

Maternity Care Planning for Neurodivergent Women and Birthing People

This is the first edition of this guidance. This guidance is for healthcare professionals who care for women, non-binary and trans people in the perinatal period.

This guidance has been written with input from those with lived experience of neurodivergence. There is variation in preferences regarding terminology in neurodivergence among the neurodivergent community. However, research has shown that the majority of neurodivergent people prefer 'identity-first language' i.e. autistic person,¹ therefore this is the model of language used in this guidance. However, when caring for an individual, it is important to ask and respect their preference.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Maternity and gynaecology services and care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

1. Purpose

Neurodivergence refers to natural variations in the brain and nervous system that influence how a person thinks, learns, communicates, and processes the world, reflecting the diversity of human cognition. The most common identified minority neurotypes are autism and attention deficit hyperactivity disorder (ADHD), along with dyslexia, dyspraxia (developmental coordination disorder), and other neurodevelopmental differences.

In the UK, it is estimated that 15–20% of the population are neurodivergent – around 7 million people.² Many of these people remain unrecognised and undiagnosed, particularly in female and gender non-conforming populations. Some may self-identify and this should be considered in care planning.

Increasing research and service user feedback highlights the additional challenges faced by neurodivergent people during their pregnancy, birth and postpartum periods. These include worse clinical outcomes, including higher rates of preterm birth, pre-eclampsia, caesarean birth^{3–5} and perinatal mental health conditions.⁶ In addition, neurodivergent parents report higher rates of poor experiences of care during pregnancy and birth.^{7–9}

In neurodivergent people, illness or injury may present atypically, and delayed presentation to healthcare services is common.^{10,11} This can be influenced by the way many neurodivergent people process pain and bodily signals. Pain may feel muted, overwhelming, hard to pinpoint, or fluctuate,¹² which can make it harder to recognise concerning symptoms or explain them clearly. In maternity care, this can affect how someone interprets contractions, identifies labour progression, or notices and explains changes that require urgent review. Sensory elements, including noise and harsh lighting in clinical environments, can cause pain and distress and may thus further delay seeking help. Differences in communication can also mean that clinicians may not understand that help is being sought.

2. Introduction and background

In the psychosocial model of care, neurodivergence is understood as a natural variation in brain functioning that may interact with social, psychological, and environmental factors, influencing an individual's mental health, daily functioning, and wellbeing. Providing care in accordance with this model focuses on both addressing medical or clinical needs when necessary and supporting psychosocial adaptation and inclusion.

Appendix I provides an overview of diagnostic frameworks and further information, and Table 1 an overview of various common minority neurotypes. It is important to note that there is a great deal of overlap, and many individuals are multiple neurodivergent. Furthermore, neurotypes impact all individuals in different ways. Clinicians should be aware of how these conditions could affect presentations and consider how care should be adapted. Specific strategies to support people experiencing these challenges are discussed in this guidance.

Table 1. Neurodivergent conditions.

Neurodivergence	Common strengths/differences	Common challenges
Autism (formerly autism spectrum disorder/condition [ASD or ASC])	Strong focus, pattern recognition, honesty, attention to detail	Sensory sensitivities, social communication differences, routine reliance
Attention deficit hyperactivity disorder (ADHD)	Creativity, high energy, hyper focus on interests, adaptability	Difficulty with sustained attention, hyperactivity (may be internalised and not visible), impulsivity, distractibility
Dyslexia	Strong reasoning, problem-solving, visual-spatial skills	Reading and writing difficulties, slow processing of written language
Developmental coordination disorder (DCD), formerly called dyspraxia	Creativity, unique movement strategies, spatial reasoning	Difficulty with fine/gross motor tasks, coordination challenges
Dyscalculia	Creative problem-solving, strong verbal and artistic skills, intuitive reasoning	Difficulties with number sense, math concepts, sequencing, time estimation
Dysgraphia	Strong storytelling, imagination, verbal expression	Challenges with handwriting, written organisation, fine motor tasks
Sensory processing differences	Heightened perception, attention to detail	Over- or under-sensitivity to stimuli, difficulty in busy environments

