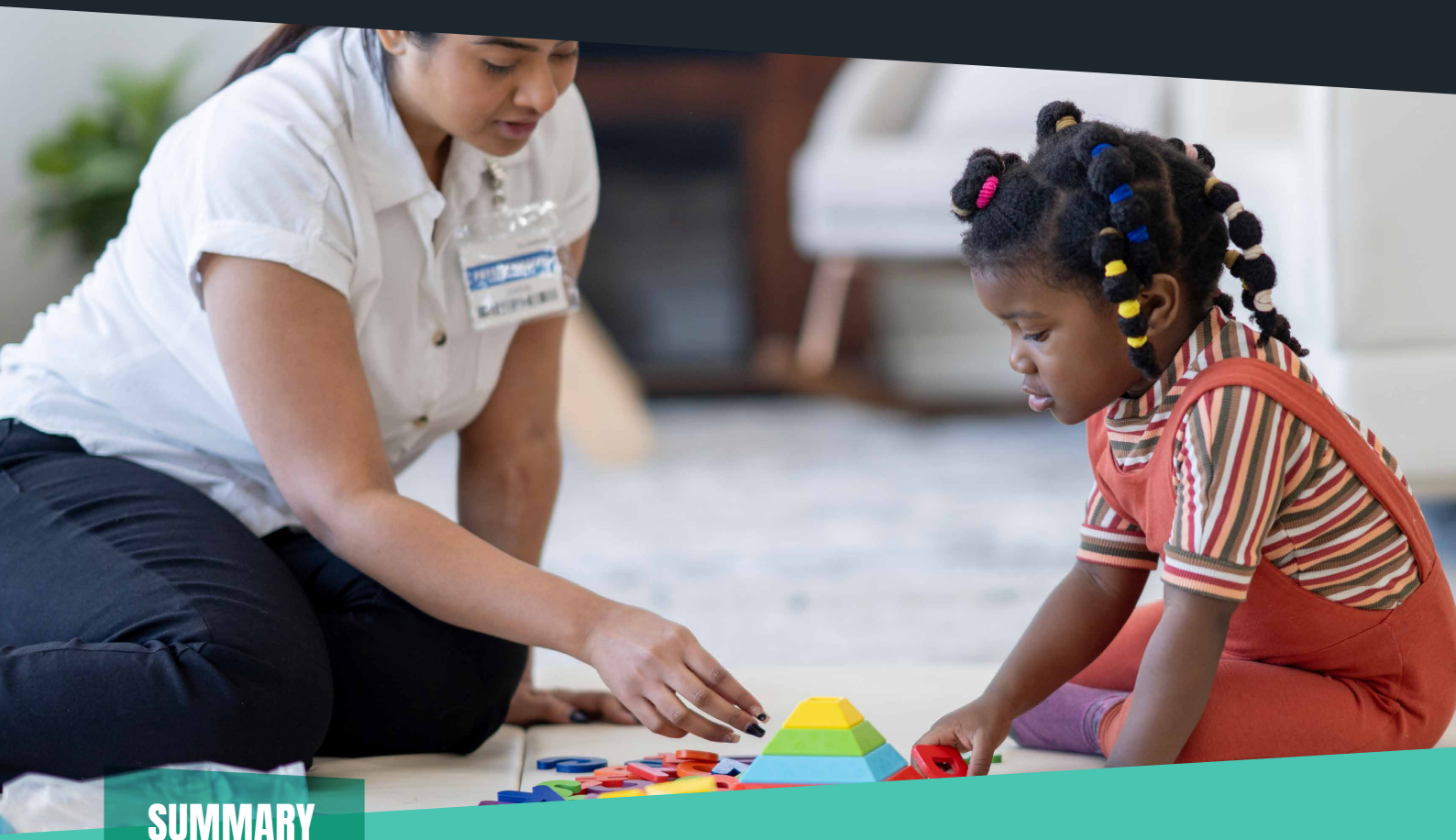
BRIEFING 65

University of York
The York Policy Engine

Centre for Mental Health

STRENGTHS-BASED SUPPORT FOR NEURODIVERGENT CHILDREN AND YOUNG PEOPLE

EVIDENCE FOR REFORM



SUMMARY

Neurodivergent children are more likely to experience mental health difficulties when their needs are not understood or supported. The problem is not neurodivergence itself but the lack of adjustment in schools and services. Many interventions assume a single way of thinking, learning and communicating. This creates barriers and leads to distress. When support is adapted, outcomes improve.

