

Neuro-affirming Environment Audit Tool: Health

Audit the physical and social environment in your health setting. Plan to adapt the environment.

Long Form



Neuro-affirming Environment Audit Tool: Health (Long Form)

National Autism Implementation Team 2025

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This document is available online <https://www.nait.scot>

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Background

Health environments can have a profound impact on how neurodivergent people access and experience care. Environmental factors, both physical and social, can either challenge or support individuals - increasing or reducing anxiety, encouraging or discouraging attendance and supporting or interfering with communication. While some settings already consider physical accessibility, other aspects of healthcare environments are often overlooked. Even small adjustments, such as offering low-stimulation spaces or improving staff understanding of neurodivergent experiences, can make a significant difference. Although some changes may require planning or investment, many others are easily achievable.

How we developed the tool

We became aware of the need for this tool after practitioners in the Neuro-affirming Community of Practice Scotland highlighted a desire to audit their spaces, but no suitable tool could be identified. To address this, we first carried out a rapid literature review to gather potential items from online sources, including a range of published materials and research, listed below. We then consulted with stakeholders and reviewed feedback from previous NAIT events and groups. These processes informed the identification and selection of items for inclusion in the tool. Key resources include the following:

NAIT Beyond Accommodations Employment Guides

<https://nait.scot/document/supporting-autistic-professionals-in-health-and-education-2024/>

Autistic SPACE Framework

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

NHS England Sensory Friendly Resource Pack

NHSE: <https://www.england.nhs.uk/long-read/sensory-friendly-resource-pack/#sensory-friendly-ward-principles>

Autism Informed Services ebook

<https://differentminds.scot/wp-content/uploads/2025/01/Downloadable-e-book-PDF.pdf>

CIRCLE materials (Maciver et al; QMU)

<https://nait.scot/document/circle-primary-resource-international-version/>

Neurodivergent Emabler Online Guides

<https://www.neurodivergentemabler.com/resources.php>

How you can be more inclusive?

<https://wearenchc.nhs.uk/news/how-can-you-be-more-neuro-inclusive/>

Waiting rooms for neurodivergent patients

<https://change.nhs.uk/en-GB/ideas/establish-dedicated-waiting-rooms-for-neurodivergent-patients>

Who is the tool for?

The **NEAT-H long form** is intended for use by healthcare staff working in clinical, residential or community health settings with adults. It is designed for services making a stronger, more robust commitment to being neuro-affirming - for example, autism-specific services, mental health services, or intellectual disability teams. It supports an in-depth reflection on environments used by adults who:

- have communication and sensory support needs
- are autistic
- have ADHD, Dyslexia, Developmental Co-ordination Disorder (also known as Dyspraxia), Developmental Language Disorder, Intellectual Disabilities, Fetal Alcohol Spectrum Disorder (FASD)
- identify as neurodivergent

We can expect 15% of the population to be neurodivergent and so all healthcare settings should be designed as inclusive spaces to meet the needs of everyone who might use them.

What is this tool for?

This tool is intended to support in-depth reflection on how neuro-affirming a health environment is. Being neuro-affirming means that you believe in a strengths and rights-based approach to developmental differences and aim to provide support and adaptations that affirm the person's neurodivergent identity.

A neuro-affirming mindset affects:

- the way we use language in every context
- the social and physical environment we provide
- the questions we ask
- how we talk with and about neurodivergent people and their families
- our choice of language in assessment, goal setting and report writing
- the evolution of tools and approaches we use and how we interpret what we observe and hear
- how we involve neurodivergent people in planning and delivering neuro-affirming services
- how we interpret and act on evidence

The tool can be used to:

- identify reasonable adjustments that could improve accessibility and comfort.
- raise awareness of how spaces inadvertently create barriers for neurodivergent adults.
- encourage environments where neurodivergent adults feel safe, heard, welcomed and supported.
- assess existing environments and to inform design considerations for new environments.
- provide a scoring system to help identify actions required.
- offer a process as a guide. The list of items is not exhaustive.