3. Recognising neurodivergence in maternity care

Some neurodivergent individuals may already be identified through medical records, an autism passport, or reasonable adjustments flags. However, many neurodivergent women and birthing people may be presenting to healthcare services for the first time in pregnancy. Presentations of neurodivergence in maternity services may be subtle or 'masked' (unconsciously concealing or suppressing one's true identity, feelings, or neurodivergent traits to fit in with societal expectations or avoid negative judgment).¹³ For example, in one study of 87 687 pregnant people,³ 2.7% scored in the clinical range for autism screening, but only 0.02% had a diagnosis. Co-occurring mental health issues (e.g. depression, anxiety) can overshadow neurodivergence. Misdiagnoses such as emotionally unstable personality disorder may also occur.

Signs of possible neurodivergence as observed in maternity care:

- Difficulty understanding verbal requests
- Repeating questions
- Sensory sensitivities
- Irritability, distraction, or stimming
- Anxiety or heightened emotions
- Atypical communication
- Challenges with attending or preparing for appointments.

Consider intersectional factors:

- Cultural identity, sexual orientation, socioeconomic background, and gender identity can influence presentation and masking.
- Avoid assumptions and practice culturally sensitive, personalised care.

It may be helpful to:

- Ask specifically about known or suspected neurodivergence for the pregnant person, partner, and family history at booking.
- Consider formal screening (e.g. Autism Quotient (AQ-10)¹⁴ (see Appendix II) for those with relevant features or co-occurring conditions (see section 4), approved by the National Institute for Health and Care Excellence *Autism spectrum disorder in adults: diagnosis and management* [CG142],¹⁵ and designed to be administered by non-specialists. Local processes should be followed for referral should a score of six or above be obtained. While it is acknowledged that a formal diagnosis is unlikely to be achieved within the timeframe of accessing maternity care, a score of six or above would indicate that the pregnant woman or birthing person may benefit from the support discussed in this guidance.

4. Co-occurring conditions

Neurodivergent conditions often co-occur and it is likely that someone who has one identified neurotype may be multiple neurodivergent, whether or not this has been formally recognised. For example, meta-analyses¹⁶ indicate 50–70% of autistic individuals also meet criteria for ADHD, while 20–50% of those with ADHD meet the criteria for autism.

Additionally, neurodivergent people often experience other co-occurring conditions that can influence medical, social, and psychosocial aspects of life,¹⁷⁻¹⁹ making it essential for maternity care to be personalised, needs-led and responsive to both diagnosed and undiagnosed conditions.

Understanding overlapping conditions will facilitate safe, inclusive, and person-centred obstetric care, as co-occurring conditions can affect pregnancy, labour, birth, postnatal recovery, and healthcare experiences. Awareness and proactive management of these conditions supports better outcomes for families.

Table 2. Examples of co-occurring medical considerations.^{6,18,20–25}

Medical condition	Medical impact	Implications	Management
Musculoskeletal differences (hypermobility/Ehlers–Danlos syndrome, chronic pain)	Joint instability, fatigue, pain	Limits birthing positions, discomfort during examinations and recovery, can affect physiology of labour, Ehlers–Danlos has known association with local anaesthetic resistance	Joint care with MDT input. Pain management, mobility support, adaptable examination setups, early and ongoing physiotherapy.
Endocrine disorders (thyroid imbalance, polyendocrine metabolic ovarian syndrome)	Hormonal imbalance, irregular ovulation	Fertility challenges, gestational diabetes, pre-eclampsia	Joint care with MDT input. Sensory- and executive-functioning-friendly education and weight management advice. Standard thyroid monitoring and treatment.
Fibromyalgia	Chronic pain, fatigue, reduced mobility	Discomfort during labour, slower postnatal recovery	Joint care with MDT input. Adjust positioning, provide mobility aids, additional physical support.
Neurological disorders (epilepsy)	Seizures, hormonal impacts	Maternal and fetal risk if unmanaged	Joint care with MDT input. Careful medication management, seizure monitoring, medication regimes that assist concordance, in line with RCOG Green-top Guideline No. 68 <i>Epilepsy in Pregnancy</i> . ²⁵
Cardiovascular issues (hypertension, arrhythmias)	Increased cardiac strain	Pregnancy and anaesthesia risks	Medication regimes that assist concordance, collaborate with cardiology and anaesthetics teams, along with routine MDT input.
Metabolic concerns (obesity, gastrointestinal issues)	Nutritional challenges, metabolic strain, food avoidance, sensory eating challenges	Gestational diabetes, pregnancy complications, pain, nutrient absorption issues	Joint care with MDT input. Nutritional guidance, sensory- and executive-functioning-friendly education, and stress reduction strategies.

