Neuro Inclusion Index™
The Neuro Inclusion Project

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The Unrecorded Injury

Neuro-inclusion must be measured like health & safety

Exclusion at work is an occupational hazard. It causes injury, sometimes fatal injury. It must be assessed, controlled and measured exactly as every other workplace hazard is.

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95%

Rise in employment tribunal cases involving neurodivergent conditions, 2020 to 2025.

Irwin Mitchell, 2026

3 in 10

Autistic people of working age in any kind of work, the lowest rate of any disability group.

ONS; Autistica

£44,483

Mean disability discrimination award at employment tribunal, 2023/24.

Ministry of Justice

OPENING

The injury nobody records

When a worker falls from a ladder, the organisation records it. There is an accident report, an investigation, a root cause, and a review of the controls that failed. If it is serious enough, the regulator is told.

When a neurodivergent worker is worn down over months, nothing is recorded. The harm comes from an adjustment that never arrives, a manager who reads difference as poor performance, and a working environment they have to mask their way through every day. They go off sick. They are put on a capability plan. They resign, or they are managed out. Some of them do not survive it.

There is no accident book for that. No investigation, no root cause, no lessons learned. The injury happened at work, and the workplace never knew.

This paper takes one position: exclusion at work is an occupational hazard. It causes injury, sometimes fatal injury. It must be assessed, controlled and measured exactly as every other workplace hazard is.

SUMMARY

At a glance

This summary mentions suicide. Support details are at the end of the paper.

The hazard

Exclusion at work contributes to burnout, long-term sickness, lost careers and, in the worst cases, suicide. Autistic adults without intellectual disability face around ten times the general population's risk of suicide.

The gap

Employers already have a legal duty to assess risks to health. Almost none assess neurodivergent exposure, and no common measure exists.

The cost

Organisations already pay through turnover, absence and tribunals. The mean disability discrimination award at tribunal was £44,483 in 2023/24.

The precedent

Every invisible hazard in health and safety, from noise to stress, came under control once its exposure was measured rather than its casualties counted.

The standard

Seven requirements any credible neuro-inclusion measure must meet, set out in section 7.

The instrument

The Neuro Inclusion Index meets six of them today. Validation against outcomes, the seventh, is in progress.

SECTION 1

Why a health and safety professional is making this case

I have spent much of my career responsible for fire, health and safety. As a Fire, Health & Safety Officer I carried out audits and risk assessments. I have also been the health and safety officer inside businesses, answerable for what happened on the floor.

That work teaches one discipline above all others. You identify the hazard. You establish who is exposed. You put controls in place, you check they work, and you review. You do not wait for the injury to tell you the hazard exists.

I built the Neuro Inclusion Index the way I was trained to manage any hazard. This is not an analogy, and it is not a comparison chosen to sell a product. It is the same discipline, applied to a hazard that has been left off the register.

The position is in four parts:

1. Exclusion is an occupational hazard.
2. It causes measurable harm to health, up to and including death.
3. Employers already have a legal duty to assess and control it.
4. It can be measured, so it must be.

SECTION 2

The human cost

Content note: this section discusses suicide. Support details are at the end of this paper.

The harm is not hypothetical, and it is not mild. It runs from exhaustion to lost careers to lost lives.

Exhaustion and lost function. Researchers define autistic burnout as a syndrome caused by chronic life stress and a mismatch between expectations and abilities without adequate supports. It brings exhaustion lasting typically three months or more, loss of function and reduced tolerance to stimulus. Participants linked it to lost work, damaged health and suicidal behaviour (Raymaker et al., 2020). Read that definition as a health and safety professional would: sustained demand, exceeding capacity, with no controls. That is a hazard description.

Lost careers. Around 3 in 10 autistic people of working age are in any kind of work, the lowest rate of any disability group, against 53.5% of disabled people overall and 81.6% of non-disabled people (ONS data via DiversityQ; Autistica evidence to Parliament). Those in work are paid a third less on average.