What does the tool assess?

The tool asks you to reflect on current practice and rate how well it's being done. You'll also consider whether change is needed and how difficult that change would be.

We know that **person + environment = outcome**. We need a good understanding of the impact of environments. The primary support for neurodivergent people throughout life is via environmental adjustments and adaptations, which support individuals to:

- trust the people and places around them because they are desirable and predictable
- be 'their authentic self' without the need to mask
- feel well regulated and reduce the likelihood of distress and anxiety
- communicate what they want to in the best way for them

The environment is understood broadly to include:

The social environment

Defined in the tool using these categories: Mindset and training; Overwhelm, meltdown or shutdown; Predictability; Understanding of internal body states; and Communication.

The physical environment

Defined in the tool using these categories: Physical environment (general); Sensory: Sound; Sensory: Touch; Sensory: Light and visual; Sensory: Temperature and Sensory: Smell and taste.

How it's structured – This is the long form of the tool.

Each includes three parts, applicable to any health environment:

- Appointments (the same as the short form Appointments section)
- Social environment
- Physical environment

A NEAT-H short form is available at www.nait.scot and can be used for a quick audit. It contains three parts, each applicable to any health environment.

How to use the tool:

- Complete it alone or as a team and ensure to include neurodivergent people in the assessment wherever possible.
- Having Allied Health Professionals in the Multi Disciplinary Team and specifically Occupational Therapy and Speech and Language Therapy specialist assessment and advice will enhance the environment assessment process.
- Use it for service reviews, development plans, staff discussions, or CPD evidence, as a baseline to track progress, or when changing spaces.

Action Planning Sheet:

- Record areas to improve
- Note down actions, who's responsible, timescales, and resources

Scoring Instructions:

If the item is not applicable note this and move on.

For each question, ask:

'Is there evidence this practice is happening consistently?'

1. NO: Practices are Not Happening

There is no evidence that practices are being followed or implemented in the setting.

2. NO: Patchy or Inconsistent Practice

There is some minimal or occasional evidence, but these practices are inconsistent.

3. YES: Practices Present but Requires Some Development

The practices are in place somewhat, but they require further development to improve consistency or effectiveness.

4. YES: Strong and Consistent Practice

These practices are well embedded and consistently applied across the setting.

If you're unsure between two scores, pick the lower.

Can this change?

Then ask: *'Is a change required?'* and note this, if yes, then ask: *'How difficult would it be to change this?'*

1. Not Possible:

It is unlikely or impossible to improve this aspect in the setting due to significant barriers (e.g., space limitations).

2. Possible with Effort:

Improvements can be made, but they will require resources, effort, or time (e.g., changes in policy, staff training, structural adjustments, complex paperwork).

3. Easily Possible:





Improvements can be easily implemented with little effort or cost (e.g., rearranging space, implementing a simple policy change, implementing a simple paperwork change).

Summary steps to follow:

- Think about each item in your setting using observations, patient feedback, and staff experience.
- Score it for implementation (1–4), whether action is needed (yes/no), and can this change? (1–3)
- Focus on things you can realistically change.
- Use the Action Planning Sheet to log what you'll do.




Scoring Quick Reference

1. Implementation

Score	Rating		Description
1	No: Practice not Happening		No evidence of this practice in the setting
2	No: Patchy or Inconsistent		Some minimal or occasional evidence; practice is unreliable or inconsistent
3	Yes: Needs Development		Present but requires improvement in consistency or effectiveness
4	Yes: Strong and Consistent		Well embedded and applied consistently across the setting

If unsure between two ratings, choose the lower. Use your professional judgement. The scoring process should be quick and reflective.

2. Can This Change?

Score	Rating		Description
1	Not Possible		Significant barriers (e.g., physical layout, resources, beyond your control)
2	Possible with Effort		Change is achievable but needs time, training, or investment
3	Easily Possible		Low-cost, low-effort changes (e.g., signage, seating, simple policy)

Neuro-affirming Environment Audit Tool: Health (Long Form)

The following pages are available as fillable forms.
You are permitted to copy, print or save these for
your own use.