MDT, multidisciplinary team.

Table 3. Co-occurring psychosocial and social considerations.

Condition	Social/behavioural Impact	Psychosocial/emotional Impact	Possible adaptations
Social anxiety/ isolation	Difficulty attending appointments, limited engagement	Increased stress, reduced support network	Flexible appointments, supportive communication, virtual options
Communication differences (non-speaking, situational mutism, alexithymia)	Difficulty expressing needs, pain, or emotions	Difficulty obtaining shared understanding of health needs, stress	Allow alternative communication methods (such as electronic devices), unhurried, active listening, written or visual supporting information, longer appointment times
Mental health vulnerabilities (anxiety, depression, post-traumatic stress disorder, eating disorders, obsessive-compulsive disorder)	Reduced participation in activities	Emotional distress, risk of burnout	Trauma-informed care, mental health support with MDT input, routine monitoring
Trauma/PTSD	Avoidance of healthcare or stress triggers	Compounded mental health challenges	Trauma-aware obstetric care, clear explanations, reassurance
Sensory processing differences	Avoidance of crowded/noisy spaces, declining admission or medical procedures. Self-discharge against medical advice	Overstimulation, stress, reduced participation	Sensory-friendly environments, quiet spaces, gradual exposure

Neurodivergent people can be at increased risk of manipulation by others, in part because differences in interpreting facial expressions, intentions, and motivations can make it harder to recognise unsafe situations. As a result, there may be increased exposure to interactions, relationships, or environments that heighten vulnerability, including risks of physical, emotional, or sexual harm, as well as substance misuse.²⁶

These challenges can occur at any life stage and may contribute to a complex history leading to crisis presentations during pregnancy or in the early years of parenthood. Recognising this higher prevalence is essential so that supportive, trauma-informed care planning can be put in place without bias, judgement, or comparison, and with genuine understanding. It is particularly important to be aware of trauma-informed approaches to internal examinations, given the higher prevalence of sexual assault in neurodivergent people.²⁷

As a consequence of the above, neurodivergent people may be in an unhealthy relationship or living situation and may face a higher likelihood of social-services involvement. Being neurodivergent is not a reason for social-services involvement on its own; rather, it highlights the importance of

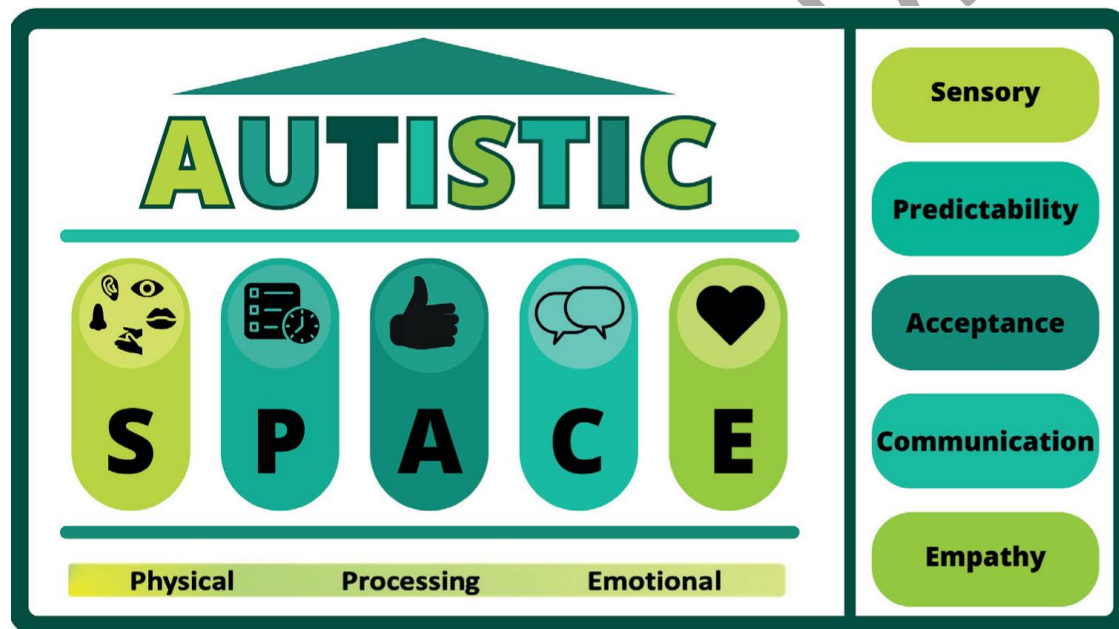
recognising potential additional challenges and ensuring that appropriate care planning, support, and advocacy are available when needed in a collaborative and supportive approach.