Lost lives

- A Swedish study of more than 27,000 autistic people and 2.7 million controls found premature death about 2.5 times more likely. For autistic people without intellectual disability, the risk of suicide was about 10 times the general population (Hirvikoski et al., 2016; The Transmitter).
- Among 374 UK adults diagnosed autistic in adulthood, at an average age of 31, 66% had contemplated suicide, against 17% of the UK population. 35% had planned or attempted it (Cassidy et al., 2014). These are working-age adults who went through education and employment without anyone recognising their needs.
- A Danish nationwide cohort of 2.9 million people found suicidal behaviour among people with ADHD at 415.6 per 100,000 person-years, against 75.5 across the cohort: 2.6 times higher after adjustment (British Journal of Psychiatry).
- UK primary care data shows adults with diagnosed ADHD are living shorter lives than they should. The researchers attribute this to modifiable risk factors and unmet support needs (O'Nions et al., BJPsych).

The workplace link

A 2018 study looked for risk markers for suicidality unique to autistic adults. 72% of autistic participants scored above the psychiatric cut-off for suicide risk, against 33% of the general population. Two markers unique to autism predicted suicidality: camouflaging, and the number of unmet support needs. Employment was a further risk marker. The study was an online survey of 164 autistic adults, and it did not separate work from the rest of life (Cassidy et al., 2018).

Camouflaging is what people do when an environment is not safe to be themselves in. An unmet support need, at work, is an adjustment that never arrived. Neither is caused by work alone. But both are shaped directly by the conditions an employer creates, and both can be measured.

We do not claim that workplaces cause every one of these deaths. Asbestos did not cause every lung cancer either. The claim is narrower and harder to dismiss: the workplace is a significant source of exposure, and almost nobody is measuring it.

Beyond autism and ADHD. The strongest published mortality evidence concerns autism and ADHD, because that is where the research has been done. That is a gap in the research, not evidence of safety. Dyslexia affects an estimated 4 to 10% of the population (TUC, citing the British Dyslexia Association), and around 5% of people have dyspraxic traits (GMB and Dyspraxia

Foundation). The 2018 Westminster AchieveAbility Commission found that among people with dyslexia, dyspraxia, autism or attention deficit disorder, 52% had experienced discrimination at interview or selection and 43% had been discouraged from applying at all (Yahoo News). In health and safety, an unstudied hazard is never treated as a safe one.

SECTION 3

The cost to the organisation

Organisations already pay for this hazard. They never see one invoice for it, because the cost is spread across absence, turnover, tribunals and lost output, and each line sits in a different budget.

COST LINE	FIGURE	SOURCE
Replacing one employee	£30,614 on average; £39,887 in the legal sector	Oxford Economics and Unum (2014; likely higher today)
Disability discrimination award at tribunal	Median £17,218; mean £44,483; highest £964,465 (2023/24)	Ministry of Justice tables, via MFMac
Poor mental health, all UK employers	£51 billion a year, of which presenteeism is about £24 billion	Deloitte, 2024
NHS sickness absence	About £4.6 billion a year and more than 8 million clinician days	Policy Exchange, via Healthcare Management
Work-related stress, depression and anxiety	22.1 million working days lost (2024/25)	HSE, via Human Focus

Tribunal awards understate the cost. They cover only cases that reach a remedy hearing, and exclude legal fees, management time and settlements.

A worked illustration. No published figure yet shows how many exits, absences or claims poor neuro-inclusion causes, so this uses a range rather than a single estimate. Take an organisation of 5,000 staff. If the one-in-seven estimate holds, around 700 of them are neurodivergent. If poor conditions drive between 5 and 20 avoidable exits a year, then at the average replacement cost that is roughly £153,000 to £612,000. One disability discrimination claim reaching the median award adds £17,218 before legal costs. None of this counts absence, presenteeism or the cost to the person. The range shows the scale; the real figure comes from the organisation's own absence, turnover and case data, which is what an assessment uses.

Every figure in this table is a lagging indicator: the cost of the injury after it has happened. Measuring exposure is the cost of preventing it, and it is the smaller number.

SECTION 4

This is already a health and safety duty

Employers do not need a new law to act. The duty to assess and control this hazard already exists, twice over.