1: Appointments	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is a variety of booking methods available beyond phone-only systems? (e.g., email, text, online)				
2. Are alternatives to in-person appointments available? (e.g., video, phone, digital)				
3. Are clear pre-appointment details shared in advance, in writing, including format, duration, staff involved (with photos), directions, agenda with key questions, expectations, and future steps?				
4. Are longer appointment times allowed for neurodivergent patients?				
5. Are breaks allowed during appointments? (e.g., for movement)				
6. Is the number of professionals present during appointments minimised where possible, and are patients asked in advance if they are comfortable with students or other staff attending, with time to respond without pressure?				
7. Are reception staff trained in neuro-inclusive or neuro-affirming practice?				
8. Are reminders sent 1-2 days before the appointment? (e.g., text/phone call reminders)				
9. Are all written materials provided in accessible formats for people with a range of language, literacy or other support needs?				
10. Are appointment changes or delays, along with staff changes or other disruptions, communicated clearly, promptly, and in advance?				
11. Are updates, self-care tips, and escalation options provided for patients awaiting appointments?				
12. Is waiting in sensory-stressful areas minimised, is a quiet waiting area available, and is waiting in other settings allowed? (e.g., car, outside)				
13. Are patients asked about specific sensory and communication accommodations and supports needed (including if they can bring someone with them) for access and comfort before appointments?				

2: Social environment: Mindset and training	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Do your team understand that they will meet neurodivergent people every day at work?				
2. Are all individuals/families explicitly asked if they are neurodivergent and might require reasonable adjustments, and what those reasonable adjustments are?				
3. Does staff training provided support an up-to-date understanding of neurodivergence, including recognising that we expect neurodivergent people in our communities, understanding of increased mental and physical health risks, and understanding specific issues such as masking, sensory differences, communication preferences, interoception, alexithymia, burnout, meltdowns and shutdowns and double empathy?				
4. Does your organisation/department have mechanisms to consistently gather and act on neurodivergent people's feedback, including involving neurodivergent individuals in designing, planning, and evaluating services, an identified person or contact to seek and review feedback, and regularly reviewing the environment with their input?				
5. Are staff trained to identify mental health needs in neurodivergent people, and knowledgeable in onward referral to neurodivergent-appropriate mental health supports, where relevant or appropriate?				
6. Are staff trained in having difficult conversations with neurodivergent people (e.g., serious illness, death, bereavement)?				
7. Are staff knowledgeable and skilled to provide holistic care, (e.g., neurodivergence with eating disorders, ADHD with addiction, or autism and depression), avoiding diagnostic overshadowing and accounting for all needs?				
8. Are staff trained to address conscious and unconscious bias, stigma and stereotypes, and trained in relevant equality, diversity, and inclusion policy and law?				
9. Are staff trained to accept and accommodate neurodivergent actions, responses and preferences (e.g., stimming, sensory needs or preferences, communication styles) without judgement, and without viewing adjustments as overly demanding? Are staff able and willing to make a range of adjustments for individuals regardless of diagnosis?				

Social environment: Overwhelm, meltdown or shutdown	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Are staff trained to respond empathetically to distress - responding to distressed actions and responses as an indication of unmet needs, rather than as defiance or 'difficult behaviour'?				
2. Is there a familiar person/people that neurodivergent individuals can seek out when feeling distressed or overwhelmed?				
3. When individuals are distressed, is personal space increased, sensory input actively minimised (e.g., reducing noise, bright lights, and movement), communication kept very simple, and touch avoided unless absolutely necessary?				
4. Are staff trained to recognise stimming and tics as coping mechanisms during dysregulation or distress and support them appropriately?				
5. Are staff able to recognise and accommodate monotropic thinking (very strong, focused attention on a limited number of experiences at a time), particularly when an individual focuses on very specific details or becomes very focussed on something?				
6. After a period of distress, is time and space provided for recovery, including access to solitude, to help individuals re-establish equilibrium?				
7. Is safety prioritised, with clear procedures in place to ensure the well-being of neurodivergent individuals and staff? Are staff confident to undertake a neuro-affirming risk assessment and implement anticipatory supports?				