5. Autistic SPACE Framework

The [Autistic SPACE framework](#)²⁸ has been developed by three leading members of Autistic Doctors International with key lived experience, with the aim of facilitating equitable clinical services at all points of access and care for autistic people, using the acronym 'SPACE'.

This encompasses five core autistic needs: **Sensory needs, Predictability, Acceptance, Communication and Empathy**. Three additional domains are represented by physical space, processing space and emotional space. This simple yet memorable framework encompasses commonalities shared by autistic people, and recommendations for improving accessibility in each of the domains and spaces. While the framework has not yet been evaluated in maternity care, the guidance is based on a range of evidence.^{10,11,29}

Although the framework relates to autistic people, the overlapping nature of neurodivergence means that the framework is likely beneficial for many non-autistic neurodivergent people.



6. Principles of maternity care for neurodivergent women

Neurodivergent-informed maternity care should be consistent across all stages, with a focus on individual needs, accessibility, and reducing distress while promoting autonomy and safety. This approach recognises that every person experience pregnancy, labour, and postnatal recovery uniquely, and that respecting neurodivergent differences is essential to supporting positive outcomes for both parent and child.

- Use a trauma-informed, neuroaffirmative, sensory-aware approach.
- Individualise care (sensory, communication, positioning, environment).
- Provide clear, accessible information to support informed consent.
- Allow extra time for processing and decision-making.
- Ensure continuity of care wherever possible.
- Coordinate multidisciplinary support when needed.

- Cluster care tasks to allow uninterrupted rest.
- Recognise meltdowns (external distress) or shutdowns (withdrawal, inability to communicate) as distress responses requiring appropriate support, not judgement.

Neurodivergent-informed care also emphasises the importance of collaboration and co-creation. Involving the person in all aspects of planning, discussing preferences, and anticipating potential stressors allows care teams to proactively mitigate distress. Regularly reviewing and updating care plans ensures flexibility and responsiveness to evolving needs.

Effective care requires a coordinated, multidisciplinary approach, integrating obstetric, medical, mental health, and allied health expertise. Local pathways will vary but the multidisciplinary team (MDT) may include:

- **Consultant obstetrician (if obstetric-led care is indicated):** neurodivergence alone is not an indication for obstetric-led care or birth on an obstetric unit.
- **Community midwife**
- **Consultant midwife**
- **Specialist midwife for mental health**
- **Consultant obstetrician with an interest in mental health**
- **Perinatal psychiatrist and psychologist**
- **Trust/hospital/health board Neurodiversity Liaison Team**
- **Neonatologist (if care is indicated)**
- **GP**
- **Health visitor**

Medical subspecialties (as needed):

Endocrinology, rheumatology, cardiology, neurology, gastroenterology/hepatology, genetics, anaesthetics/pain specialists – supporting condition-specific pregnancy needs.

