based services that are embedded in the community.

- People want local accessible spaces where they feel safe
- Everyone wants to be listened to and 'heard', and this is particularly important for people who do not feel heard in so many areas of their lives.
- Make discussions needs-based, not talking about diagnosis as this puts people off
- We have shared values and people know we are all working from the same understanding, this is crucial for gaining trust.

Familiar faces and shared values—trust is built through relationships and word of mouth.

- Frontline staff, demeanour, attitude is vital. People need to be relaxed, friendly, non-judgemental and welcoming.

Accessible, local spaces with drop-in options and clear, jargon-free communication.

- Parents and young people need to be able to access somewhere they are accepted and helped easily.
- These will often be run best by small local community groups
- There must be an easy front door process with no waiting (e.g. for a call back)

Peer support and lived experience are powerful tools for engagement.

- It is also very important to have neurodivergent people from diverse backgrounds as again people need to see themselves reflected in the team
- The idea of having neurodivergent community champions is a great one.

Choice and flexibility, including gender and age of staff, and in-person vs. phone options.

- Access to be able to speak to male or female and a mix of ages
- Some people prefer to talk to someone outside of their community

5. Awareness raising and education

Finally, every participant stressed the vital importance of education on both mental health and neurodivergence to the communities which they were representing. Sometimes this was just general awareness raising, but sometimes it was necessary to target particular groups to change engrained misinformation. One example given highlighted this. An interviewee had recently advocated for a 16-year-old girl who had brought concerns to her parents, but they didn't understand or recognise what was going on. They sought support from their pastor who prayed for her but didn't recognise that she was hallucinating. Believing that the prayer would heal her, her parents took no further action. The young person ended up in psychosis with over a month as an inpatient because no-one had recognised the signs earlier or looked for appropriate help.

> *It's about making people more aware. We need to up-skill schools, youth services and other places where young people go to help them to identify when someone needs support, particularly young people from the Global Majority Heritage communities. (REN)*

> *We need to educate religious leaders so that they can recognise mental health and that is our strategy … when we can get Faith and community leaders on board, it will cascade down to parents. (A)*

> *Education so that people know what neurodiversity is. Our staff would benefit from this (SE)*

Interviews with Stakeholders Working with Refugees and Asylum Seekers

Asylum seekers and refugees are a group of people who have, by nature of their status, a higher likelihood of having experienced trauma than the general population. At the same time, language barriers and no recourse to public funds makes it even harder for them to access help. Interviews were held with three staff members of a project working with asylum seekers, two of whom had initially come to the country seeking asylum, and one individual with refugee status who also arrived as an asylum seeker.

Demographics

- Neurodivergent, trans man from Eastern Europe
- Woman from Algeria, working to support refugees into work
- Man from Pakistan, now CEO of a charity working with asylum seekers
- Male staff member from project working with asylum seekers

Appendix 9 – Additional Detail of Focus Groups and Interviews with Staff

1. Understanding Mental Health Crisis

All interviewees emphasized that **mental health issues are widespread** among asylum seekers due to:

Trauma from their home countries and migration journeys, often compounded or continued in the UK through poverty, stigma and lack of support.

> *"Almost all asylum seekers experience poor mental health, they have experienced trauma in the country they have fled, and this has often been reinforced on their journey or within the UK."*

> **"***I work as an interpreter and see lots of people who have no sleep, are self-harming or even suicidal***."**

Isolation, lack of support, and uncertainty about their future. Asylum seekers do not know where they will live from one day to the next. They often have little or no English and are expected to attend appointments and exist with no recourse to public funds.

> *"Most people are dealing with so many practical problems that they just keep going… even if it is from one crisis to the next to try and stay safe and, in any way, well. Their mental health is not considered until they hit crisis point."*

> *"You can't talk about it when you need to, so you feel isolated. Lots of people struggle with anxiety and depression as it takes so long and you can't plan anything"*

Fear, especially fear of being misunderstood by authorities or doing anything that might jeopardise their claim.

> *"I suffered depression but didn't ask for help as I needed to protect my children. We don't know how the law works in this country and the fear of losing children is high. By my third child I couldn't feel happiness or breastfeed, but I kept quiet."*

2. Stigma and Stereotypes

All interviewees agreed that there was stigma about mental health and neurodivergence within their communities and that there was stigma attached to being an asylum seeker or a refugee which also affected mental health.

> *"People think you are an economic migrant, sitting at home looking after your children and taking benefit. This stigma is really hard, and it brings you down"*

> *"The general public (*in Eastern Europe*) doesn't think about mental health. They are more likely to focus on practical concerns or medical issues where there is a potential cure like cancer."*

> *"Due to stigma and attitudes my husband can't accept I have mental health issues. He will think it is his fault if he acknowledges them."*

3. Barriers to accessing services

Many of the barriers raised were similar to those experienced by people from ethnically & culturally diverse communities above. Where these are repeated, duplication of explanation has been avoided. Where they are backed by further quotes, these can be found below.

Lack of trust

"People need reassurance that they are safe and will not be reported to the government. Some people don't even want to give their name for fear of a gang reprisal."

"Even then (at crisis point) they are unlikely to seek out help as they wouldn't know where to go or trust in a service."

Language barriers and lack of qualified interpreters.

"Even depending on a translator is hard. You have no idea if they are translating right."

"People do not always want someone they may know interpreting for them."

Technology access.

Many people do not have a phone or access to technology when they first arrive. Even if they do, they may not be able to use the technology as their language knowledge may prevent them. They may not use the same script, so even typing into google would be difficult.

"There would be barriers for people accessing the crisis pad (crisis alternative) as they have to self-refer and may not be able to find the way to do this, or not know how to express their need, particularly with language barriers."

Cultural misunderstandings and lack of mental health awareness

This may be misunderstanding of mental health within a particular culture or misunderstanding of different cultures by Western practitioners.

"In most Post Soviet Union countries anything 'weird' or 'deluded' is classed as schizophrenia"

"Doctors in the UK aren't understanding of people's spiritual understanding and experiences which causes distrust."

"The majority of asylum seekers or refugees will just call their GP stating physical symptoms that are often related to their mental health. This is using up a lot of time and money and does not provide a solution."