Social environment: Predictability	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Do staff maintain predictable routines with consistent timetables / schedules, appointment formats, and seating or rooms, minimising changes to schedules, environments, or people and reducing unnecessary reorganisation of physical spaces?				
2. Do staff provide realistic advance information about procedures and expected people, including photos or videos of the environment and staff, to ensure patients understand the purpose of activities or care?				
3. Are patients prepared for changes to routines or expectations with advance notice, timely updates, and clear explanations of unexpected changes?				
4. Are regular breaks planned and communicated to patients?				
5. Are clear intentions stated (or shared in an accessible way) at the start of interactions and outcomes reviewed at the end of interactions?				

Social environment: Understanding of internal body states	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Do staff avoid assumptions about a patient's wellbeing based on outward presentation, resist clinical judgements based solely on 'behaviour', and believe patients' self-reported sensory experiences, pain, discomfort, or other symptoms, paying close attention to what they say rather than how they act?				
2. Do staff understand that neurodivergent non-verbal and verbal pain expressions may differ, that patients may exhibit atypical pain presentations (e.g., greater, milder, or absent responses), and that neurodivergent patients may experience all senses more or less intensely?				
3. Do staff recognise alexithymia (difficulty understanding and processing emotions) and that patients may have difficulties using language to describe body sensations or may need an adapted approach to talk about feelings, such as talking about energy levels?				
4. Do staff recognise interoception differences (difficulty recognising internal body states) and that patients may not always know when they are hungry, thirsty, in pain, need to use the toilet, or are feeling sick?				
5. Do staff use concrete, appropriately formal and medically accurate terminology for body systems and symptoms, avoiding euphemisms, and instructing patients explicitly to indicate areas of tenderness or pain during exams?				
6. Do staff use adapted pain scales, observations, and direct questioning for assessment?				

Social environment: Communication	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is there a process in place to identify and accommodate individual communication preferences?				
2. Do staff use clear, direct, unambiguous communication, avoiding jargon, sarcasm, buzzwords, acronyms, and metaphors, and employing inclusive, non-stereotyping language, with respect for individuals' preferred terminology?				
3. Are augmentative or alternative communication tools available for expression and understanding, including documents, information, and instructions offered in multiple formats (e.g., written, visual, verbal, pictorial, social story)?				
4. When asking questions, do staff allow extra time (e.g., for processing, responses, decision-making or clarifying questions), waiting without rephrasing questions?				
5. Do staff recognise the double empathy problem, sharing responsibility for communication success, and making efforts to 'meet neurodivergent patients in the middle' with mutual understanding of shared information prioritised? Are assumptions about shared social knowledge avoided?				
6. Are differences in neurodivergent communication (e.g., eye contact, directness, processing time) anticipated and not judged?				
7. Are staff alert to situational mutism (it is understood that communication may decline under stress or overload) and are breaks, alternative communication options offered if a patient becomes non-speaking? (e.g., a pen and paper or an iPad, alphabet board or symbol communication system)				
8. Are virtual meetings enabled with subtitles or captions? Is use of chat functions instead of verbal participation allowed, are individuals permitted to choose whether cameras are on or off during virtual interactions? and are alternatives offered to avoid phone-only communication?				
9. Is a psychologically safe environment fostered to reduce people-pleasing pressure or masking?				
10. Is detailed factual information provided when requested, with information broken down into clear, predictable segments?				
11. Is all paperwork available in an 'easy read' format (e.g., information is presented in a certain way, with large text and pictures)?				