Allied health and support services:

- Physiotherapy and occupational therapy
- Speech and language therapy
- Social work/safeguarding
- Lactation consultant/infant feeding specialist

Summary of recommended neurodivergent-informed adjustments across maternity care

Care phase	Challenges for neurodivergent women and birthing people	Recommended adjustments
Antenatal	• Difficulty processing verbal information, especially in stressful or unfamiliar settings. • Anxiety related to new environments, uncertainty, and changes to routine. • Sensory sensitivities (light, sound, smell, touch, temperature).	• Provide information in multiple formats (written, visual, verbal). • Break information into clear, step-by-step chunks. • Allow extra time for appointments and processing. • Offer predictable structure (same clinician, clear schedules). • Provide reminders (texts, apps, checklists).

	• Executive functioning differences (planning, organisation, memory, task initiation). • Decision-making fatigue and cognitive overload. • Difficulty navigating new locations or systems. • Pain may be muted, absent, delayed, heightened, or atypical. • Behavioural or facial expressions may not reflect pain. • Standard pain scales may be inaccessible. • Interoceptive differences (recognising contractions, hunger, pain, bodily functions).	• Offer quiet, low sensory environments. • Support recording of consultations. • Ask about and document preferences. • Ensure continuity of carer. • Share information early about scans, labour and interventions. • Offer photos/videos or visits to maternity settings. • Co-produce personalised birth plans (sensory and communication needs). • Discuss possible changes and alternative scenarios. • Ensure accessible, supported informed consent. • Encourage self-advocacy and support persons. • Practice coping strategies for sensory regulation.
Intrapartum	• Sensory overload in clinical environments. • Communication differences under stress or pain. • Unfamiliar procedures and rapid changes. • Difficulty expressing needs or pain. • Meltdowns (external distress) or shutdowns (withdrawal, inability to communicate). • Pain responses may be reduced, absent or heightened. • Behaviour may not reflect severity. • Possible differences in response to analgesia/anaesthesia. • Multiple stimuli may lead to overwhelm.	• Reduce sensory input (dim lights, reduce noise, limit staff). • Use clear, step-by-step explanations. • Allow processing time wherever possible. • Always seek explicit consent before touch. • Agree on stop/pause signals. • Encourage use of sensory supports (headphones, familiar items). • Support preferred movement (or stillness). • Involve support person actively. • Offer flexible, individualised pain management. • Be aware of altered pain presentation and medication responses. • Check in frequently about comfort levels. • Offer brief breaks or pauses when safe. • Pre-brief staff on neurodivergent needs. • Use visual cues for consent. • Maintain a small, predictable team.
Postnatal	• Fatigue and reduced executive functioning. • Anxiety about infant care. • Ongoing sensory sensitivities. • Altered pain perception or difficulty recognising pain. • Sensory challenges with feeding.	• Maintain calm, low stimulation environment. • Provide clear, written postnatal instructions. • Offer structured follow-up and clear contact routes.

	• Difficulty asking for help or reporting concerns. • Interoceptive differences (pain, hunger, thirst, fatigue, bladder/bowel awareness).	• Allow flexible routines (visiting, meals) where possible. • Support feeding choices without pressure. • Continue individualised pain assessment. • Encourage involvement of support person. • Signpost to neurodivergent-friendly parent support groups. • Offer routine mental health check-ins and peer support. • Ensure long term care planning with GP, health visitor and mental health services.
Operative/emergency care	• Rapid changes and unpredictability. • High sensory load (lights, alarms, multiple staff). • Reduced ability to process information or communicate. • Increased distress impacting care.	• Use calm, clear, concise language. • Avoid jargon and figurative language. • Provide information in small chunks. • Allow brief processing time where possible. • Use visual aids if helpful. • Involve support person in decision-making. • Minimise sensory overload (dim lights if safe, reduce noise, limit staff, reduce simultaneous touch). • Use existing plans (birth plan, passport). • Maintain presence of trusted support person. • Offer comfort tools (headphones, familiar items). • Recognise behavioural changes as signs of distress or deterioration. • Allow short pauses where safe to reduce overwhelm. • Where possible, allow for sequential performance of clinical tasks rather than performing multiple tasks simultaneously. • Pre-briefing staff about neurodivergent-specific needs, using visual cues for consent, and maintaining a small, predictable team can greatly reduce distress and improve outcomes for both patient and clinical team. • Perform preoperative procedures (checklists, canulation) on ward or in labour room prior to moving to theatre.