Health and safety law. Section 2 of the Health and Safety at Work etc. Act 1974 requires employers to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees. Health includes mental health. Regulation 3 of the Management of Health and Safety at Work Regulations 1999 requires a suitable and sufficient assessment of risks to health. HSE is explicit: employers have a legal duty to protect workers from stress at work by doing a risk assessment and acting on it (HSE).

Equality law. The Equality Act 2010 requires reasonable adjustments for disabled employees, which in practice covers many neurodivergent people.

Now put the hazard and the duty side by side. HSE's Management Standards name six sources of work-related stress: demands, control, support, relationships, role and change. A neurodivergent worker facing unadjusted sensory load, unclear

communication, unannounced change and a manager without the competence to respond is exposed on every one of them, often more heavily than colleagues.

Yet in most organisations, no risk assessment considers neurodivergent exposure at all. Around one in seven people in the UK is neurodivergent (Autistica NDEI report via The Star). A risk assessment that ignores a seventh of the workforce is not suitable and sufficient. In any audit I have carried out, that would be a finding.

SECTION 5

Invisible is not the same as unmeasurable

Every invisible hazard in health and safety history was first declared impossible to measure. Every one was measured.

HAZARD	WHY IT WAS CALLED UNMEASURABLE	HOW IT WAS MEASURED
Noise	Hearing loss builds silently over years	Decibel readings and exposure limits
Dust and asbestos	Disease appears decades after exposure	Airborne concentrations and workplace exposure limits
Radiation	It cannot be seen, felt or heard	Personal dosimeters
Work-related stress	Too subjective, too personal	HSE Management Standards (2004): six measured conditions
Psychosocial risk	Not a 'real' hazard	ISO 45003 (2021): managed inside the safety system

The answer was the same each time. Stop waiting for the casualty and measure the exposure. Outcomes, when they finally arrive, validate the measure; they never replace it.

The history also shows what moves organisations. The first factory law, in 1802, was a duty with no one checking, and it was ignored. Behaviour changed only when inspection made failure visible, compensation made it expensive, standards made good practice certifiable, and buyers refused to contract with anyone who could not prove it.

Neuro-inclusion today has the duty and the rising cost. Tribunal cases involving neurodivergent conditions rose from 265 in 2020 to 517 in 2025 (Irwin Mitchell). What it lacks is the measure. Neuro-inclusion is not unmeasurable. It is unmeasured, and that is a choice.

SECTION 6

The objections, answered

Every hazard that health and safety now manages was first met with the same objections. Neuro-inclusion is meeting them now.

"Causation isn't proven."

Health and safety has never required proof that a hazard caused a specific person's harm before controlling exposure. The legal duty is to assess risk, not to wait for proof of injury. Work-related stress is managed on exactly this basis: established associations and a plausible mechanism. Here the mechanism is documented. Camouflaging and unmet support needs predict suicidality, and the workplace shapes both. What is not yet proven is that measuring these conditions reduces harm. That is what validation is for, and it is why measurement has to start now rather than after the proof.

"This is HR's job, not health and safety's."

Where the harm is to health, the law already makes it a health and safety matter: section 2 of the 1974 Act and regulation 3 of the 1999 Regulations. HR owns the process; health and safety owns the risk. Leaving it to HR alone is why it is handled case by case, after the harm, instead of systemically, before it.

"Neurodivergence is overdiagnosed. You're medicalising difference."

A conditions-based measure does not depend on diagnosis at all. It measures the environment everyone works in. Whether or not a person has a label, an adjustment that takes six months to arrive is a failed control. Arguing about who has a diagnosis while nobody measures the conditions is like arguing about whose hearing is damaged while nobody measures the noise.

"It's another burden on business."

Section 3 shows organisations already carry the cost; they just do not see it. The duty already exists, so measurement is how an organisation shows it has been met. The Löfstedt review found the burden in health and safety came from paperwork aimed at the wrong things, not from the law. A good measure reduces wasted effort by showing exactly where to act.

"We already have a policy and training."

A policy is not a control, and training completion is not evidence of effect. The question any auditor asks is simple: show me that it works. Without measurement, nobody can.