This briefing is a summation of work carried out by the Children and Young People's Mental Health Policy Research Group and its partners based at the University of York and covers research published since 2018. In drawing upon this body of research, this briefing – the first in a short series – explains why many neurodivergent children and young people experience high levels of distress and why current mental health support often fails to meet their needs. Neurodivergence – a term which refers to people whose brains process information in ways that differ from what society considers typical – includes autism, ADHD and developmental language disorder. These are not mental health conditions, yet many neurodivergent children face anxiety, depression, sleep problems and low self-esteem. The research we used for this review mainly focused on autism. Research shows that between 40-70% of autistic children experience at least one significant mental health difficulty. Rates are higher for autistic girls and for children from racialised communities. Many also face bullying, family stress and school environments that do not meet their needs.

Standard mental health programmes often do not work well for neurodivergent children and young people. Such programmes rely on extended periods of talking, abstract thinking and verbal reflection. These approaches assume a neurotypical way of processing information. They expect children and young people to name feelings, focus on internal thoughts and change patterns of thinking. Many neurodivergent children and young people find these tasks difficult or stressful. Some experience sensory overload or struggle to explain emotions. Others face barriers linked to language or communication. As a result, engagement is low and any benefits are often short-lived. Some children and young people feel pressure to hide their distress, which can lead to burnout.

Play-based therapies use shared interests, visual learning and sensory activities to support communication and emotional growth. Many neurodivergent children and young people learn through repetition, movement and hands-on exploration. For children and young people with speech, language and communication needs, play can offer a way to express feelings without relying on words. Studies show that these approaches can reduce distress and improve peer relationships, although more large-scale research is needed.

LEGO®-based therapy is one of the most promising examples. Research shows that it can improve social skills, reduce isolation and support emotional regulation. It is low-cost and can be delivered in mainstream schools. It does not replace other forms of clinical care but offers an early form of support that many children and young people find engaging. Evidence also suggests that it can help children and young people with developmental language disorder, who often face high levels of anxiety and depression but have few tailored interventions available to them.

New sensory technologies are now becoming available that can offer novel ways to support neurodivergent children's mental health. Early studies show that virtual reality and sound-based tools can help children and young people manage sensory sensitivity and anxiety. These tools use controlled environments to introduce sounds or situations that children and young people find difficult. Children and young people can explore these experiences at their own pace. The research is still small and early, so these tools should be seen as promising rather than proven. They may offer a useful option for children and young people who face long waits for support or who do not engage with talking therapies.

Psychoeducation is another critical area. Many neurodivergent young adults fall through gaps in services. They often receive help only when in crisis. Psychoeducation gives young people and families clear information about mental health, coping strategies and ways to seek support. It can be delivered in groups, one-to-one or online. Programmes work best when neurodivergent young people help design them. This builds trust and ensures that the content reflects real needs and experiences.

The briefing calls for a shift in policy. Mental health support for neurodivergent children and young people should be seen as a reasonable adjustment, not a treatment for difference. Schools should receive investment to deliver sensory-informed and play-based approaches. Diagnostic delays could be reduced through school-based assessment pathways that give quicker access to screening, early specialist input and clearer support. Mental health services should adapt to neurodivergent communication and sensory needs, rather than expecting children and young people to adapt to services. Psychoeducation should be offered as part of autism specialist pathways, with options for group or one-to-one delivery.

The evidence shows strong support for early identification, sensory-informed practice and coproduced interventions. It also highlights gaps. Some groups remain underrepresented in research. Long-term outcomes are not always measured. Implementation varies between schools. These gaps point to the need for ongoing evaluation and equity monitoring as approaches scale. The briefing argues for a system that recognises neurodivergent strengths, reduces barriers and provides support that fits real lives.