Physical environment (general)	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is literal, unambiguous wording used in signage, with bold, contrasting, well-lit signs (text vs. background, sign vs. surface) fixed to doors at eye level, placed at key decision points (e.g., toilets, exits, way out signs), and are glass doors clearly marked?				
2. Is a visual timetable or schedule for appointments used, and are photo name badges or staff photo boards used for identification?				
3. Are waiting areas adjusted based on feedback (e.g., reduce noise when asked)?				
4. Is a range of seating options available?				
5. Are a range sensory of aids available and easily accessible (e.g., noise reducing devices, fidgets, sensory items, clothing and bedding items)?				
6. Do features of the environment (e.g., seats, doors, tables, toilets) obviously look like what they are and what their function is, without abstract, obscuring or unusual design?				

Physical environment: Sensory: Sound	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is there a process in place to identify and accommodate individual preferences and sensitivities for sound?				
2. Are accessible quiet areas available, with minimal background sensory input?				
3. Is auditory clutter (e.g., heating systems, TVs, overlapping voices, equipment hum) identified and reduced?				
4. Do staff consider the impacts of all aspects of environmental sound, including pitch, loudness, duration, frequency, low hums, ticking, echoes, reverberations, and vibrations?				
5. Are noise-producing objects (e.g., devices, equipment) promptly adjusted, moved, or switched off to reduce auditory impact?				
6. Are soft furnishings such as carpets and curtains, and sound-absorbing materials like acoustic panels, used to reduce environmental noise?				
7. Can audible alarms be safely replaced with silent alternatives?				
8. Can doors be closed gently to avoid sudden or loud noises and are doors consistently closed gently by staff?				
9. Are spaces designed/situated such that there is minimised noise from adjacent rooms, external road traffic, or crowded areas with noise from people?				
10. Is a supply of sensory sound tools readily available – such as noise-cancelling headphones, standard headphones, or earplugs?				
11. Are there systems in place to support uninterrupted focus time in quiet areas, such as switching devices to 'Do Not Disturb', diverting phones to voicemail, limiting co-worker interactions, setting expectations, or using visual indicators like signs or headphones?				

Physical environment: Sensory: Touch	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is there a process in place to identify and accommodate individual texture preferences for hygiene items, personal care items, food, clothing and physical examinations?				
2. Is extra physical space available to reduce proximity discomfort, and are situations requiring close contact with others minimised wherever possible?				
3. Is informed consent always obtained before physical touch, with casual touch avoided unless consented to?				
4. Is a range of sensory-friendly bedding, furniture, personal care items, hygiene products, and clothing options available?				

Physical environment: Sensory: Light and visual	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is there a process in place to identify and accommodate individual lighting and visual preferences?				
2. Is the environment kept tidy and uncluttered, with minimal stimulating décor, and limited visual clutter, displays, or strong patterns, especially in clinical and waiting areas?				
3. Are furnishing choices free from shiny surfaces, strong colours and strong patterns, and are furnishings selected to minimise glare and reflections?				
4. Are signs clear, easy to understand, with colour coding, symbols, or graphics, and are landmarks (e.g., plants, paintings) used to support navigation?				
5. Are all windows fitted with blinds, and blinds are plain, adjustable blinds that minimise patterned light and reflections, and can users control them?				
6. Is lighting adjustable (dimmed or switched off), with user control, natural light maximised, and minimal bright light or deep shadows?				
7. Is warm, yellow, diffused lighting used where possible, with high-quality LED bulbs that reduce flicker and noise?				
8. Are fluorescent lights checked regularly, and are flickering or oscillating features (e.g., broken bulbs, displays, fans, TVs) able to be removed/fixed or switched off?				
9. Are alternative light sources (e.g., desk or floor lamps) available?				
10. Are individuals allowed to use sunglasses indoors without judgement?				
11. Are floor surfaces matte, without bold or patterned carpets? Are abrupt changes in floor finish minimised. Are steps and other trip hazards easily visible?				