SECTION 7

The standard neuro-inclusion measurement must meet

Any measure worth the name must do what a competent health and safety assessment does. Seven requirements follow.

1. **Put the hazard on the register.**
   Exclusion belongs on the organisational risk register, with an owner, alongside every other risk to health.

2. **Assess exposure, not individuals.**
   Measure the conditions the organisation creates: how work is organised, managed and adjusted.

3. **Require no disclosure.**
   Nobody is asked to declare hearing loss before the noise is measured. The same applies here.

4. **Test controls in practice.**
   A policy is not a control. An adjustment process that exists on paper but takes six months to deliver is a failed control.

5. **Be repeatable and comparable.**
   The same measure, applied the same way, so trends show over time and organisations can be benchmarked.

6. **Be validated against harm and cost.**
   Better scores must show up as lower absence, attrition, adjustment delays, grievances and claims.

7 **Sit inside the existing safety system.**

Risk assessment, audit, ISO 45001 and ISO 45003, governance reporting. Not a parallel HR exercise.

SECTION 8

The Neuro Inclusion Index: health and safety method, applied

The Neuro Inclusion Index (NII) was not mapped onto health and safety after it was built. It was built as a health and safety assessment, by someone who has carried them out for a living. Its nine diagnostics cover the full management cycle.

Plan
Govern and set direction

I01
Structural Risk Governance
Structural barriers and inclusion risks needing governance attention.
H&S: risk register and board oversight

I02
Inclusion Strategy Effectiveness
Whether strategy reaches everyday practice.
H&S: policy and objectives

I06
Inclusion Change Readiness
Capacity to implement and sustain change.
H&S: management of change

Do
Deliver the controls

I03
Adjustment Access & Friction
How easily adjustments are accessed and implemented, and where they stall.
H&S: control measures in place and working

I04
Management Practice Reliability
How consistently managers apply inclusive practice.
H&S: supervisor competence

I05
Neuro-Inclusive Working Conditions
Whether working conditions support or constrain sustainable work.
H&S: exposure monitoring

Check
Test against experience

I07
Disclosure, Safety & Trust
Whether people feel safe to raise needs, and trust the response.
H&S: reporting culture

I08
Lived Experience
Whether working arrangements are usable and sustainable in practice.
H&S: worker consultation and health surveillance

Act
Close the loop

I09
Policy-to-Practice Integrity
Whether commitments become decisions and corrective action.
H&S: audit and management review

Measured against the standard

NII meets six of the seven requirements in section 7 today. The seventh is under way.

REQUIREMENT	HOW NII MEETS IT	STATUS
Put the hazard on the register	I01 assesses structural risk at governance level and reports it to the board	Met
Assess exposure, not individuals	All nine diagnostics measure organisational conditions; I05 measures working conditions directly	Met
Require no disclosure	Results describe the organisation; nobody has to identify as neurodivergent to take part	Met

REQUIREMENT	HOW NII MEETS IT	STATUS
Test controls in practice	I03 tests whether adjustments are delivered; I09 tests whether policy becomes practice; I07 and I08 test leadership's picture against staff experience	Met
Be repeatable and comparable	The same nine constructs every time, so results trend over time and compare between organisations	Met
Be validated against harm and cost	Findings are expressed as avoidable cost; independent validation against outcomes is being established with an academic partner	In progress
Sit inside the existing safety system	The diagnostics map onto plan, do, check, act, the risk register and audit	Met

Other approaches fall short at specific points. Approaches that audit policies, or survey staff opinion alone, fail the fourth requirement: they record what exists or how people feel, not whether controls work. Approaches that count diagnosed or disclosed staff fail the third.

Validation against outcomes is the requirement every new measurement system has to earn. Exposure limits earned their authority the same way. What sets NII apart is where it comes from: it was built by a neurodivergent, Fire, Health & Safety professional, using health and safety assessment methodology from the first line, not adapted from a diversity survey.

ILLUSTRATIVE SCENARIO

What an assessment looks like

This scenario is illustrative. It is not drawn from a real organisation or from NII pilot data.