RECOMMENDATIONS

1. The Government and NHS England must ensure that the expansion of school and college Mental Health Support Teams includes individualised provision for neurodivergent children and young people
2. NHS children and young people's mental health services should ensure they are adapted to the needs of neurodivergent young people with co-occurring mental health needs
3. The Department of Health and Social Care should require in the forthcoming Modern Service Framework for Children and Young People that mental health support for neurodivergent children and young people is individualised, adapted, and evidence based
4. The Department for Education should explore how schools and colleges can be better adapted to the needs of neurodivergent children and young people
5. Research funders should prioritise research exploring how to scale up promising approaches to meeting the mental health needs of neurodivergent children and young people.

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GLOSSARY OF KEY TERMS

Autism / Autistic

Autism is a lifelong developmental difference that affects how a person communicates, processes information and experiences the world. Autistic people may have strong interests, sensory sensitivities and distinct ways of thinking and learning. Autism is not a mental health condition. The term autistic is widely used by autistic people themselves and reflects a positive identity rather than a medical label.

Burnout

A state of exhaustion caused by extended periods of stress, masking or unmet needs. The briefing links burnout to increased distress and reduced engagement in school.

Coproduction

Designing services or programmes with the people who will use them. In this briefing it refers to involving neurodivergent young people in shaping psychoeducation and support models.

Comorbidity

When a person experiences more than one condition at the same time. In this briefing it refers to mental health difficulties such as anxiety, depression or sleep problems that often occur alongside autism, ADHD or developmental language disorder.

Developmental language disorder (DLD)

A condition that affects a child's ability to understand and use spoken language. It is not caused by hearing loss or learning disability. Children and young people with DLD often struggle with talking therapies because these rely on verbal skills.

Emotional regulation

A person's ability to manage and respond to their emotions. Many interventions in the briefing aim to support emotional regulation through sensory or play-based approaches.

Externalising behaviours

Behaviours such as acting out, restlessness or aggression.

High-risk groups

Groups of neurodivergent children and young people who face greater likelihood of mental health difficulties. This includes autistic girls and neurodivergent children and young people from racialised communities. These groups often experience unmet need, reduced access to support and higher levels of distress.

LEGO®-based therapy / Play brick therapy

A structured group activity where children and young people work together to build LEGO® models. It supports social interaction, emotional regulation and communication.

Masking

When a neurodivergent person hides or suppresses their natural behaviours to fit in or meet expectations.

Neurodivergent / Neurodivergence

A broad term that refers to people whose brains process information in ways that differ from what society considers typical. This includes autistic people and people with ADHD or developmental language disorder.

Play-based therapy

Support that uses play, shared interests or sensory activities to help children and young people build relationships, regulate emotions and communicate. It is often more accessible for children and young people who find verbal therapy difficult.

Protocol driven interventions

Standardised programmes such as generic Cognitive Behavioural Therapy (CBT) or mindfulness that follow fixed steps.

Psychoeducation

Information and guidance that helps young people and families understand mental health, recognise signs of distress and develop coping strategies.

Reasonable adjustment

Changes that organisations and people providing services must make under the Equality Act if someone's disability puts them at a disadvantage compared with others who aren't disabled. This could be a change to an environment, teaching method or support system that helps a child take part on equal terms.

School-based assessment pathways

Diagnostic or support assessments delivered in schools rather than clinics. These can reduce waiting times and improve access for children and young people who face barriers to traditional services.

Sensory processing differences

Differences in how people experience sounds, lights, textures, movement or other sensory input. Many autistic children and young people experience sensory overload or sensory sensitivity.

Speech, language and communication needs (SLCN)

A wider category that includes children and young people who have difficulties with speaking, understanding or communicating.

Special educational needs and disabilities (SEND)

Any disability, condition or difficulty that can affect a child or young person's ability to learn. The UK Government SEND code of practice (2014) 0 to 25 years defines a child or young person as having special educational needs if they have a learning difficulty or disability which calls for special educational provision to be made for them.

INTRODUCTION

Recent debate about support for neurodivergent children and young people sits within a wider national conversation about the future of SEND provision and the direction of mental health reform. The SEND system remains under pressure, with long waits, uneven access, and rising tribunal cases shaping public concern. National reviews and policy discussions have drawn new attention to questions of legitimacy, assessment practice, and the role of schools in early identification. Comments about rising diagnosis rates and the need for clearer pathways have prompted strong responses from families, practitioners, and researchers who argue that unmet need, not overdiagnosis, drives current patterns. At the same time, national debate about attendance, behaviour, and inclusion has placed neurodivergent children at the centre of political discussion. This briefing enters a moment where policy choices will shape whether support moves toward adjustment and equity or continues to rely on narrow clinical models. This briefing draws on a mixed but complementary evidence base spanning population cohort findings, qualitative studies of lived experience, systematic review evidence for play-based approaches, and intervention evaluations.

