The Compassion Gap

Why We Accommodate Some Disabilities But Punish Others

Mark Friese MEng MIET

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MARK FRIESE

RESEARCH PAPER

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Why We Accommodate Some Disabilities But Punish Others

Society provides ramps for wheelchairs and extra time for dyslexia, yet excludes children experiencing emotional meltdowns and penalises neurodivergent employees for the consequences of adjustments never provided. The evidence is unequivocal: emotional dysregulation, sensory processing issues, and trauma responses have the same neurobiological basis as recognised learning disabilities — and when these conditions co-occur, they compound each other with measurable physiological consequences. This paper examines how we got here, what it costs, and what works instead.

Mark Friese MEng MIET

Independent researcher and advocate

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Executive Summary

Emotional dysregulation, sensory processing differences, and trauma responses share the same neurobiological basis as recognised learning disabilities. Both categories involve measurable structural brain differences, altered neural connectivity, and neurotransmitter dysfunction (Bo et al., 2024; Zhang, Bo, Wager & Gross, 2025). Yet while one receives accommodation and support, the other faces exclusion, criminalisation, and a pipeline from school to custody.

This disparity reflects not scientific reality but arbitrary social values rooted in visibility bias, perceived controllability, and historical moral frameworks that continue to mistake neurological differences for character flaws.

Critically, these conditions rarely occur in isolation. Approximately 80% of adults with ADHD have at least one co-occurring psychiatric condition, and up to 42% of autistic adults experience lifetime anxiety. When conditions multiply, they do not simply add risk — they multiply it. UK primary care data shows neurodivergent adults lose between six and nine years of life expectancy, with mortality risk escalating exponentially as comorbidities accumulate.

5×

the rate at which pupils with Additional Support Needs are excluded from Scottish schools compared to those without ASN (Scottish Government, 2024/25).

80%

of children cautioned or sentenced in England and Wales have special educational needs or neurodivergence (UCL Institute of Education, 2025).

6–9 years

of life expectancy lost for UK adults diagnosed with ADHD or autism — driven by co-occurring conditions that interact physiologically and compound each other (O'Nions et al., 2023; 2025).

Meanwhile, successful alternatives exist and are proven. Restorative approaches in Oxfordshire saw 90% of trained schools reduce suspensions. Barnet schools using restorative justice achieved a 51% reduction in fixed-term exclusions while non-trained schools saw a 65% increase. These approaches work for all pupils, reduce socioeconomic disparities alongside disability disparities, and are more cost-effective than exclusion and custody pipelines.

The question is no longer whether emotional needs deserve equal accommodation — the science settled that. The question is when our systems will catch up to what neuroscience, philosophy, and basic justice demand.

Same Brain, Different Treatment

The fundamental premise underlying the double standard — that emotional dysregulation differs categorically from learning disabilities — collapses under neuroscientific scrutiny.

Research published in *Nature Neuroscience* in 2024 used a novel systems identification approach to map how the brain handles emotion regulation, revealing that the neural machinery is largely shared with emotion generation itself (Bo et al., 2024). The study identified distinct brain systems, but its central finding was that the vast majority of brain regions activated during emotion regulation — including much of the prefrontal cortex, the anterior midcingulate cortex, and the insula — are also active during emotion generation. Only a small subset of regions, comprising approximately 15% of the relevant brain volume, responded selectively to regulation demands: the frontal pole (anterior prefrontal cortex), the temporoparietal junction, and the anterior inferior temporal gyrus (Zhang, Bo, Wager & Gross, 2025). These are not character traits or willpower systems. They are measurable neurological structures with chemical substrates — the study implicated cannabinoid (CB1) and serotonin (5-HT2A) receptor systems in particular.

This finding is more powerful, not less, for the argument that emotional dysregulation deserves equal accommodation. It means emotion regulation is not a separate "willpower module" that some people choose not to use. It relies on the same neural infrastructure as emotional experience itself — and when that infrastructure develops atypically, or is disrupted by trauma, the regulatory capacity is directly compromised.

Developmental studies show emotion regulation abilities improve with age as prefrontal brain regions mature late in development — following the exact same maturational trajectory as other executive functions. If emotional regulation

were simply about willpower or character, it would not follow such a clear developmental pattern linked to brain maturation.