An NHS trust of 6,000 staff believes it is in good shape. It has a neurodiversity policy, an active staff network, and high completion rates for awareness training. On paper, the controls are in place.

The assessment finds otherwise:

I03 **Adjustment Access & Friction.** Adjustment requests routinely take months to implement. Most stall at one point: the handover between an occupational health recommendation and line manager action. Nobody owns that step.

I04 **Management Practice Reliability.** Practice varies sharply between directorates. Two directorates account for most of the trust's formal capability processes.

I07 **Disclosure, Safety & Trust.** Many staff with unmet needs have not raised them, because they fear being seen as a problem.

I09 **Policy-to-Practice Integrity.** The policy promises adjustments within a set timeframe. Practice does not meet it, and nothing in the governance system has noticed.

Read as a health and safety professional would, this is a textbook finding. The hazard was known. A control existed on paper. It failed at a single handover. And there was no monitoring in place to detect it.

The actions follow the same logic as any other failed control:

1. Give the occupational health to line manager handover a named owner and a time limit.
2. Target manager competence in the two directorates where formal processes cluster.
3. Review open capability cases for unrecognised adjustment needs.
4. Build the cost case from the trust's own absence, turnover and case data.
5. Retest at twelve months to confirm the controls are working.

SECTION 9

What must happen now

None of what follows needs new legislation. It needs organisations to apply the duties they already have.

Boards	must put neuro-inclusion on the risk register with a named accountable director, and receive an annual exposure baseline and trend, as they would for any material risk to health.
Every psychosocial risk assessment	must consider neurodivergent exposure. An assessment that does not is not suitable and sufficient.
Serious harm must be investigated	When a neurodivergent employee goes on long-term sickness absence, is managed out, or dies by suicide, the organisation must ask what it would ask after any serious incident: what conditions contributed, which controls failed, and what changes now. Closing an HR case is not an investigation.
Health and safety professionals	must bring neuro-inclusion inside the safety management system, working with HR, occupational health and EDI rather than leaving it to them.
HSE	has not yet published guidance of its own on neurodivergent workers; that guidance currently comes from Acas, CIPD and the RCN. HSE must name neurodivergent exposure explicitly in its psychosocial and stress guidance, and ask about it on inspection.
NHS commissioners	must require conditions-based measurement of neuro-inclusion in workforce commissioning, and treat it as the cost improvement lever it is.
Standards bodies	must develop guidance on neurodivergent exposure within ISO 45003 practice, so results compare across organisations.

If a workplace hazard were injuring people this often, and sometimes killing them, and no one was recording it, every health and safety professional in the country would call it a failure of the system. This is that failure.

The injury is real. It is happening now. It is not being recorded. That has to end.

APPENDIX

The NII method in brief

This appendix sets out how the Neuro Inclusion Index is designed. Item wording, weightings, scoring and the cost model are proprietary and are shared with commissioners and research partners under a non-disclosure agreement.

Unit of measurement	The organisation, not the individual. Results describe the conditions people work in, by organisation and, where the data supports it, by directorate or team.
No disclosure	No member of staff is asked to disclose a diagnosis, or to identify as neurodivergent, at any point. The measure applies to the whole workforce.
Sources of evidence	Each diagnostic triangulates more than one source, so no finding rests on a single perspective: questionnaires completed by staff across the organisation; separate input from managers and senior leaders; existing organisational records, such as absence, turnover, adjustment requests, formal cases and occupational health referrals; review of policies and procedures, tested against what happens in practice; and, where needed, interviews, focus groups and checks of the working environment.
Consistency	The same nine diagnostics are applied in the same way in every organisation, so results can be compared between organisations and over time.
Retest	Each organisation is reassessed every 12 months. The retest is the point at which change is measured, and it shows whether the controls put in place have worked.
Validation	Independent validation of the link between NII results and outcomes such as absence, turnover and claims is being established with an academic partner.

Support

If anything in this paper has affected you, you do not have to deal with it alone. In the UK and Ireland, Samaritans are available free, day or night, on **116 123**. You can also text **SHOUT** to **85258**. If you are in immediate danger, call **999**.

SOURCES

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