Whilst we acknowledge that neurodivergence is a broad category, which includes autism, ADHD and developmental language disorder, the research we used for this review mainly focused on autism. The conclusions and recommendations should read with that in mind.

CONTEXT

Neurodiversity is not a mental health problem, yet neurodivergent children and young people experience disproportionately high levels of mental health difficulties. Data collected at both regional and national levels suggests that up to 70% of neurodivergent adolescents experience clinically significant mental health symptoms at some stage of schooling, with particularly high prevalence among autistic girls and young people from racialised communities (McChesney and Toseeb, 2018). Pooled data estimates that between 40-70% of diagnosed autistic children and young people face at least one significant mental health challenge, including anxiety, depression, obsessive-compulsive disorder, and PTSD-like symptoms (Beresford and Mukherjee, 2023). Neurodivergent children also commonly experience sleep difficulties and low self-esteem. Family stress, sibling bullying (Toseeb *et al*., 2018; 2020), and a poor school fit can further increase the risk of distress.

Evidence shows that many standard mental health interventions do not fit the communication styles or sensory needs of neurodivergent people. This can lead to disengagement and limited benefit.

A review of research from the University of York and its partners since 2018 points to three main areas for policy attention:

- There is a need to develop individual one-to-one support for neurodivergent young people
- There is a need to expand sensory based interventions for children in and beyond school. This includes approaches such as LEGO® therapy that help children make sense of their experiences
- Self-management tools used in psychoeducation programmes can support young adults.

Neurodivergent young people in their early teens face a higher risk of mental health difficulties than their neurotypical peers. Yet research and policy still give limited attention to the support needs that arise during this stage of life.

WHO IS THIS BRIEFING ABOUT?

- Neurodivergent children and young people, including autistic children, children with ADHD and children with developmental language disorder
- Higher-risk groups: autistic girls and neurodivergent children and young people from racialised backgrounds
- Clinical populations: neurodivergent children and young people with co-occurring anxiety, depression, sleep difficulties or emotional distress.

WHAT THE RESEARCH SAYS

DIVERSE COMMUNICATION NEEDS AND EMBEDDED APPROACHES

Mental health challenges such as anxiety, depression, and sleep disturbance are common and persistent among neurodivergent children and young people, particularly those with autism and ADHD (Shanahan, Isaac and Blackwell, 2021). However, interventions typically fail to reflect these intersectional experiences and diverse communication needs. Many school-based psychological interventions rely on standardised, verbal, protocol-driven formats that assume neurotypical processing and self-reporting styles (Wimmer and Dorjee, 2020). Assumptions like these can block access to support for neurodivergent children and young people. Many have strong sensory differences that make sounds, lights or touch feel intense or confusing. Some find it hard to notice or name their own feelings, which is known as alexithymia. Others may struggle to express thoughts or needs through spoken language. These factors can shape how they take part in mental health support and how well it works.

When mental health support interventions are misaligned with the needs of neurodivergent children and young people, families report increased masking, burnout, and distress, rather than relief. As a result, engagement with mainstream mental health support is often low, dropout rates are high, and gains tend to be narrow and short-lived.

Despite these clear needs, neurodivergent children and young people are routinely offered interventions that were not designed with them in mind. Widely implemented tools like cognitive behavioural therapy (CBT) and school-based mindfulness programmes tend to rely on neurotypical assumptions about cognition, language, and emotion regulation. Both CBT and mindfulness-based programmes also often ask children and young people to convert abstract feelings into verbal thoughts and sustain attention in ways that do not take into consideration diverse processing needs. Evidence suggests such approaches have weaker engagement and higher dropout rates among neurodivergent participants, with any observed gains typically narrow and short-lived (Wimmer *et al.*, 2023; Hutchinson, Huws and Dorjee, 2018).