4. Overcoming barriers and creating an accessible service

The main themes that emerged from all interviews were those of fear and lack of trust. Asylum seekers and refugees are facing multiple stressors daily, with many living in a constant state of heightened arousal. They have had to flee their home country and leave everything they know, often under traumatic circumstances. They are suspicious of any formal institution and have little knowledge of the UK system or our understanding of mental health. It is imperative that services are offered in safe spaces and in partnership with trusted organisations specialising in support to this

group. Any support needs to start by raising awareness and using appropriate language such as wellbeing and stress rather than mental health. It must include:

Qualified interpreters trained in mental health

Having a mix of ways in which interpreters will be accessed and ensuring confidentiality are crucial. Interviewees also expressed the need for interpreters to understand mental health and to be able to access the correct language to help people explain themselves.

> *"They (Interpreters) need to be available on the phone as people will not want to see others from their community and will not want to give details."*

Safe, welcoming spaces where people feel comfortable sharing.

These spaces must be staffed with people who understand the factors affecting people and the cultures from which asylum seekers may come. They must provide confidentiality and allow people to build relationships (see next point).

> "We also need quiet, peaceful and inviting places for people to meet face to face with people from a different culture."

> "It's very important to have an understanding of faith and what it can be good for."

> "They want to know that they won't have to disclose info on mental health if they go back to their home country."

Relationship-building with service providers to foster trust.

Asylum seekers are very unlikely to go to an unknown space with people they don't know. The spaces (above) need to be provided by organisations or people with whom they are starting to have a trusting relationship. Crisis alternatives would need to do outreach work into these spaces.

> *"Building relationships with individuals or at least an organisation so they know where to find help when they need it and some trust that they will be listened to and not judged."*

> *They need someone with experience who they can build up a relationship with and begin to trust*.

Peer support and community connection, such as through charities for asylum seeking people.

One person noted how difficult it was, coming from certain cultures, not only to have mental health issues but also to be gay, non-cis gender or neurodivergent. Given the statistics shown above and in other cited research that indicate higher rates of neurodivergence in LGBTQ+ communities, isolation and loneliness can be compounded for individuals who might be questioning their identity or neurotype. Masking neurodiversity or keeping their sexuality or gender identity hidden is common and connection with like-minded individuals can be critical in supporting mental health.

Awareness raising and education amongst asylum seekers, refugees and professionals.

Whilst most of the interviewees had little knowledge of neurodivergence, one had an in-depth understanding and was passionate about education. Offering education on mental health and neurodivergence to asylum seekers and refugees but also ensuring professionals realise the barriers they face and how they can best support people. Suggestions included:

- Explaining the social model of disability
- Spending more on educating people about mental health and overcoming stigma
- Educating medical professionals to explain what something means in detail and provide information
- Not assuming that people aren't neurodivergent when they turn up to services as they may not be aware.
- With children and young people, remember that you are working with their parents who may have much more outdated ideas.

Interviews with other stakeholders

Four interviews were held with stakeholders working with groups who experience mental health crisis as follows:

- A charity offering 'Mental Health Hub' support for young people
- A charity working with people who self-harm
- A charity working with people with sensory impairments
- A crisis alternative provider working with Deaf and hard of hearing people

The summary of these interviews can be found in the main body of the report. Most of this reinforced learning that has already been raised within this research and may be found in the discussion. Despite their different focusses however, there were some common themes which are highlighted below.

1. Understanding of Mental Health Crisis

All four stakeholders felt that, to their users, crisis would mean serious self-harm or suicidality. It appears that in these 4 organisations, people are already facing mental health challenges or other physical disabilities daily. Stakeholders explained that people with sensory impairments had social care involvement and that social care's view of mental health crisis was threat to life, which was generally taken on board. For these groups even psychosis was not seen as crisis unless it was leading to them taking their life. The mental health hub and the self-harm charity were seeing people (mostly young people) regularly for their mental health, so it was only when this escalated to psychosis or suicidality that it was felt beyond their service and hence crisis.

2. High levels of neurodivergence and LGBTQ+ young people

The two stakeholders providing mental health support identified higher than average rates of neurodivergence within their service users. The mental health hub felt that most of the young people who attend their wellbeing service are neurodivergent. They also noted that:

"We see a much larger number of LGBTQ+ young people and the combination of being trans / gender neutral and neurodivergent is big"

One worker also felt that in schools, for neurodivergent girls, there appeared to be a 'trend' that in looking for their identity, questioning their gender was a natural part of this. The attendees of their under 18 wellbeing café are almost exclusively trans or at least LGBTQ. For the post 18 group, there appears to be a divide between a similar group and another, culturally different group who don't understand the gender questioning issue and may find it threatening.

3. Acceptance of neurodivergence

Unlike many of the ethnically and culturally diverse communities these groups and communities were all very accepting of neurodivergence. People with sensory impairments can find that they suffer diagnostic overshadowing that means their neurodivergence is not necessarily recognised but put down for example to their blindness. However, if it was recognised it would be accepted.

4. Communication

Whilst communication has been raised continually as an issue for neurodivergent people, this is even more pertinent for those with sensory impairments. Poor practice was highlighted including:

6. Continually sending paper letters to visually impaired people and expecting them to turn up to appointments.
7. The digital base for getting help – not being adapted to visually or hearing-impaired people
8. Offering online support or groups that are not accessible
9. People who are hard of hearing find it hard to access services – needing a phone to make referral. Don't have enough varied ways to refer.
10. Asking the question 'do you have any access needs?' in an appropriate way, at the start of any interaction would be a very significant development.

5. Food as an issue

The project working with self-harm raised the point of food being used as a form of self-harm, and being an issue for some neurodivergent people, particularly women. The link between eating disorders and neurodivergence in young women has been established in research as well as many neurodivergent children struggling with ARFID. The point was made that sometimes-having food available in a common space could be triggering and that separating this was good practice.