Sensory Processing: The Invisible Brain Difference

Sensory processing disorder exemplifies the erasure of invisible disabilities despite concrete evidence. Groundbreaking UCSF research in 2013 used brain imaging to demonstrate for the first time a biological basis for SPD in brain structure, showing measurable regional differences and altered white matter connectivity (Owen et al., 2013). SPD affects 5–16% of school-aged children — as common as ADHD — yet has never been formally recognised in the DSM or ICD, leaving millions without legitimacy or support.

Trauma Responses Are Involuntary

Trauma responses involve documented structural brain alterations that are involuntary and physiological. Research published in *Dialogues in Clinical Neuroscience* demonstrates traumatic stress causes smaller hippocampal volume, overactive amygdala, and underactive prefrontal cortex (Bremner, 2006). The clinical literature on complex trauma has documented these patterns extensively: trauma fundamentally alters brain structure and function in ways that produce involuntary, physiological responses to perceived threat (Herman, 1992; van der Kolk, 2014).

> These responses to trauma are involuntary. Trauma lives in the nervous system. The body reacts immediately to perceived danger before our thinking brain can accurately name what is going on. It is not a matter of choice — their brain is in survival mode.
>
> — Adapted from Bremner (2006) and Porges (2011)

A 2018 *NeuroImage* study compared brain activity in children with dyslexia, dyscalculia, and comorbid conditions. Despite behavioural differences, brain activity profiles were more similar than expected, showing substantial neural similarity in how they deviated from controls (Peters & De Smedt, 2018). The same structural parallels exist between learning disabilities and emotional dysregulation: both involve brain structure differences, disrupted functional connectivity, neurotransmitter system variations, and non-volitional manifestations.

Polyvagal Theory: The Unifying Framework

Dr Stephen Porges' polyvagal theory establishes that feelings of safety have a neurophysiological substrate measurable through heart rate variability and vagal tone. The theory identifies three hierarchical response states — social engagement (ventral vagal), fight/flight (sympathetic), and shutdown (dorsal vagal) — that the nervous system moves through based on unconscious threat detection called "neuroception."

Crucially, Porges emphasises these state shifts occur without requiring conscious awareness. This explains why telling someone to "calm down" is neurobiologically futile when their defensive systems are activated. These feelings are not intentional or under voluntary control but are part of an adaptive reflexive system wired into the nervous system (Porges, 2011; van der Kolk, 2014).

When Conditions Multiply

The neuroscience summarised above establishes that individual conditions — ADHD, autism, emotional dysregulation, trauma — have measurable brain-based differences. But these conditions rarely occur in isolation. For most neurodivergent adults, daily life means managing multiple co-occurring conditions whose effects interact physiologically, compound each other, and create a cumulative burden that no single-condition framework can capture.

This is not a marginal phenomenon. It is the norm.

The Scale of Multi-Morbidity

A systematic review by Choi et al. (2022), comparing psychiatric comorbidity across populations, found that approximately 80% of adults with ADHD have at least one co-occurring psychiatric disorder. Meta-analytic odds ratios show dramatically elevated risk: anxiety disorders at five times the population rate, major depressive disorder at 4.5 times, bipolar disorder at 8.7 times, and substance use disorders at 4.6 times (Cortese et al., 2025; citing Hartman et al., 2023).

For autistic adults, a UK-led meta-analysis of 30 studies by Hollocks et al. (2019) reported current anxiety prevalence of 27% and lifetime anxiety of 42%, with current depression at 23% and lifetime depression at 37%. The co-occurrence of ADHD and autism itself is remarkably common: a meta-analysis of 63 studies found a pooled ADHD prevalence of 38.5% among autistic individuals (Rong et al., 2021), with shared genetic factors accounting for approximately 72% of variance in both conditions.

UK population-level data confirms this picture. Underwood et al. (2022), using the Welsh SAIL Databank covering 3.6 million people, found that 47.63% of autistic adults had at least one co-occurring psychiatric diagnosis — they were 2.83 times more likely to experience a co-occurring condition than matched controls.