Framing distress as a 'skills deficit' can also reinforce stigma and place the burden of change on the child or young person, rather than the school or system (Charman *et al.*, 2021). Families frequently describe cycles of anxiety and burnout when children feel pressure to 'perform regulation' to meet expectations rather than have their needs understood. These issues are particularly acute in clinical populations, including children with neurodevelopmental conditions, but also affect children in high-risk groups who have not been diagnosed.

Universal interventions like school-based CBT often fail to accommodate the learning needs of children with developmental language disorder (DLD) or complex comorbidities (Knowland *et al*., 2022; Toseeb and St Clair, 2020). Some studies promoting mindfulness or CBT exclude neurodivergent youth entirely or fail to show how the outcomes differ for neurodivergent and neurotypical children (Breedvelt *et al*., 2019).

Delayed or missed diagnoses can further exacerbate social isolation, educational disengagement, and caregiver stress (Fairthorne, Mori and Leonard, 2018). Evidence from targeted programmes shows that school-based diagnostic assessments, when adapted and embedded in inclusive environments, can reduce waiting times, improve access for marginalised groups, and are positively received by both families and educators (Allgar *et al*., 2021; Wright *et al*., 2022). Interventions like the adapted ADI-R (autism diagnostic interview-revised) for Deaf children (Ackroyd and Wright, 2018) demonstrate how diagnostic tools can be tailored to meet intersectional needs. These assessments, when linked to sensory-based support programmes, represent a move away from clinical gatekeeping and towards school-initiated care. One such example is the use of creative play groups in primary schools, which offer relational, sensory-informed support without reliance on diagnosis or external professionals. These have shown measurable improvements in wellbeing for neurodivergent children, including reduced distress and better peer interaction (Wright *et al*., 2023). While research on long-term impact remains limited, early findings support their inclusion as scalable, low-cost responses embedded in everyday school life.

By contrast, adapted, sensory-informed and play-based approaches delivered in familiar settings such as schools improve engagement, wellbeing and mental health outcomes.

PLAY-BASED THERAPIES

Effective support for neurodivergent children and young people, particularly those with clinical diagnoses or at-risk profiles, requires more than therapeutic access. They should use visual scaffolding tools, offer interest-led activities based on the child's interests and make sensory adjustments where needed, particularly in familiar environments such as classrooms. Tools such as Social Stories, developed for neurodivergent learners, and practical accommodations for auditory hypersensitivity have a strong evidence base when delivered as part of whole-school inclusion frameworks (Wright *et al*., 2020).

Play-based therapies, especially those designed around shared interests and sensory experiences, have also shown promising wellbeing outcomes. Sensory needs affect approximately 92% of neurodivergent people (Francis *et al*., 2019), and toy-based or visual-spatial approaches can enable prosocial development during stages where verbal communication is limited. For children with speech, language, and communication needs (SLCN), non-verbal or embodied play can serve as both a therapeutic outlet and a communicative bridge (Hobson *et al*., 2022; Francis *et al*., 2022). However, there is a need for more rigorous, large-scale research on the measurable impact of these approaches.

LEGO®-based therapy is now seen as a low-cost group intervention that supports emotional regulation and social skills through play. Studies show that it can be adapted for mainstream schools. It has been used with autistic children and children with ADHD and DLD with positive results (Varley *et al*., 2019; Toseeb *et al*., 2020; Wright *et al*., 2023). Although based on small-scale and pilot studies, reported outcomes include improved peer relationships and reduced externalising behaviours. Importantly, LEGO® therapy focuses on embodied and sensory communication and does not replace access to clinical services, if needed (Wang *et al*., 2022). It aligns with the ways in which many neurodivergent children learn, often through repetition, play, and routine, and supports early self-advocacy skills (Beresford and Mukherjee, 2023).

As an early intervention, LEGO®-based therapy offers potential benefit for high-risk groups, such as children with developmental language disorder, who are known to experience high comorbidity with anxiety and depression but face a shortage of tailored interventions (Conti-Ramsden *et al*., 2019). Although promising, the model requires scaling, with attention to workforce training and contextual implementation across diverse settings.