6. Joined up working and knowledge of services

There was a general feeling that services were not well advertised or known about and additionally people did not find it easy to access lots of different services. Points included:

iii. more information and awareness raising to staff about crisis alternatives, who can access them and when was required. Crisis is a very misunderstood term.
iv. There is not enough information / joined up working between services to enable young people to move smoothly between them.
v. The main issues with deaf people accessing the Connect Service are awareness that it is available and communication

APPENDIX 10 – COMMENTS FROM NEURODIVERGENT PARTICIPANTS

The following statements and quotes were made by neurodivergent people either in questionnaires, interviews or focus groups. They are listed here to evidence each of the themes that emerged from the research.

i.'Offering me a safe space I can access'

- Sometimes I just want a **space to let everything out**, and for someone to make sure I don't go into a complete hole and use harmful tactics on myself.
- **Food or drink** available. A quite small room **I can go in to feel safe**
- **Feeling safe** is important, feeling noticed and **not being overwhelmed**.
- Room decoration is often way too busy with too many colours and patterns
- Not being cramped into a tiny room
- **Nice environment** not run down or clinical.
- Reduce expectations on the individual and **be person centred in adaptations** - some people might be sensory seeking whilst others avoidant
- I would be too heightened from being in a new environment to access the environment
- Would just be nice to be **asked if the lights are too bright,** if there's anything else can help me feel more comfortable.
- C/YP- **Letting me move about** as much as I need to. Not making me sit on hard chairs or looking at someone. Soft things to hold/touch
- A **quiet waiting space** away from other people
- *P/C* - A children's safe space to attend that is **not clinical** / Somewhere that feels calm and comfortable and definitely not clinical or sterile.
- All settings should have a room for individuals who need **a safe place to protect themselves and others** from violent outbursts.
- It would be important for me to feel comfortable if accessing crisis services and if the environment was **outside in nature**
- If the venue was in **nature/outside** that would be preferable
- Not having to wait in busy areas to see a crisis service. **As few people as possible** Awareness and acceptance of need to **stim or fidget**.
- **Snacks**. Playing with blue tac or something like it
- Being given various options, upfront, to access systems and **not just through telephone** calls/appointments/assessments.
- Often when I need to use a service is when it is closed or when everyone who I live with is asleep so I can't leave the house without waking them and alerting them to my crisis. Therefore, **having the service offer a nighttime text service** as well would be very helpful as it would mean that I would be able to access the service even if I am unable to get to it in person. I'd also prefer to access a local crisis service rather than a

national one as often the information and signposted services that national services provide are more generic and they don't have knowledge of smaller organisations near me that would be helpful.

- I **prefer face to face appointments** as struggle to read people via tone of voice and require a visual to read body language. Fitting this in when I work full time is very difficult. More availability in "out of hours" appointments would be appreciated.
- When I was in crisis, I couldn't travel anywhere. Taxis are stressful as I'm not in control of that environment. Other options may be important for other people to refer, but I can't use digital options. I need to get out of the house so **face to face is very important**.
- **Not having to use the phone**. A text service would be ideal, or email that is picked up as quickly as a phone call would be too difficult.
- A lot of services expect you to call by phone and this can reduce accessibility for individuals who find **phone calls difficult**.
- You need to know where to go and you **need to know the person or service beforehand**.
- **Bus stop location** for people who used public transportation other than taxis
- Support for me to get him there safely
- Finding the places is hard. There needs to be **more publicity**

ii. 'Communicating with me in ways that I can understand'

- Having a **pen and paper** around for if I feel I can't ask for something then I can still communicate
- **Pen and paper** but don't set it as a task just have it there. Not using complex language
- My inability to communicate at times of high stress and/or sensory overload is not actually me refusing to engage
- **Simple** to the point language
- C/YP: Explaining things in a certain way for me to **understand**
- **Listen** to what I'm asking for, not what is assumed that I need
- **extra time to process** and having a variety of options - at different times I may need different things
- Confirmation that staff **understand** that lack of ability to communicate e.g. going non-verbal isn't the same as not engaging
- Having **printed documents** printed on different colour paper to assist with my Irlen Syndrome. Giving me extra time to communicate if my physical disability is affecting my ability to in the moment
- Being able to give the person I am seeing my **written thoughts**/experiences/feelings that I have catalogued in the days/weeks/months leading up to my appointment and know that they will read them to understand and support me better.
- **Listen** - but I often shift from topics and can't always describe situations well, make me comfortable

- **Text based**
- Using **diagrams, charts and mind maps**. Using a flip chart. Not needing to repeat myself every time. Send no online surveys to ask for feedback - they don't help me and nothing ever changes. I can't access digital devices. People knowing more about delayed recall. (ADHD)
- The summary afterwards would be positive as long as it was a true account of what has happened. Many times, I have received letters or read notes about appointments that are untrue and I'm unable to change these. Please listen! **And please listen if I say I need someone I know with me.** There is nothing scarier than being in crisis and being trapped with strangers who don't understand and aren't listening to me
- Provide option of **physical text-based resources** to accompany any verbal advice/information/instructions given during the visit.
- I am able to take part in **face-to-face** environments, but unable to take part in online groups, for I can't process what is going on.
- People saying what they mean - in **literal language**.
- **Too many vague questions**. Or questions that are worded in a way as to get a specific answer out of me, like they want me to say something that fits within their criteria for supporting me.
- **Not being pressured** to answer questions immediately (selective mutism)
- Staff being very **patient** and giving me enough time to **process information** or questions and time to respond (not interrupting or prompting)
- If they asked me more questions and **told me the purpose of each appointment** as I kept visiting and having a chat, but a chat didn't seem helpful, and I don't know if they thought I needed their services less as I wasn't saying what they needed to hear but they didn't ask.
- A variety of options, **understanding that communication needs may vary** and I may need something different at different points
- **Symbols to hold up** when I'm feeling overwhelmed. When I need space, time out, support, or needing to leave the room, etc
- **Ability to use badges/visual aids** to express how easy it is to talk. I am a mostly speaking Autistic person, but crisis/distress and pain take away my verbal skills. I would like to be able to communicate this clearly.

iii. 'Seeing me for 'me' and treating me holistically'

- **No judgement**, open minded, being listened to and being receptive to what I say is an issue rather than what is assumed Not feeling othered
- Staff to have a **greater understanding of neurodiversity** in general and understand when people have multiple conditions and how this may affect how we process the world - I'm an autistic ADHDer also screened as dyslexic, I don't necessarily see that I fit what people expect of someone who had ADHD or who is autistic - I am unique please understand this.
- Posters on the wall making it clear that **LGBT+ people are welcome**
- Allowing me to feel a certain way about an issue **without being told that I am being silly** or that it isn't a real problem - allowing me to feel my own feelings and express them without

other people projecting their own opinions on the matter**.** If I know, allowing me to explain what I need rather than just assuming or offering me support - this is especially important with regards to my physical disability