Physical environment: Sensory: Temperature	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is environmental temperature monitored, patient-led adjustments of environment temperature allowed, and functional and room temperature adjustable and/or fans/heaters provided as needed?				

Physical environment: Sensory: Smell and taste	Not applicable (tick)	Implementation (1-4)	Change required (Y/N)	Can this change? (1-3)
1. Is there a process in place to identify and accommodate individual smell, taste and food preferences?				
2. Are strong or unpleasant smells identified, and attempts made to minimise their impact, including those related to food, cleaning products, personal scented products/perfumes, or planned activities such as painting? Are staff aware that even if they do not have a strong reaction to a smell, others might experience it differently?				
3. Are toilets located away from main areas, and is toilet odour effectively managed so it is not noticeable in shared or clinical spaces?				
4. Are there usable areas where food smells can be avoided, and are food smells in shared spaces controlled?				
5. Are windows or ventilation systems available and accessible to patients to manage airflow, and can doors be closed to help contain unwanted odours?				
6. Are patients allowed to use preferred or familiar scents to help mask or manage unwanted smells?				
7. Is food pressure avoided, and do staff support choice and autonomy around eating without enforcing neurotypical norms, including preferences for food taste, texture, food appearance, food separation, and/or food colour being respected without judgement?				
8. Are medication options available in a variety of taste and texture forms, and are non-standard formulations offered when needed to meet individual needs?				

Neuro-affirming Environment Audit Tool: Health Plan for areas to target based on information gathered

Person completing tool:	
Environment(s) assessed:	
Is this a review or an initial audit:	
Date completed:	Date for next review:

What are the key areas where development is needed?

Appendix: Strategies to use to develop a more inclusive environment

The strategies listed below are designed to provide examples of practical steps. The list is not exhaustive and not all will be relevant in every context.

Involving neurodivergent people and listening to their experiences can be a neuro-affirming way of identifying changes that will make the greatest difference to individuals accessing your service.

Having Allied Health Professionals in the multi-disciplinary team and specifically having access to Occupational Therapy and Speech and Language Therapy specialist assessment and advice will enhance the environment assessment and planning process.

Appointments

- Offer a variety of appointment booking methods (e.g., email, text, online) beyond phone-only systems.
- Provide alternatives to in-person appointments, including video, telephone, or one-to-one digital options for consultations and follow-ups.
- Share clear pre-appointment details in advance, including format, duration, staff involved (with photos of staff), directions, and expectations. Some individuals may experience prosopagnosia (difficulty recognising faces) so staff should ensure they clearly identify themselves when greeted.
- Provide key questions or discussion points in writing before appointments.
- Minimise the number of professionals present during consultations where possible.
- Provide clear post-appointment information in writing, including contact details, timelines for results, and advice.
- Train reception staff in neurodivergent awareness.
- Send appointment reminders.
- Allow longer appointment times for neurodivergent patients.
- Communicate appointment changes or delays clearly and promptly.
- Provide updates, self-care tips, and escalation options for patients awaiting appointments.
- Minimise time in sensory-stressful areas.
- Allow waiting in familiar settings (e.g., car, outside).
- Plan and communicate staff changes or facility disruptions in advance.
- Ask patients about specific accommodations needed for access and comfort in appointments.