SENSORY TECHNOLOGICAL APPROACHES

In addition to LEGO®-based therapy, emerging research on sound-based and virtual reality interventions adds another dimension to neurodiversity-affirming practice. Small pilot studies such as SoundFields (Johnston, Kearney and Egermann, 2018) use game-based formats to reduce anxiety and sound sensitivity in neurodivergent children. By gradually introducing challenging auditory stimuli in safe, interactive settings, children aged 9–19 reported reduced distress and improved tolerance after short exposures (Johnston, Egermann and Kearney, 2019).

While participant numbers remain limited and longer-term data is not yet available, these findings suggest that technology-based sensory therapies may provide viable low-intensity interventions. They offer accessible tools for general or high-risk populations that may otherwise face long NHS waits, or are excluded from talking therapies such as CBT due to diverse communication needs not being met. These interventions harness engagement through music, gaming, and familiar technology, making them both scalable and non-invasive.

PSYCHOEDUCATION AND SELF-MANAGEMENT PROGRAMMES

Neurodivergent young adults, particularly those with co-occurring mental ill health, often fall through gaps in mental health services, receiving support only when in acute distress (Mukherjee and Beresford, 2023). Current mental health support services, such as talking therapies, often fail to provide adequate support, with only a small number of autism psychoeducation programmes available. Mukherjee and Beresford's research identifies the need for investment in the development and evaluation of a model psychoeducation programme for adults diagnosed with autism. Psychoeducational interventions, including digital or self-paced formats, offer an alternative, early pathway to support. Psychoeducation provides information about mental health conditions, their symptoms, and treatments, delivered in group or one-on-one settings. It aims to empower individuals and their families by teaching coping skills, improving understanding, reducing stigma, and helping them manage their mental health more effectively. Programmes can be brief or long term and can be delivered through workshops, individual or group therapy sessions, or online platforms.

Success in the uptake of psychoeducation programmes has been noted when neurodivergent young people have been involved in the creation and development of the programme (Beresford and Mukherjee, 2023). Embedding young people within the consultation process encourages self-engagement strategies mirrored in the psychoeducation programmes, which ultimately build capacity for emotional regulation and help-seeking.

As pressures on child and adolescent mental health services grow, such scalable interventions offer a way to meet the diverse needs of neurodivergent young adults earlier and more appropriately. However, to be effective, programmes must be designed using a 'by-and-for' approach with neurodivergent young adults, rather than just for them.

Outcomes associated with the co-occurrence of neurodivergence and unmet mental health needs

Wellbeing outcomes

- Increased distress, burnout and emotional exhaustion
- Reduced sense of belonging and safety in school settings
- Social isolation and strained peer relationships

Measurable mental health outcomes

- Higher prevalence of anxiety and depressive symptoms
- Sleep difficulties and emotional dysregulation
- Increased school absence and exclusion

WHAT IMPROVES OUTCOMES

Research led by the University of York highlights the importance of adapting mental health support to neurodivergent people's diverse needs. Sensory-informed and play-based approaches, including LEGO®-based therapy, support social interaction, emotional regulation and engagement by building on children's strengths and interests. These approaches are particularly effective when delivered in familiar environments such as schools, reducing reliance on clinical settings.

School-based assessment and support pathways have also been shown to reduce diagnostic delays and improve equity of access, particularly for children from marginalised groups. Early identification and timely adjustment can mitigate the escalation of distress and reduce the likelihood of later periods of mental ill health.

CONCLUDING KEY MESSAGE

The evidence outlined in this briefing shows that whilst neurodivergence itself is not a mental health problem, neurodivergent children and young people are at high risk of mental health difficulties when needs are unmet. Standard, protocol-driven interventions (including generic CBT and school-based mindfulness) are often poorly matched to neurodivergent communication and sensory profiles, contributing to low engagement and limited benefit.

The strongest direction of travel in the evidence supports inclusive, strengths-based approaches: early identification and adjustment; school-based assessment pathways; and sensory-informed, play-based and co-produced supports that improve engagement, social connection and emotional regulation.

This briefing identifies that studies present strong evidence on prevalence and risk, with multiple cohort and longitudinal studies consistently showing high rates of co-occurring mental health difficulties among neurodivergent children and young people, with heightened risk for neurodivergent girls and some minoritised groups.