- **Staff that are aware** that every autistic person presents individually and not make assumptions about me, my abilities or my needs based on outdated stereotypes.
- I **think all colleagues should be made aware** where possible to avoid issues as we all work different
- **Understand** everyone is different. One neurodivergent person is not the same as another.
- Create a **'menu card'**. In hospital do it for food. Instead, it could be for everything you can have /do and have lots of detailed options. To not be constantly grilled about symptoms and what they are
- **Understanding** situational, non-speaking (selective mutism) is crucial.
- A **reassurance** that my crisis *is* a crisis - e.g. I'm not suicidal or likely to hurt myself or others, but I can't do simple daily tasks like figure out what to eat from the cupboard (even food that doesn't require preparation) or pick out clean clothes or keep myself clean, because I'm too overwhelmed/distressed/don't have the mental resources to do so at that time (and don't get support with this - so not like, this is my usual and I have scheduled support that helps me with this, but like, I have become unable to function in looking after myself and I don't have the capacity to fix this)
- **Knowledge** that even though I do not ‘appear’ to have many needs in terms of my autism and ADHD diagnosis, when in crisis or overwhelmed I lose many of my usual skills and sensory issues become extremely heightened. Having to say I am autistic is a challenge so if this was highlighted on my notes this would be easier. **Don’t assume** that every autistic person needs the same accommodations, ask if it’s not clear and **listen** if something isn’t working
- To be treated with **care and compassion**. I'm seen as high functioning and used to be a mental health nurse. A lot of bad life events lead to crisis point and dismissal by mental health services. I've had on my notes autism and ADHD not confirmed on GP records, not believed or treated in the way I need to be to recover and get well
- **Better autism trained staff.**
- Some sort of **visual acceptance of something LGBT**-related always helps. Even if it's just leaflets for MESMAC or something. My GP has absolutely nothing - the practice manager is known to be transphobic, but I worry that other places are starting to remove LGBT-related material for fear of offending other groups or for being seen as "political".
- I'm lactose intolerant so it's always another layer of stress when finding places in public to eat or drink.
- The hub do games night for people like me, it is great
- **Understanding** when I struggle to speak and verbalise, not getting angry and assuming I'm doing it on purpose or that I don't want to talk **Being aware** that when in crisis I struggle even more to process things and need things simplified and reinforced to make sure I have understood. Writing things down for me so I have a visual reminder even if it's things that seem really straightforward to someone else Not expecting eye contact or clear

communication Patience! No awkward silences, this makes it harder to talk **Not judging me** or assuming they know the reason I'm acting a certain way

- **Focus on what I am telling you** I need, not how well I look or seem to be coping on the outside. I can look like I'm coping and handling everything amazingly, but if I'm asking for help it's because I am desperate. **Listen** to what I'm asking for, not what is assumed that I need
- **Understanding** the impact of late/misdiagnosis with certain groups of Autistic people and how the process of unmasking can often bring up crisis
- **Actual knowledge** not surface-level knowledge. If no personal experience of neurodivergence then taught by people who are etc.
- I think **lived experience** is vital - even if it's just one member of the team that can share that experience and insight with others, I would be massively offended if a crisis service that is there to support me only had a basic awareness - **ALL frontline services need to do better** than this,
- Lots of basic mindfulness techniques etc will not work for people with ADHD**. Be aware of this** and have techniques at hand that are more likely to work with ADHD. Be aware that most people with ADHD who have accessed any service before will have been handed lists of unhelpful coping tools
- **Knowledge** on flashback management and dissociation/ dissociative disorders
- **The ability to take on board any suggestions/criticisms/feedback** without taking it personally and use it to benefit their approach in the future with myself and any other patients they see.
- There's no point to having services which aren't **trauma informed**. It's like a sticking plaster on a sucking chest wound
- **Understanding diverse groups** - **Learning** about breadth and depth of sensory input and how being this affects you as a neurodivergent person. Staff having **self-awareness** is vital. They must also have curiosity and an interest in people. A desire to **improve their knowledge**. Need to better **understand** neurodivergent stress.
- Use the correct terminology- e.g.- Not referring to autism as an 'illness'
- I think all staff who work with autistic individuals should be **trained often and listen to autistic people t**hemselves.
- Not within these services specifically, but I've met people who simply aren't aware of how exactly the recent supreme court ruling has affected the mental health of trans people. I've also met people who aren't aware that the Labour party and the government in general is anti-trans and how much of an effect this is having on the mental health of trans people too.
- Know how different methods of communication affect neurodivergent individuals

iv. 'Involving me in a process in which I can feel safe'

- **Written information** where possible, and **time** to read it
- **Questions in advance**

- Details of who else might be there/how many people
- **A video tour explaining the service** which can be readily accessed online, perhaps tick box section to help indicate when it is a crisis - I tend to catastrophise a lot so end up either accessing help when I don't need to or recognise I might be catastrophising so don't seek help and then find out I probably should have
- Before attending - **Clear outlines** of how long a session lasts, what a session looks like, what happens after the session
- **Understanding** that I may appear very different in crisis/when overwhelmed and that being heard at this time is important so that I can trust you
- **Being told when things are happening** or planned to happen so that I am able to prepare myself for it without it being sprung onto me without warning. This is especially important with regards to if I have to use/do something which requires a buffer time to work
- The chance to **look around** when I'm not in crisis
- Having access to crisis service facilities outside periods of crisis so that you can establish it as a safe space **ahead of time**.
- Having **information** about the buildings fire drill day/times to reduce anxiety.
- Being **reassured** that I am in the right place is important but being reassured that I'm not wasting people's time isn't.
- Being told how long the wait will be if there is one **Knowing when and why things are happening** Knowing how to access a venue, what it looks like, what happens inside and where the exits are. What is around the venue as well as what is inside
- I think I was informed of places they had tried to refer me to but had rejected my referral because they felt it was due to my unmanaged ADHD and the ADHD service wanted me to wait ages so there was nowhere to turn which actually made me more poorly and I wasn't able to verbalise this
- **Not to be seen on a one-to-one basis** and to have a witness as mainstream mental health staff have bullied and overwhelmed me causing loss of communication with them and causing increased risk. Classing it as behaviour rather than sign posting involving a more suitable service.
- Being given the **time and space** to explain how I feel, no one trying to predict or enforce their assessment. Not finishing my sentences
- Being given **time to process** questions without judgement and an understanding that I may not know what I need and this is not me trying to be difficult.