> **80%**
>
> of adults with ADHD have at least one co-occurring psychiatric disorder. Multi-morbidity is the norm, not the exception (Choi et al., 2022).

Yet UK policy frameworks — the Equality Act 2010, NICE guidelines, Acas guidance, occupational health assessment protocols — all default to single-

condition models. They assess and respond to conditions individually. The Equality Act recognises "cumulative effects" when determining whether someone qualifies as disabled, but provides no framework for assessing how reasonable adjustments should work when multiple qualifying conditions interact.

The Self-Reinforcing Cycle

The physiological interactions between these conditions form a multi-system feedback loop. Four interconnected pathways are documented.

HPA axis dysregulation is present in both ADHD and autism. A meta-analysis of 34 studies found children with ADHD had significantly lower morning awakening cortisol, consistent with chronic HPA axis exhaustion. In autism, adults show elevated anticipatory cortisol and sustained stress reactivity. The pattern is consistent with the body's stress response system progressing from overactivation to exhaustion under chronic stress.

Chronic inflammation accompanies both conditions. A meta-analysis of peripheral blood inflammatory markers found significantly elevated IL-6 levels in ADHD (Misiak et al., 2022), while autism shows a distinctly pro-inflammatory cytokine profile with elevated IL-1β, IL-6, IL-8, and IFN-γ (Masi et al., 2015). Critically, IL-6 and TNF-α levels in unmedicated ADHD adults are directly related to cortisol awakening response (Corominas-Roso et al., 2017), connecting the inflammatory and neuroendocrine pathways.

Sleep disruption affects 25–50% of individuals with ADHD and up to 83% of those with autism. Sleep disturbance elevates CRP and IL-6, amplifying inflammatory cascades that worsen co-occurring conditions. Sleep disruption functions as both a symptom of ADHD and autism and an amplifier of the inflammatory pathways that damage long-term health.

Cardiovascular risk provides the clearest evidence of end-organ damage. A Swedish cohort study of 5.4 million adults found ADHD was associated with doubled risk of any cardiovascular disease (HR=2.05), persisting after adjustment for all conventional risk factors (Li et al., 2022). A Mendelian randomisation meta-analysis confirmed that genetic predisposition to ADHD increases coronary artery disease risk, while ASD genetic predisposition raises atrial fibrillation and heart failure risk.

Each pathway worsens the others. Cortisol dysregulation increases inflammation. Inflammation disrupts sleep. Sleep disruption elevates cortisol. The cycle is self-reinforcing, and for someone managing ADHD, autism, anxiety, insomnia, and physical health conditions simultaneously, the cumulative physiological burden operates continuously.

> A single adjustment — a written agenda, a flexible start time, asynchronous communication — is not managing one condition. It is

load management across multiple interacting conditions, reducing the total demands on a system already running at capacity.

— The Compassion Gap analysis

The Mortality Evidence

Two landmark UK studies provide the most policy-relevant mortality data available globally.

O'Nions et al. (2023), using the IQVIA primary care database covering nearly 10 million people, found that autistic people without intellectual disability had 1.71 times the mortality rate of controls, with a life expectancy reduction of 6.14 years for men and 6.45 years for women. The study was published in *The Lancet Regional Health – Europe*.

O'Nions et al. (2025), in the first study to estimate life expectancy for adults with diagnosed ADHD using mortality data, drew on a UK primary care database of 9.6 million people to identify a matched cohort of 30,039 adults with diagnosed ADHD and 300,390 controls. The life expectancy reduction was 6.78 years for males (95% CI: 4.50–9.11) and 8.64 years for females (95% CI: 6.55–10.91). The authors emphasise these are "apparent estimates" because only diagnosed ADHD was included; since approximately 89% of UK adults with ADHD remain undiagnosed, the diagnosed cohort likely overrepresents those with more severe presentations and comorbidities.

The most compelling evidence for multi-morbidity as a distinct mechanism comes from Sun et al. (2019), who followed 2.7 million individuals in Sweden. Mortality risk increased in a dose-response fashion with number of psychiatric comorbidities.

HR = 25.22

Mortality risk for ADHD with four or more comorbidities — compared to HR = 1.41 for ADHD alone. Comorbidity does not add risk; it multiplies it exponentially (Sun et al., 2019).