		• Provide information about noises and sensations likely to be felt in theatre (blood pressure cuff, pulse oximetry).
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7. Pain response and anaesthetic care

Pain is a common presentation in obstetrics and assessing it can be critical to identifying obstetric emergencies. Because of sensory, social and communication differences, neurodivergent people report that their obstetric pain has been undertreated, owing to their muted pain expressions.⁷⁻⁹

Atypical pain sensations (e.g. allodynia), decreased or absent pain reactivity and, paradoxically, greater responsiveness to painful stimuli have all been reported.¹² The latter may in part be owing to discomfort, fear or distress caused by environmental factors or medical manipulation (e.g. use of tourniquet, light touching, cardiotocography [CTG] bands, etc.). Behavioural reactions and facial expressions in response to pain may be absent or different and there may be difficulty localising the source of pain. An individual's pain response may be best recognised by people familiar to them.

Clinicians should therefore explore the woman's past experience of pain sensation and identify any barriers to pain assessment, and explore whether their partner or family have noted any concerning signs or behavioural changes suggestive of pain. Abnormal observations, e.g. tachycardia, may be useful indicators of pain.

Neurodivergent individuals may have difficulty using pain self-assessment tools or scales (numerical or pictorial). Individualised assessment should be considered prior to use of these tools to ensure appropriate pain assessment is made.³⁰

Anaesthetists can utilise the SPACE framework, as described in detail by Brown et al.,³¹ to identify aspects of anaesthesia that may prove distressing. Consideration should be given to all reasonable adjustments, including anaesthetic medication doses, choice of technique and location (see section 8), as well as whether alternative pain scores in postoperative recovery might be necessary.

For individuals on stimulant medications for ADHD, consideration should be given to the known cardiovascular adverse effects (arrhythmias, hypertension). Exposure to some inhalational anaesthetics may also increase this risk. The [British National Formulary \(BNF\)](#) should be consulted for specific drug interactions.

All neurodivergent women should be offered a referral for antenatal anaesthetic review. This is particularly important if an operative procedure is planned, the risk of operative intervention is high, or if past experience of anaesthesia has identified need for adjustments. At a clinic appointment reasonable adjustments to routine anaesthesia can be discussed. These may include arranging practise visits to the operative theatre if elective caesarean birth is planned. Involving other members of the theatre team who are experienced with this group of patients may help both in the prior planning and on the day of surgery.³²

Additional information for health professionals and women on pain relief and anaesthesia choices for labour and childbirth is available from [LabourPains](#), the public information arm of the Obstetric Anaesthetists Association, and for resources about operating theatre from the [College of Operating Department Practitioners](#).

8. Response to medication

Anecdotal reports and expert opinion suggest that atypical or paradoxical responses to some medications (in particular, psychotropic medication) are more common in autism.³³ In addition, autistic people may be more sensitive to the effects of medication and are more likely to suffer adverse effects.³⁴ This may, in part, be owing to different sensitivity to sensory stimuli.

Prior to starting any new drug, clinicians should explore whether there is a history of increased sensitivity and adverse reactions to medications. Where this is identified, it is recommended to seek expert advice.

9. ADHD medication in pregnancy

Careful management of medications is needed with the MDT. Local pathways should be followed, such as referral to an obstetrician with special interest in perinatal mental health if there is limited experience of these medications in pregnancy. The following key principles to inform care are advised:

- Refer to individual drug monographs on [UK Teratology Information Service \(UKTIS\)](#) and [Best Use of Medicines in Pregnancy \(BUMPS\)](#) for the most up-to-date scientific and public information.
- Review early: preconception or as soon as pregnancy is known.
- Coordinate with GP and perinatal mental health services when needed.
- Continually review to ensure informed and shared decision making: risks of medication against risks of untreated ADHD to be evaluated; effects on management of co-occurring mental health vulnerabilities to be considered.
- If continuing medication: use lowest effective dose; aim for a single medication where possible; avoid abrupt stopping; monitor wellbeing.
- Depending on risks identified in drug monograph, consider if additional fetal monitoring will be required.
- If stopping/reducing medication: do so gradually and add non-medication supports.
- Avoid contraindicated medicines; do not use drugs with known/suspected teratogenic risk, seek advice if exposure occurs.
- Refer to relevant resources for latest scientific information regarding use in breastfeeding if medication is continued or restarted postnatally, for example, [LactMed® database](#).
- Clarify responsibility for prescribing routes (especially with private prescriptions); pre-pregnancy shared care agreements (GP prescribing) may not automatically apply in pregnancy, reverting prescription to specialist services.
- Consider whether neonatal monitoring post birth is required, dependent on risks identified in monograph and exposure in the final weeks of pregnancy.
- Document plan: record risks/benefits and agreed approach.

10. Future considerations

To enhance care for neurodivergent individuals in maternity settings, the following priorities should be considered:

1. Integration with perinatal mental health services

Establish clear pathways for collaboration between maternity teams and perinatal mental health specialists to ensure holistic support.

2. Fast-track access to diagnosis during pregnancy

Develop streamlined processes for timely assessments for neurodivergence, reducing delays that can impact care planning and emotional wellbeing.

3. Continuity of carer

Limited research⁹ and first principles suggest that neurodivergent individuals would benefit significantly from continuity of carer to build trust, reduce anxiety, and improve communication. Further research should prioritise this group and study improvements in experience and outcomes.

4. Implement neurodivergent-friendly services for all

Embed neurodivergent-friendly principles across maternity services - such as sensory adaptations, clear communication, and predictable routines - benefiting all women and birthing people, not just those who are neurodivergent.

5. Support and identification of neurodivergent maternity staff

Implement systems to identify and support neurodivergent staff within maternity and related services, fostering an inclusive and understanding workplace culture.

6. Consider long term family focused care planning

Neurodivergent parents may be more likely to have neurodivergent children, so it is important to develop neurodivergent-inclusive infant care pathways that support early recognition of individual needs and develop appropriate, responsive care planning collaboratively with paediatricians, GPs and health visitors.

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Appendix I: Diagnostic frameworks

Medical diagnostic criteria for neurodivergent conditions are found in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)³⁵ and the World Health Organization International Classification of Diseases 11th Revision (ICD-11).³⁶ Understanding the diagnostic criteria supports awareness of communication, sensory and executive function differences; however, it is important to note that many neurodivergent people reject the traditional medical model of deficit-based descriptions of neurodivergence. In addition, formal diagnosis should not be seen as a prerequisite for accessing appropriate support.

	Autism	ADHD
Core differences	• Lifelong differences in social communication and interaction • Distinct pattern of intense interests, routine and repetitive behaviours • Sensory processing differences	• Inattention • Hyperactivity • Impulsivity
Onset	Early developmental period	Before age 12
Duration	• Persistent, impairing • Affecting daily functioning	• ≥ 6 months • Affecting daily functioning
Settings	Multiple contexts	Two or more settings
Exclusion	Not explained by intellectual disability alone	Not explained by another disorder

Appendix II: AQ 10 (Autism Quotient Questionnaire)¹⁴

AQ-10

Autism Spectrum Quotient (AQ)

A quick referral guide for adults with suspected autism who do not have a learning disability.

Please tick one option per question only:

		Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1	I often notice small sounds when others do not				
2	I usually concentrate more on the whole picture, rather than the small details				
3	I find it easy to do more than one thing at once				
4	If there is an interruption, I can switch back to what I was doing very quickly				
5	I find it easy to 'read between the lines' when someone is talking to me				
6	I know how to tell if someone listening to me is getting bored				
7	When I'm reading a story I find it difficult to work out the characters' intentions				
8	I like to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant etc)				
9	I find it easy to work out what someone is thinking or feeling just by looking at their face				
10	I find it difficult to work out people's intentions				

SCORING: Only 1 point can be scored for each question. Score 1 point for *Definitely* or *Slightly Agree* on each of items 1, 7, 8, and 10. Score 1 point for *Definitely* or *Slightly Disagree* on each of items 2, 3, 4, 5, 6, and 9. If the individual scores **6 or above**, consider referring them for a specialist diagnostic assessment.