APPENDIX 11 – EVALUTION OF PILOT TRAINING

Introduction

The pilot training was developed with learning outcomes derived from the results of the Inclusive Crisis Alternatives Research. It took place over 7 hours in two sessions. 17 participants completed the course with 13 of these (76%) completing both pre and post course questionnaires. The results below are from comparing these two questionnaires. A further follow up survey was sent after 6 weeks to review the resources.

Results

1. Knowledge of Neurodivergence

Participants were asked to rate their knowledge of the following aspects of neurodivergence before and after the course:

- Basic understanding
- Sensory processing and the seven senses including alexithymia
- The double empathy problem
- Masking meltdowns and shutdowns
- Rejection sensitivity dysphoria
- Executive function differences

After the training people rated their knowledge of neurodivergence as good or very good in 97% of responses

The options for both times were Poor, Ok, Good, Very Good. Each was allocated a score as follows:

Poor =1

Ok = 2

Good = 3

Fair =4

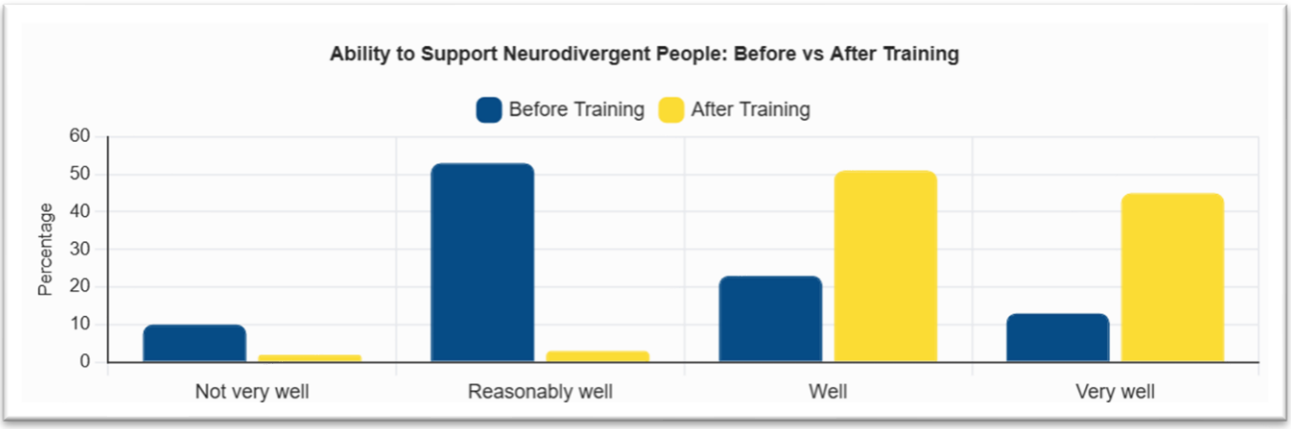
Differences in knowledge were calculated by subtracting the pre-course score from the post core score. This showed that:

- Where an increase in knowledge was possible[60], **93% of responses increased by at least one level**
- **32%** of the responses recorded an increase in knowledge of more than 1 point
- One response recorded a decrease in knowledge of 1 point from very good to good. This may be due to the individual realising there was more to know than they first thought.
- 100% of responses recorded an improvement in understanding of the Double Empathy Problem.
- After the training **97% of the knowledge ratings were Good or Very Good**. Only 3% (2 responses) were OK.

[60] This excludes any responses where the pre-course questionnaire recorded very good, hence no chance for improvement. If these were included 82% of the responses recorded an increase

2. Ability to provide good, appropriate support

Participants were asked how well they thought they were able to offer high quality support to neurodivergent people in crisis before and after the training[61]. The chart below shows how the results compare.



The chart shows a strong improvement with 'well and 'very well' increasing significantly after the training. Along with a large reduction in 'not very well' and 'reasonably well' after training, the overall pattern indicates training had a **very positive effect** on confidence and capability.

3. What participants valued most

Participants were asked what the most helpful part of the training was for them. The most common responses were:

- Learning from lived experience and hearing / sharing stories
- The resource pack and the chance to try it out

Other responses included: having a checklist to implement in the service, using case studies to look at the pack, and gaining a general understanding of neurodivergence.

4. What participants would change

Participants were asked what they thought would improve their experience of the training. Responses that came up more than once were:

- More time – it felt rushed
- More interactive experiences/ time for group discussions
- Providing the pack (or excerpts of it) before the training
- Printed out slides or handouts to make notes on

Other responses included: Keeping participants on task (first cohort only!), a more streamlined presentation and going through the booklet methodically.

[61] Only 6/13 participants responded to this question on the pre-course questionnaire. All 13 responded after the course.

Conclusion

The quantifiable results show that the training improved people's knowledge and confidence to deliver a high-quality service to neurodivergent people. The content of the course was seen as relevant, and the resource pack was valued.

In terms of improvement, the evaluation would suggest the following adjustments:

- The theoretical input delivered by PowerPoint should be streamlined and take less time
- More of the learning should be through group activities
- Ideally the course would be slightly longer to allow more time for discussion
- The case studies (only used in the second cohort) should be strengthened and added to.
- Lived experience needs to remain central to all delivery
- There should be more supporting materials provided (e.g. the pack before the course and the slides/ handouts during it)

APPENDIX 12 – GOOD PRACTICE CASE STUDIES

Section 1b- Provision for Young People

Service Name:	**Leeds Survivor Led Crisis - Safe Zone**
Provides for:	Crisis Alternative support for young people aged 11-17
Place:	Leeds
Partnerships with:	CAMHS
Website:	Leeds Survivor-Led Crisis Service » Safe Zone

Safe Zone is a free, on-the-night face-to-face mental health crisis support service for **11–17-year-olds** and their **parents/carers.** Statistically, **90% of CYP** using the service identify as **neurodivergent**. It has been designed with feedback from young people and meets most of the criteria they would like to see in a crisis alternative service in that:

- It is in a **non-clinical welcoming** building with one room designed with feedback from children and young people. Every area has access to sensory equipment and offers adaptations. Young people are shown around and offered a drink and a biscuit when they arrive (If they are up to that). This mostly gives them time to feel more comfortable.
- The provision is for **11–17**-year-olds which CYP felt was a good age range, although more support for those aged 18+ is needed.
- It **offers holistic support** addressing mental health and supporting with practical needs where these impact on their wellbeing.
- It offers support **before during and after crisis**, young people are encouraged to call before they reach crisis point and can have a preventative appointment to avoid escalation. They are also encouraged to come back for support after the crisis has subsided. The aim is to prevent future crisis.
- All staff are **survivors of mental health** issues who are chosen for their ability to relate to children and young people.
- Support is offered to the **whole family**, **but CYP are always asked** if they want their parents or carers to be in with them at every stage. **CYPs voices are listened to,** and workers will look out for any potential pressure on them by parents and carers.
- As the whole family is welcomed and worked with, if necessary, this is **appealing to a wide range of cultures** who may be family focussed.
- Although CYP cannot just drop-in due to capacity and safety, there are **multiple communication options:** text, chat, email, phone.
- It is advertised well in schools, with staff doing outreach visits and encouraging people to visit when their **wellbeing is getting worse**, not just to wait for the crisis to happen.
- Professionals are invited to come to the service and visit.
- **Pathways from CAMHS and Accident and Emergency** are diverting more young people there and feedback is that they prefer the support there.
- **Taxis** are provided to and from the service if needed.
- Clear, accessible information and predictable processes.

- Inclusive representation in staff (gender, race, neurotype, sexuality).

The service manager identified the following things that would improve the provision:

- It is only open two nights a week due to funding and this limits when people can get help
- The building is shared with adults on other nights of the week, preventing it from being as CYP focussed as they would like.
- As the service is getting busier, they sometimes have to tell people there is no room that day which they do not like doing for trust and continuity.

Section 2 – Service Case Studies

Service Case Study 1

Service Name: People Focussed Group (PFG)
Provides for: Crisis Alternative and ongoing support
Place: Doncaster- based in Intake (near the city Centre)
Partnerships with: NHS (RDaSH), South Yorkshire Police and Yorkshire Ambulance Services
Website: peoplefocused.org.uk

Background

PFG is a Peer Support Charity running three main services, the Wellness Centre, Safe Space Crisis Alternative Service and Better You, a service working with young people referred during a crisis, most of whom are neurodivergent. The Wellness Centre is the heart of the community and everyone attending is encouraged to give back as part of the receiving and healing process.

Service Offers

1. Wellness Centre

Delivery: The Wellness Centre operates Monday to Friday from 9am to 4pm, and additional community groups use the space at weekends, ensuring a consistent presence in the community every day. It offers a wide range of services encouraging every user to be involved in giving back however they are able. This might be doing odd jobs about the centre, cooking meals, or befriending lonely neighbours. This solid core service allows for users of Safe Space and Better You to access a range of community-based support which prevents further escalation. Some users I met even travelled from Rotherham as they felt the service was so good.

One neurodivergent woman who describes her 8 years struggling with NHS services here and is now volunteering for Safe Space says: '*Compared to the past decade, the People Focused Group (PFG) has been offering me more actual person-centred support and a place to rant about the mental health team. They gave me a place where I didn't have to feel alone in all of this'.*

Age Range: The service works mostly with adults but also with children / young people in different projects. It has just secured funding for 2 Children Wellbeing Practitioners for the next 3 years.

Results: See some individual case studies below. Many people claim their lives have been turned around or even saved as a result of their involvement.

Reach: The service is very well known in the community and local demographic is well represented. This is a largely white British area, and this is reflected by service users.

Outreach: PFG employ Community Connectors, to support the culturally and ethnically diverse and LGBTQ+ communities and work directly with an independent Veterans Group that was initially set up by PFG, and Choice for All Doncaster (CHAD), a community LD/Autism Group

Capacity: There is no 'capacity' as such as there are a range of services, many delivered by volunteers and peer support workers.

Uptake: The service is thriving and could always offer more if resources were available.

Staffing: Most staff are members of the local community, and everyone feels they contribute to the success of the service. There is a real sense of community ownership.

Benefits for neurodivergent service users:

- The service offers a place to find friends, be accepted and belong. It does not have a beginning and an end and will accept people back after periods of being away. This is a major benefit to neurodivergent service users.
- Users are encouraged to give support and feel they have a purpose. This kind of support is **particularly valued by men** and was evident with men to whom I spoke.
- The ability to drop in and ask for support rather than have to use the phone or technology is valued.

Disadvantages for neurodivergent service users:

The drop in element of the service could also be overwhelming at first as the service is busy with several things happening at once.

2. Safe Space

Delivery: Safe Space is a crisis alternative provision, open every day of the year from 2pm to 2am. Referrals all come through the crisis team, police or ambulance service. However, as people can drop into the Wellness centre during the day, they can often be supported to access the service through this route if necessary. When a referral is received, the person will be contacted immediately by the team to explain the service and gather any further information required to begin the development of a support plan. A further call or face-to-face meeting will usually be arranged within 48 hours. The support plan, which will involve other relevant agencies includes **up to 12 weeks of contact**, giving plenty of time for the crisis to subside and further preventative measures developed. This may include involvement with the Wellness Centre or Better You.

Age Range: 16+

Uptake: The service is very well used, with 926 referrals in 2025.

Capacity: In 2025, the service supported 1,157 people face-to-face supports and delivered 20,575 phone supports.

Partnership: The partnership with RDaSH is extremely positive with Safe Space staff having access to service user records which dramatically helps risk management and support.

Outreach: Safe Space is advertised as one of PFGs services. See connections above.

Staffing: Many staff members are grown from the local community. Staff are well supported with monthly 1:1s and external support is brought in if required.

Benefits for neurodivergent service users:

- The 12 weeks of support and holistic interagency working enables neurodivergent users to receive support in a joined-up way and to receive consistent support over a longer period.
- The Wellness Centre is based in the same building and can provide ongoing support, support the development of skills for life and work and give purpose to any individual who chooses to engage.