This dose-response relationship is the single most important finding in the multi-morbidity literature. It demonstrates that someone managing multiple co-occurring conditions is not in a slightly worse version of the same situation as someone with one condition. They are in a qualitatively different risk category.

UK-specific suicide data adds urgency. Cassidy et al. (2022) analysed 372 coroners' inquest records from two English regions and found that 10% of those who died by suicide had evidence of elevated autistic traits — 11 times higher than the population autism rate. The LeDeR Annual Report 2023 (republished with corrections, January 2026) documented a median age of death of 62.5 years for people with learning disabilities and autistic people, compared to approx-

imately 82 for the general population — a gap of 19.5 years, with 40.2% of deaths classified as avoidable (King's College London et al., 2026).

Allostatic Load: The Missing Measurement

Allostatic load — defined by McEwen and Stellar (1993) as "the wear and tear on the body" from chronic or repeated activation of stress-response systems — provides the most promising unifying framework for understanding how multimorbidity in neurodivergent adults translates into reduced life expectancy.

Theoretical papers have proposed that social camouflaging in autism constitutes a distinct form of chronic stress contributing to allostatic overload (Mahony and O'Ryan, 2022). In 2025, Zubizarreta et al. provided the first direct empirical evidence linking camouflaging to a physiological biomarker of chronic stress: camouflaging behaviours were associated with increased hair cortisol concentration in a neurodiverse twin sample.

UK workplace studies using the Whitehall II cohort and UK Household Longitudinal Study have measured allostatic load in employment contexts. Chandola and Zhang (2018) found that re-employment in poor quality work was associated with higher allostatic load than remaining unemployed — a finding with direct implications for neurodivergent workers in non-accommodating workplaces. Chandola et al. (2019) further showed that flexible working arrangements were associated with lower allostatic load.

No empirical study has yet measured standard allostatic load biomarker panels in any autistic or ADHD adult population. This is the most significant research gap identified in this area. The theoretical framework exists. The UK research infrastructure exists. The measurement has not been done. This gap is itself evidence that understanding the cumulative health impact of neurodivergent experience is not a systemic priority.

How We Got Here

The divergent trajectories of physical versus emotional disabilities reveal how social attitudes, not objective characteristics of conditions, determine societal responses.

From the 1870s through the 1930s, learning disabilities underwent medicalisation. Neurologists coined terms like "word blindness" and "dyslexia," framing these conditions from inception as neurological issues affecting specific cognitive functions while preserving general intelligence — establishing legitimacy separate from moral character.

The landmark disability legislation of the late twentieth century cemented this medical framework. In the UK, the Disability Discrimination Act 1995 and subsequently the Equality Act 2010 established disability as a protected characteristic

requiring reasonable adjustments. In Scotland, the Education (Additional Support for Learning) (Scotland) Act 2004 created the Additional Support Needs framework — deliberately broader than the SEND systems in England and Wales, encompassing any reason a child might need additional support to benefit from education, whether permanent or temporary.

Emotional and behavioural issues followed the opposite trajectory. Despite growing understanding of their neurobiological basis, they remained stigmatised, moralised, and increasingly met with exclusion. Research consistently shows emotional issues face far greater stigma because of attributional differences: physical disabilities perceived as uncontrollable elicit sympathy and helping behaviours, while mental and emotional issues perceived as controllable elicit blame and anger.

From Exclusion to Custody

While physical and learning disabilities received accommodation, emotional and behavioural differences received punishment. The pattern is consistent across jurisdictions, though the scale differs significantly. In England, permanent exclusions rose from 4,632 in 2012/13 to 6,495 in 2021/22. Scotland tells a markedly different story — permanent exclusions fell from 21 cases in 2012/13 to just 1 in 2022/23 — but temporary exclusions remain substantial, and the disability disparity persists.

Scottish Government data for 2024/25 shows that pupils with Additional Support Needs are excluded at a rate of 28.9 per 1,000, compared to 5.8 for pupils without ASN — a gap of nearly five to one. Pupils from the most deprived areas face exclusion at nearly four times the rate of those from the least deprived areas, compounding disadvantage.