This test is recommended in 'Autism: recognition, referral, diagnosis and management of adults on the autism spectrum' (NICE clinical guideline CG142). www.nice.org.uk/CG142

Key reference: Allison C, Auyeung B, and Baron-Cohen S, (2012) *Journal of the American Academy of Child and Adolescent Psychiatry* 51(2):202-12.

Appendix III: Additional resources

Sensory is a 20-minute short film exploring the lived experience of an autistic person attending a hospital appointment. Co-produced with autistic people, carers, and staff, it features a fully neurodivergent cast. The project was developed in collaboration with the University of Bristol's *Sensing Spaces of Healthcare*, ELFT, and Inner Eye Productions (www.youtube.com/watch?v=etCCAREPCqE).

Maternity Autism Research Group Best Practice Guidelines – Supporting Autistic People in Maternity Care (www.maternityautismresearchgroup.co.uk/guidelines).

Grant A. *The Autism friendly guide to pregnancy, birth and the fourth trimester*. London: Jessica Kingsley Publishers; 2025.

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ND Birth Reasonable Adjustments Toolkit (www.ndbirth.com/downloads).

Fox D. Exploring how health inequalities can be addressed through autism training and understanding in maternity services. MIDIRS Midwifery Digest 2022.

Fox D. Considering Care Pathway planning for autistic women to improve care outcomes and reduce health inequalities. MIDIRS Monthly 2023.

The Neurodivergent Birth Podcast (theneurodivergentbirthpodcast.buzzsprout.com) explores neurodivergent experiences of pregnancy, birth and the postnatal period.

Autism from menstruation to menopause – YouTube videos by autistic health professionals for autistic people about pregnancy.

White V. *Why Neurodivergent Birth Matters*. Montag and Martin; 2025.

O'Leary N, George CV, ElDirani Z, Jenks R, Kent G. "Remember One Size Doesn't Fit All": A Scoping Review of Postpartum Supports for Neurodivergent Mothers. *Matern Child Health J* 2025;29:1528–1540.

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Appendix IV: Glossary of terminology

Alexithymia	Difficulty identifying, understanding, or describing one's own emotions and feelings.
Autism	A neurodevelopmental difference involving social communication, sensory processing, routines, and focused interests.
ADHD (Attention Deficit Hyperactivity Disorder)	A condition affecting attention, activity levels, impulse control, and executive functioning.
Dyslexia	A learning difference that mainly affects reading, spelling, and written language processing.
Dyspraxia/Developmental Coordination Disorder (DCD)	A condition affecting movement, coordination, planning, and motor skills.
Dyscalculia	A learning difference that affects understanding numbers, maths, and time concepts.
Dysgraphia	A condition affecting handwriting, written expression, and organising thoughts on paper.
Executive functioning	Mental skills used for planning, organising, remembering, prioritising, and completing tasks.
Interoception/Interoceptive differences	The ability to notice internal body signals such as pain, hunger, thirst, or contractions.
Masking	Hiding or suppressing neurodivergent traits to fit social expectations or avoid judgement.
Meltdown	An intense outward response to overwhelming stress or sensory overload.
Neuroaffirmative Care	Care that respects neurodivergent differences rather than treating them as deficits.
Neurodivergence	Natural differences in how a person's brain processes information, learns, communicates, and experiences the world.
Neurodivergent	A person whose brain works differently from what society considers typical or expected.
Neurotype	A person's particular pattern of thinking, learning, communicating, and processing information.
Sensory overload	Distress caused by too much sensory input, such as noise, light, or touch.
Sensory processing differences	Differences in how the brain receives and responds to sights, sounds, touch, and other sensations.
Shutdown	A withdrawal response where communication or functioning becomes difficult.
Situational mutism	Temporary inability to speak in certain situations despite being able to speak at other times.
Stimming	Repetitive movements, sounds, or behaviours used for self-regulation, comfort, or focus.

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The review process will commence in 20XX, unless otherwise indicated.

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