Disadvantages for neurodivergent service users:

Having to use a phone to call the crisis team is difficult for many neurodivergent people.

3. Better You

Background: The idea for Better You was born out of the number of young people attending Safe Space. PFG didn't want them to become entrenched with older people who may not have worked for years, but to empower them to manage their mental health and to have the same opportunities in education, careers and leisure activities as any young adult.

Delivery: Better You provides tailored support and daily activities for young people aged 16-25 who have experienced or are experiencing a mental health crisis. It is based on a youth work model of education, empowerment, participation and equality of opportunity. Young people can attend daily or as many times a week as they feel they need. It is open 10am-4pm Monday to Friday extending to 7pm on a Tuesday. There are a range of activities on offer which aim to build emotional resilience and confidence, promote positive lifestyle choices, reduce social isolation and develop skills for life and work.

Age Range: 16-25

Uptake: The service receives referrals from a wide range of agencies including Safe Space, CAMHS, Inpatient Wards, Accident and Emergency, colleges and self-referrals. It is well used particularly by neurodivergent young people who find it accepting and accessible.

Benefits for neurodivergent service users:

The case study of an individual young person below gives good examples of these:

Charlotte *

Charlotte is a 19-year-old young woman with autism who has been attending Better You for 15 months. Before coming to the project, she had been in hospital 28 times with 3 sections. Since attending 'Better You' she has not been back in hospital.

Charlotte was diagnosed as autistic when she was first sectioned and admitted to hospital at the age of 15. She says it was a very scary experience that traumatised her. In her words 'they beat me up'. She was restrained and did not understand what was happening to her or why she was being taken away from her parents and held against her will. She says they locked her in a padded room on her own and she can't trust hospitals or nurses as they are

‘very tricky’. She did say there was one nurse who supported her and helped her to complain.

Katy, the staff member at *Better You* who works most closely with Charlotte, explained that it took around six months to build a trusting relationship, as Charlotte was initially reluctant to trust anyone. Although Charlotte attended daily, staff noticed her mental health beginning to deteriorate, and as her condition worsened, they had to limit her attendance to ensure her safety and that of other young people. Despite this, Katy continued providing intensive one-to-one support and advocated for Charlotte with the Community Mental Health Team (CMHT), ensuring she received appropriate care and medication. Katy attended appointments with her and made sure her views were heard, which was crucial in securing the right support and preventing hospital admission. However, Katy noted that the CMHT seemed resistant to her involvement and did not fully understand Charlotte’s needs as a young autistic adult struggling to communicate or process what is happening during a crisis.

Charlotte feels that people only see the negatives and see her as a problem, but told me that at Better You, “*people see the good in you, and you can help others”*

She told me that Better You had really helped her to get better and that having Katy to support her was much better than having her mum who got too involved.

People Focused Group, Doncaster is a Peer support organisation where ‘*everyone is a member and a peer supporter’.* It offers three main services which all complement each other.

1. The Wellness Centre. Open to anyone wanting to improve their wellbeing. It offers a wide range of activities which are all delivered by members.
2. Safe Space – the crisis alternative service, based in the same building but with separate access. It is gatekept by the NHS Crisis Team and relationships are excellent.
3. Better You – a service supporting 16–25-year-olds who have experienced or are experiencing mental health crisis. Most young people attending are neurodivergent. There is no limit to length of support.

The main points to highlight about this amazing organisation is:

- Everyone involved feels an important part of the organisation, gaining self-efficacy and self-esteem through giving as well as receiving.
- Although people referred to Safe Space (crisis support) in an emergency might not get involved in the wider organisation, even this service is built on a peer support model.
- The Crisis Alternative Service offers a soft ‘12’ sessions of support. This is particularly good for neurodivergent people due to social, communication and executive function differences.
- At the end of the 12 sessions at Safe Space, or even before that, people can get involved with the Wellness Centre which offers them support and the opportunity to contribute.
- Better You works on youth work principles and enables mostly neurodivergent young people who are struggling to get into work or continue with education, support to manage their mental health and achieve. It gives one-to one support as well as opportunities to develop self-esteem, self-efficacy and new skills.

Whilst it is a local charity, based in Intake, people travel from all over Doncaster and even further afield to access it.

Service Case Study 2

Service Name: Everyturn – **Together in a Crisis (Tiac)**
Provides for: Crisis Alternative
Place: Several places across the North East.
Partnerships with: Everyturn has internal Crisis Hub service and external partnerships.
Website: Everyturn Mental Health

Background

The service launched as a pilot in Newcastle in 2017 after NHS crisis teams observed that many individuals presenting in crisis had non-clinical needs contributing to their deteriorating mental health. To address this recurring "revolving door" pattern, the TiaC model was introduced. The pilot was independently evaluated and demonstrated excellent outcomes. The service is now commissioned by 6 local authorities in the North East. Some only take referrals from the NHS Crisis Team, whereas others accept self-referrals.

Service Offer

The Service offers 12 sessions of support, once a week, to address practical issues such as housing, finance, relationship breakdown, drug and alcohol problems or social isolation. The website explains the service as:

> *This service is here to support you with active, empathetic listening, helping you develop coping strategies, problem solve, and connect with local services and resources. We can support you if you are in a mental health crisis caused by practical situations that are impacting your life.*

Delivery: After receiving a referral (multiple options for this) first contact is made over the phone within 48 hours but can continue by phone, virtually or face-to-face as required. At the first appointment, within 5 working days, the service user will be fully involved in creating a 12-week plan. The same worker (leave and sickness excepted) will take each session, building up a rapport and working at the client's own pace. Peer Support workers are also employed and can be engaged, if more appropriate, or give continued support for issues such as anxiety management or social isolation.

Age Range: This is an adult only service from 18, but uptake of young adults is good due to outreach with the university and local colleges.

Results: The service uses the nationally recognised 14-point WEMWBS[62]score with **89.2%** of service users showing an **improvement** in their score at the end of the 12 weeks.

Reach: The service does not advertise much due to current service demands. Statistically, the demographics of service users represent the community in gender, ethnicity and age. However, Everyturn recognises that as marginalised communities suffer more with their mental health, they might expect higher numbers of certain groups. They are committed to addressing this, but resources make it difficult.