Across England and Wales, 80% of children cautioned or sentenced within the youth justice system have special educational needs or neurodivergence. Of young people in custody, an estimated 12% have ADHD, 15% are autistic, and between 60% and 90% have speech, language, or communication difficulties. The Youth Justice Board reports that 72% of sentenced children have mental health needs. These figures should be read alongside the fact that neurodivergent conditions are routinely not identified until after a child enters the justice system — routine screening does not exist before sentencing.

What Drives the Disparity

Visibility creates credibility. Physical disabilities often involve wheelchairs or hearing aids. Learning disabilities demonstrate through testing. Emotional dysregulation lacks visible markers and faces scepticism.

Perceived controllability shapes response. Through Weiner's Attribution Model (Weiner, 1985): onset-uncontrollable conditions like dyslexia elicit support; onset-controllable conditions like behavioural differences elicit blame.

The moral model persists. Children with behavioural differences continue to be labelled "bad," "lazy," "defiant," "seeking attention," with emphasis on discipline and character-building.

Informal exclusion compounds the problem. Scotland's Children and Young People's Commissioner has raised concerns about unlawful practices including parents being asked to collect children early, the prolonged use of part-time timetables, and children missing school due to a lack of suitable placement or support — none of which appear in formal exclusion statistics.

The Human Cost

Behind every statistic is a child whose needs were not met. While UK data protection and the Children's Hearings system in Scotland rightly limit public identification of individual children, documented cases from other jurisdictions illustrate the pattern that exclusion data reveals.

In one widely documented US case, a 12-year-old boy with diagnosed bipolar disorder and an individualised education plan was handcuffed in front of classmates during a behavioural incident that his own school officials determined resulted from his disability. Despite having documented recommendations for individual instruction, daily therapy, and specific de-escalation strategies, none were in place. He was charged with three counts of assault, denied return to his regular school, and eventually placed on a homebound programme with just four hours of weekly teacher contact.

In another case, a girl who was sexually abused at age 6 developed trauma-related behavioural issues. Schools suspended her more than 24 times, expelled her twice, and provided minimal therapeutic support. During expulsions she received little or no schoolwork.

> Nobody never took the time to really guide me the right way when it came to my emotions. Wake up, eat cereal, go back to sleep, and wait until everybody got out of school. It's like y'all wanted me to die out there.
>
> — Keyanna Tucker, reflecting on her repeated school exclusions

These are not just American stories. Scotland's own legal system has confronted the pattern directly. In McGibbon v Glasgow City Council (ASNTS, Decision ASN_D_07_12_2017), the Additional Support Needs Tribunal found that many disabled or autistic pupils exhibit behaviour as a result of their condition, and that applying the same exclusion policy without differentiation or reasonable adjustment is discriminatory. During proceedings, Dr Gillean McCluskey, an expert on school exclusions, gave evidence that exclusions are ineffective and potentially make matters worse for the pupil, their family, and their wider school community.

The Numbers

The link between school exclusion and later criminal justice involvement is well established across the UK.

80%

of children cautioned or sentenced in England and Wales have SEND or neurodivergence (UCL / Michael Sieff Foundation, 2025).

5×

Pupils with ASN in Scotland are excluded at nearly five times the rate of those without (Scottish Government, 2024/25).

72%

of sentenced children in England and Wales have mental health needs (Youth Justice Board).

Population-based evidence shows children with ADHD are approximately six to nine times more likely to be excluded from school than their peers (John et al., 2022; adjusted OR 6.1, 95% CI: 5.7–6.4). Screening studies of excluded pupils confirm the reverse picture: secondary school children with two or more fixed-term exclusions show significantly elevated ADHD symptomatology, lower cognitive ability, and high rates of unidentified neurodevelopmental needs compared to matched peers (Lawson et al., 2022). Autistic children are three times more likely to be suspended. Of children in custody, dyslexia rates range between 43% and 57%, and rates of communication disorders range between 60% and 90%. These children enter custody at higher rates, at an earlier age, tend to receive longer sentences, and are associated with higher rates of reoffending.

In Scotland, 43% of all pupils — nearly 300,000 children — are now identified as having Additional Support Needs, more than doubling from 22.5% in 2015. Over the same period, the number of specialist schools has fallen from 144 to 107. The Scottish Children's Services Coalition has described the situation as "unsustainable," noting that those with ASN are drawn disproportionately from poorer neighbourhoods.