The research presents moderate evidence on 'service fit' problems, identifying a consistent pattern across qualitative and observational research that shows standardised interventions often assume neurotypical communication and sensory processing, contributing to weaker engagement and short-lived gains for neurodivergent learners. There is stronger intervention evidence in specific areas of the research, including comparatively robust intervention evidence for some adapted approaches, including school-based LEGO® therapy/play brick therapy, supported by trial evidence and economic evaluation (for example, cost-utility analysis).

The research presents emerging evidence for sensory-technology approaches, with tools such as virtual reality and 3D sound interventions showing promising early results, but they are based on smaller studies and narrower age ranges, so findings should be treated as preliminary until replicated at scale. The research also identifies that design and equity gaps remain. Across the evidence base, neurodivergent subgroups are not always well represented, long-term follow-up is often limited, and outcomes can vary depending on school context and implementation quality. This highlights the need for coproduction, equity monitoring and real-world evaluation as interventions scale.

Taken together, the evidence is sufficiently strong to justify policy action on the points outlined below, particularly on reasonable adjustments, earlier identification, and scaling adapted supports, while also identifying clear priorities for strengthening the evidence base in under-researched groups and delivery contexts.

POLICY IMPLICATIONS: WHAT NEEDS TO CHANGE

Policy responses that frame neurodivergence as difference rather than deficit, and prioritise reasonable adjustment and inclusive design, are more likely to prevent avoidable mental health difficulties and reduce longer-term demand on specialist services. Research from the University of York and its collaborators has illuminated both the scale of this challenge and promising new directions. These include psychoeducation programmes co-designed with neurodivergent young people and sensory strengths-based therapies such as LEGO®-based play interventions.

While many school mental health initiatives rely on protocol-driven interventions like CBT or mindfulness, the evidence increasingly suggests that such approaches do not meet the cognitive, communicative, or sensory profiles of many neurodivergent learners, particularly during adolescence. Commissioning of autism-specialist diagnostic services should include a group-delivered psychoeducation programme to equip young people with self-management skills, with the option of offering this programme in a one-to-one format if required.

To improve outcomes and reduce health inequalities, policies need to prioritise interventions that support local, accessible, individualised, and relational approaches to mental health care. In practice, this means adapting currently embedded approaches within education settings, scaling up play-based interventions, and ensuring that mental health support is shaped by neurodivergent young people themselves.

The research evidence suggests the following areas of importance:

- Mental health support for neurodivergent children should be framed as a reasonable adjustment, not a treatment of difference
- Investment should be made in sensory-informed and play-based approaches within mainstream education settings
- Diagnostic delays might be reduced through school-based assessment and support pathways
- Mental health services should adapt to neurodivergent communication and sensory needs, rather than expecting children to adapt to services.

RECOMMENDATIONS

- The Government and NHS England must ensure that the expansion of school and college Mental Health Support Teams includes individualised provision for neurodivergent children and young people. This should include the provision of evidence-based interventions that meet their needs, and where necessary support for parents and carers. Support should fit children's needs, not vice versa, and it should not be contingent on getting a diagnosis.
- NHS children and young people's mental health services should ensure they are adapted to the needs of neurodivergent young people with co-occurring mental health needs. It is vital that there is 'no wrong door' to mental health support for a neurodivergent young person and that services are able to work with all communication styles. Neurodivergence should never be an exclusion criterion for accessing a mental health service.
- The Department of Health and Social Care should require in the forthcoming Modern Service Framework for Children and Young People that mental health support for neurodivergent children and young people is individualised, adapted, and evidence based. The new Modern Service Framework is an important opportunity to set standards for mental health services, including equitable provision for neurodiversity.
- The Department for Education should explore how schools and colleges can be better adapted to the needs of neurodivergent children and young people. Preventing mental distress can be achieved by adapting school policies, cultures, environments and processes.
- Research funders should prioritise research exploring how to scale up promising approaches to meeting the mental health needs of neurodivergent children and young people; understanding and addressing co-occurring needs; and developing interventions outside school settings.

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CENTRE FOR MENTAL HEALTH

BRIEFING 65

STRENGTHS-BASED SUPPORT FOR NEURODIVERGENT CHILDREN AND YOUNG PEOPLE: EVIDENCE FOR REFORM

Written by Becky Higgins and David Woodhead

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