[62] The Warwick and Edinburgh Mental Wellbeing Score: WEMWBS

Outreach: This is largely through professional agencies and social media in areas with self-referral.

Capacity: Services vary in size in each area from 1.6 FTE (full-time equivalent) staff in South Tyneside to 10.6 in Newcastle. All FTE members of staff have a caseload of 25 clients. However, Newcastle also runs a Safe Haven with staff working across both services, hence having lower caseloads for TiaC.

Uptake: The service is generally running at maximum capacity or is oversubscribed. In all the areas taking self-referrals, the service has had to close to new referrals at some point.

Staffing: The service is commissioned on an annual basis, and this can cause staff to become unsettled and leave. Everyturn does give a great package of support to its staff.

Benefits for neurodivergent service users:

- The service offers a longer period to build up a trusting relationship with the service user, offering the same staff member for 12 sessions.
- In Newcastle, the service is linked with the Safe Haven, meaning people initially attending the Safe Haven can usually be given the same staff member at TiaC if they prefer.
- Neurodivergent users say they like to have their support broken down over a longer period as it gives them time to process and take in information one step at a time.

Disadvantages for neurodivergent service users:

Most of the support is delivered over the phone as that allows the service to maximise capacity. If everyone asked for face-to face, the service would not be able to meet its targets. As this is the expected form of support, neurodivergent users would have to specifically ask for face to face which they many not feel confident to, or know they can, do.

Service Case Study 3a

Service Name: Welcome House
Provides for: Asylum Seekers and Refugees
Place: Hull
Partnerships with: HEY Mind, Hull Help for Refugees, The refugee Council.
Website: Home - Welcome House

Welcome House was set up in 2020 during Covid by Bashir Siraj who has lived experience of being an asylum seeker and working within the voluntary sector. The aim of the service is to address the immediate and changing needs of asylum seekers. During Covid this demographic were hit very hard and the funding was available to offer support. It has continued since. (In contrast to what the Muslim women from Peel House were saying).

Bashir says that there is a lot of good will in Hull to newcomers, but there is also hostility. This was seen most recently in the riots a couple of years ago. By getting volunteers from the local community involved and by encouraging the asylum seekers to participate in their community, these

relationships can be improved. They do community activities such as a litter pick or a community picnic.

Welcome House centre is now open 6 days a week to the general asylum-seeking population and is used by the Ukrainian society on a Saturday. It offers a place where they can sit and socialise in safety without any fear of prejudice. They are offered hot drinks and culturally appropriate refreshments. They now have sessions for women only, men only and joint sessions. They work with Hull Help for Refugees who have a room at the centre and sessions where they give out practical help (maybe clothes or other necessities) and advice. The centre has partnerships with a wide range of agencies who provide sessions including HEY Mind and the Refugee Council.

They have recently begun to expand to East Riding and now have drop-in to sessions in Beverly and Goole. They have also been approached by the local council in Grimsby.

Bashir feels that most people are struggling with their mental health, but that they are so busy holding their lives together that they neglect doing anything about it and just struggle through. He says refugees can sometimes be seen to have deteriorated badly and are found wandering the streets extremely unwell. Welcome House, in providing practical and emotional support contributes greatly to improving people's mental health but it is often not enough. Partnerships with organisations such as Mind who can hold sessions there or have outreach workers building relationships are important.

Tackling the environment in which people live is also a priority as mental health is undoubtedly improved by positive environments, particularly with green space. Bashir has been in contact with Erica Daley (Place Director for ICB) to see if there could be some money / partnership to address this.

Welcome House works in a holistic way to tackle the root causes of issues with Asylum seekers such as employment, housing and the asylum system.

Quote from Bashir:

"*Our service users are often seen as a liability, and we want to turn that into an asset"*

Service Case Study 3b

Service Name: The Warren Youth Project
Provides for: Young People aged 16-25
Place: Hull
Partnerships with: Mathews Hub, Welcome House, HEY Mind
Website: The Warren Youth Project | A place for young people

This service will be shown through the journey of Zane

Zane is a 22-year-old autistic trans man with ADHD and dyslexia who has also been a young carer for most of their life.

Diagnostic Overshadowing: Zane has tried accessing CAMHS and CMHT but with no success. Zane feels as though being trans is something that stops them getting the appropriate mental health support. Their GP tells them that their mental health is because they are trans and when they get a 'diagnosis' and hormones, it will sort itself out.

Involvement: They found The Warren Youth Project in Hull 4 years ago through a leaflet for the LGBTQ+ group at Freshers Fair. They describe The Warren as a **neurodivergent friendly**, welcoming place offering caring support as well as a wealth of opportunities.

Since then, Zane has become a youth representative on the Warren Board and been involved in a range of groups including 3 targeted at neurodivergent young people (a gym session, an art group and a silent book club).

Partnership: They told me that The Warren has enabled them to recognise that they are worthy of support and helped them to access assessments for Autism and ADHD. This was done through a partnership with **Matthews Hub**, a service specifically for neurodivergent people aged 13+ in Hull. They were also encouraged to see all they had done in caring for their mum and to join a **young carers group** and access benefits.

The Key to Good Support: I asked Zane how / why the Warren supported their mental health and they told me the following things were key:

- The service is youth-led, with no pressure. You can join in as you like and bring your ideas to life.
- The staff get to know you, and you have a relationship with them, so there is continuity of care. They will give you ‘10 minutes’ whenever you need it.
- It is very accessible with minimal paperwork or questionnaires to do
- The counsellors (they have a counselling service for young people) are excellent with neurodivergent people. They check back with you that they have understood you properly and if not, they give you the chance to explain it again
- Stimming is understood and encouraged, and you can stim with your hands without people assuming you are nervous. Fidget toys are always available.
- The support carries on for as long as you need it. They don’t turn people away.

Holistic Support: Zane got a place at Hull University to study Medicine after COVID, but with very poor A-level results. They were diagnosed with dyslexia early on but failed their second-year exams due to this and caring responsibilities. When Zane got the results and just didn’t know what to do, they came straight to the Warren to offload. After plenty of support and opportunities they are back on their feet and hope to eventually get a law apprenticeship.

Zane says:

“This place has been an absolute Godsend for me – I don’t know what I would have done without it for the last year.”