Care-experienced children face compounded disadvantage. In Scotland, they are eight times more likely to be excluded than their non-care peers. Of care-experienced children in England receiving a custodial sentence before age 24, 92% were identified as having special educational needs.

The Stark Contrast

A pupil in a wheelchair receives ramps, accessible toilets, modified desks, extra time between classes, and assistance with materials — with no sanction for mobility limitations. A pupil with PTSD or sensory processing difficulties receives

exclusion for emotional outbursts that are disability manifestations, limited access to calming spaces or sensory breaks, and removal from school rather than therapeutic support.

> A child who is classified as having an emotional disturbance is a client that we see very frequently, whose needs are not being met. They are the most outwardly-displaying their behaviours and their disability. We're not at all surprised to see that they are the most likely to be excluded.
>
> — Kathryn Meyer, Center for Children's Advocacy

The law firm Kingsley Napley, summarising the UK landscape in 2024, identified the core failing: behaviour arising from unmet needs is interpreted as an innate reflection of character rather than being understood as a disability manifestation requiring appropriate intervention. There is, they concluded, "something inherent within our education and youth justice systems that punishes difference."

The Philosophical Case

The disparity lacks principled moral justification. Thomas Nagel's concept of "moral luck" directly applies: people cannot be morally assessed for what is not their fault, or for what is due to factors beyond their control. Being born with visible versus invisible challenges, or with learning disabilities versus emotional dysregulation, represents "constitutive moral luck" — unchosen personal characteristics profoundly affecting moral judgement. If we should not hold people responsible for factors beyond their control, treating emotional dysregulation as more blameworthy than learning disabilities is philosophically incoherent.

Two interpretive frameworks exist for "reasonable adjustment." The distributive justice view treats accommodation as resource redistribution with cost-benefit considerations. The recognition and respect view frames accommodation as required by equal respect and concern — not compensating for deficits but treating differences with equal dignity. This distinction is particularly salient for invisible disabilities where accommodation costs may be low but recognition costs (overcoming stigma) are high.

Martha Nussbaum's capabilities approach argues justice requires ensuring all people can achieve basic human functionings, explicitly including emotional regulation as requiring social support. Environmental modifications can support emotional regulation just as ramps support mobility.

The parity argument from neuroscience is decisive. Both learning disabilities and emotional dysregulation involve neurobiological differences in information processing, working memory, executive function, and stress response systems. If we grant moral consideration to learning disabilities based on neurobiological causation, consistency demands equal consideration for emotional dysregula-

tion. The social model of disability applies equally: emotional dysregulation is disabling primarily through stigmatising responses, institutional structures designed for emotionally stable people, lack of environmental supports, and punitive rather than supportive responses.

The multi-morbidity evidence strengthens this further. When a person manages eight conditions simultaneously — each qualifying under the Equality Act, each interacting with the others physiologically — the moral case for accommodation becomes not just one of parity with single-condition disabilities, but of proportional response to proportional burden. The Sun et al. finding that mortality risk multiplies exponentially with comorbidity count means that failing to accommodate someone with multiple conditions is not merely neglecting a right. It is contributing to a measurable reduction in their lifespan.

Behind Rawls' veil of ignorance, not knowing whether you will have learning disabilities or emotional dysregulation, rational contractors would choose equal support for both. From recognition theory, both groups deserve equal respect. From disability justice (Berne, 2015), both are disabled by ableist structures; liberation requires transforming those structures, not creating hierarchies within disabled communities. The philosophical case is unequivocal: any position other than parity reflects not principled ethics but prejudice masquerading as principle.

What Works

Successful alternatives demonstrate equal accommodation is possible, effective, and benefits everyone. These are not theoretical proposals — they are evidence-based interventions with rigorous evaluation, many of them operating in UK schools today.

Restorative Approaches

Restorative practices replace exclusionary discipline with approaches that repair harm and relationships while addressing root causes of behaviour. UK evidence is strong and growing.

In Oxfordshire, where 70 schools have participated in restorative practice training since 2019, 90% of trained schools have seen a reduction in suspensions and 83% have seen a reduction in permanent exclusions. 100% of participating staff reported feeling more confident dealing with conflict and bullying following training.

In Barnet, an evaluation of 16 restorative justice trained primary schools found a 51% reduction in fixed-term exclusions (from an average of 3.44 to 1.75 per school), compared to a 65% increase in fixed-term exclusions in 32 non-trained schools over the same period (Moore, 2008). It should be noted that the trained schools started with higher baseline exclusion rates than the

non-trained schools, and that permanent exclusion data was unavailable for this evaluation.

An independent evaluation of restorative justice in Bristol schools found improved attendance and reduced exclusion rates. A DfE-commissioned study by Goldsmiths University found that 97% of schools using restorative approaches rated them as effective in reducing bullying (Thompson and Smith, 2011).

Scotland's Progress — and Remaining Gaps

Scotland deserves recognition for its trajectory. Permanent exclusions have been almost eliminated — from 21 cases in 2012/13 to just 1 in 2022/23 — at a time when England's permanent exclusions rose from 4,632 to 6,495. This reflects Scotland's policy emphasis on "needs not deeds," rooted in the Kilbrandon Principles, and the full incorporation of the United Nations Convention on the Rights of the Child into Scots law in 2024.

Yet the five-to-one exclusion disparity for pupils with ASN shows the work is far from complete. Informal exclusion practices, declining specialist school capacity, and a workforce under strain mean that the policy ambition outpaces the lived experience of many families.

Sensory Rooms and Calming Spaces

Dedicated environments with sensory equipment for self-regulation show measurable impact. Holgate Meadows School in Sheffield provides sensory and calming rooms in each school phase, offering safe relaxing spaces to regulate emotions and de-escalate behaviour. The rooms are designed for safety during crisis, give children control over their environment, and link to the Zones of Regulation curriculum.

International evidence from Muskegon County, Michigan found pupils 56% more engaged in classroom activities after using sensory rooms. Benefits include reduced meltdowns, improved focus, and critically, allowing pupils to stay in school rather than being sent home.

Trauma-Informed Schools

Whole-school trauma-informed approaches shift from asking "what's wrong with you?" to "what happened to you?" UK approaches include Nurture Groups providing small, supportive environments, the Attachment Aware Schools Programme, and Scotland's own neurodevelopmental support summit in December 2024. Studies consistently find these approaches improve outcomes for all pupils while reducing staff burnout and secondary traumatic stress.

The Oxfordshire Relational Schools Programme — combining restorative, trauma-informed, and attachment-aware practice — reports schools halving

suspensions, with staff describing reduced panic about high-level behaviour and a shift away from hierarchical consequences.

Recommendations

The convergence of neuroscience, philosophy, law, and practical evidence demands a fundamental shift. Emotional dysregulation, sensory processing issues, trauma responses, and nervous system dysregulation are not character flaws or moral failures. They are neurological conditions with documented biological bases. They are fundamentally similar to learning disabilities in their neurobiological substrate, developmental trajectories, genetic components, and non-volitional nature.

For Schools

- Recognise emotional dysregulation as disability. It requires reasonable adjustment, not exclusion. The Equality Act 2010 and the ASN Act 2004 (in Scotland) already provide the legal framework — implementation must match the mandate.
- Invest in prevention before crisis. Mental health support, trauma-informed practice, and restorative approaches are more effective and more cost-efficient than exclusionary discipline.
- Train all staff comprehensively. Not just specialist staff — every adult in a school needs grounding in trauma-informed, neurodiversity-aware practice. This should be mandatory and ongoing, not a one-off session.
- Provide infrastructure. Sensory rooms, calming spaces, adequate mental health professionals, and crisis de-escalation areas should be standard, not exceptional.
- Eliminate exclusion as a behaviour management tool. Scotland's near-elimination of permanent exclusions demonstrates this is achievable at scale. Temporary exclusions must follow the same trajectory.

For Policy Makers

Education is devolved across the UK. These recommendations address all four nations while recognising that Scotland, England, Wales, and Northern Ireland each have distinct legislative and policy frameworks.

- Apply Equality Act principles consistently. If we provide ramps for wheelchairs, we must provide calming spaces for emotional dysregulation. The duty to make reasonable adjustments applies equally to invisible disabilities.

- Mandate data collection on informal exclusion. Part-time timetables, early pick-ups, and "managed moves" are not captured in exclusion statistics. Without data, there is no accountability.
- Invest in the workforce. Scotland needs more specialist teachers, pupil support assistants, educational psychologists, and mental health professionals.
- Ensure routine neurodevelopmental screening before justice involvement. Currently, screening does not occur until sentencing to custody. Earlier identification prevents criminalisation of unmet needs.
- Commission research on allostatic load in neurodivergent populations. The UK has world-leading longitudinal cohorts measuring workplace stress biomarkers, but no study has yet applied these to neurodivergent adults. This gap must be closed to understand the cumulative health impact of systemic non-accommodation.

For Workplaces

- Accommodate emotional and sensory needs proactively. Flexible schedules, quiet workspaces, sensory accommodations, modified communication approaches, and time for therapy are low-cost, high-impact interventions.
- Recognise multi-morbidity as the norm. Most neurodivergent employees are managing multiple co-occurring conditions. A single adjustment — a written agenda, a flexible start time — may be managing load across multiple interacting conditions simultaneously. Assess adjustments holistically, not condition by condition.
- Assess cumulative impact from the employee's perspective, not only the employer's. Current frameworks evaluate whether providing multiple adjustments constitutes a disproportionate burden on the employer. They do not evaluate whether the cumulative benefit of receiving adjustments is the difference between sustained employment and withdrawal from work. Both perspectives matter.
- Separate adjustment failures from performance outcomes. If occupational health recommended adjustments that were never implemented, the resulting performance gap is the employer's failure, not the employee's. Performance review processes must account for this.
- Train managers on multi-morbidity. Research shows 37% of managers have received no neurodiversity training. Managers who do not understand how conditions interact cannot assess performance fairly or implement adjustments effectively.
- Track performance outcomes by disability status. Employers should know whether disabled and neurodivergent employees receive lower perfor-

mance ratings as a pattern. If they do, that is systemic and needs investigating.

- Eliminate double standards. The Ontario Human Rights Commission has ruled explicitly against differential treatment of mental versus physical health disabilities. The Equality Act 2010 supports the same principle in the UK.

The Choice Before Us

The science is settled. The philosophy is clear. The legal framework exists. The effective alternatives are proven. What remains is the choice: continue excluding children for neurological differences beyond their control and penalising neurodivergent employees for the consequences of adjustments never provided, or finally extend to emotional and nervous system needs the same compassion, accommodation, and support we provide for other disabilities.

Scotland has shown what policy commitment can achieve — permanent exclusions reduced to virtually zero. But the five-to-one exclusion disparity for pupils with ASN shows the gap between aspiration and reality. The 300,000 children in Scottish schools with Additional Support Needs deserve better. So do the 80% of children in the youth justice system whose neurodivergence was identified too late. So do the neurodivergent adults losing six to nine years of life expectancy because the systems meant to support them assess conditions individually while those conditions compound each other continuously.

We don't exclude children for needing wheelchairs. We shouldn't exclude them for needing emotional regulation support. And we shouldn't penalise adults for the consequences of adjustments we promised but never delivered.

The question is not whether emotional needs deserve equal accommodation — it's when our systems will catch up to what justice demands.

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Multi-Morbidity and Co-Occurring Conditions

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About the Author

Mark Friese MEng MIET is a neurodivergent researcher and advocate based in Glasgow, Scotland. His work examines systemic failures in how UK institutions treat people whose personal circumstances affect how they communicate and navigate systems, drawing on academic research, legal analysis, and lived experience. This paper is part of a wider research programme on disability policy and practice across education, employment, and financial services.

A note on scope: Education is devolved across the United Kingdom. This paper draws primarily on Scottish data and legislation, reflecting the author's Scottish context, supplemented by UK-wide youth justice data, mortality research, and evidence from England, Wales, and international sources where these strengthen the argument. The multi-morbidity and employment sections draw on UK-wide data. Readers in England, Wales, and Northern Ireland should refer to their respective SEND/ALN frameworks and exclusion guidance.