Social environment

Social environment: Mindset and training

- Ask about or assess everyone's sensory needs on admission and incorporate sensory accommodations into individual care plans.
- Check for communication passports or flags on case files to save people repeating their support needs and preferences.
- Ask individuals about their communication preferences.
- Review the environment regularly with neurodivergent people's involvement.
- Ask about agreed supports (e.g., headphones, blankets).
- Listen to neurodivergent feedback and act on it consistently, ensure to involve neurodivergent people in designing and planning.
- Always consider that anybody may be neurodivergent.
- Staff training should cover neurodivergent masking, sensory experiences, communication preferences, interoception, alexithymia and the double empathy problem.
- Consider a neurodevelopmentally informed and a trauma-informed care approach when working with all neurodivergent patients.
- Avoid expecting neurodivergent patients to adapt to non-neurodivergent norms.
- Acknowledge that neurodivergent patients feel empathy and may express it in neurodivergent ways.
- Avoid attributing all issues to neurodivergence (prevent diagnostic overshadowing).
- Consider intersectionality - how a patient's perceived social class, gender, race, language, accent, or cultural background might affect your perceptions.
- Respect patients' reluctance to disclose identities if that is their wish.
- Understand what neurodiversity and neuro-affirming practices are.
- Recognise and challenge stigma and discrimination about neurodivergence and challenge problematic stereotypes where you see them.
- Learn to recognise neurodivergence.
- Respond positively to neurodivergence disclosure.
- Discuss and implement accommodations post-disclosure.
- Recognise that unmasking may be difficult due to past experiences or unconscious habits.
- Recognise that being neurodivergent isn't a deficit, problem or mental health condition but that it does increase mental and physical health risks and risk for disability.
- Ensure a robust procedure for onward referral for mental health support access, with neurodivergent aware therapies and professionals available.

Social environment: Predictability

- *Prepare patients for changes to routines in advance, provide advance notice of changes or events and offer timely updates about changes and explain unexpected changes clearly and openly.*
- *Offer photos or videos of the environment and staff in advance.*
- *Provide realistic advance information about procedures, expected people and when to expect things to happen.*
- *Use consistent seating or rooms where possible.*
- *Assign consistent staff where possible.*
- *Minimise unpredictability through limiting changes to schedules, environments or expected people – reduce unnecessary reorganisation of physical spaces.*
- *Maintain predictable routines – maintain consistent timetables, steps, and schedules and follow a consistent format for appointments or procedures.*
- *Plan regular breaks and communicate when they will be happening.*
- *Ensure patients understand the purpose of activities or care.*
- *State clear intentions at the start of interactions and outcomes are reviewed at the end of interactions.*

Social environment: Overwhelm, meltdown or shutdown

- *Respond empathetically to displays of distress or discomfort.*
- *Interpret distress as a response to unmet needs, not defiance.*
- *Designate a specific person for neurodivergent individuals to approach for assistance.*
- *Increase personal space.*
- *Understand and accept stimming and tics without judgement.*
- *Recognise monotropic thinking (e.g., focus on very specific details).*
- *Allow space and time for recovery.*
- *Minimise sensory input.*
- *Avoid using excessive communication/words.*
- *Ensure safety as a priority.*
- *Provide space for restorative solitude.*
- *Avoid touch unless absolutely necessary.*
- *Prepare people for touch, get permission and provide a means of asking to pause if this is possible.*

Social environment: Communication

- Use clear, direct, unambiguous communication and avoid jargon, buzzwords and metaphors.
- Offer documents and information in multiple formats (e.g., written, visual).
- Allow extra time processing questions, for responses or decision-making.
- Recognise the double empathy problem and share responsibility for communication success.
- Use inclusive, non-stereotyping language and respect individuals' preferred language and terminology.
- Be alert to situational mutism.
- Offer pen and paper, or communication boards for communication if a patient is non-speaking some or all of the time.
- Enable virtual meetings with subtitles or captions.
- Allow use of chat functions instead of verbal participation in online meetings.
- Permit individuals to choose whether cameras are on or off during virtual interactions.
- Avoid phone-only communication; offer alternatives.
- Support augmentative or alternative communication tools.
- Anticipate differences in neurodivergent communication (e.g., eye contact, stimming).
- Avoid judging individual actions or responses (e.g. interpreting direct questions or lack of eye contact as rude).
- Allow and offer opportunities for stimming or fidgeting without forcing conformity to non-neurodivergent norms.
- Foster a psychologically safe environment to reduce people-pleasing pressure or masking.
- Break down information into clear, predictable segments.
- Confirm mutual understanding of shared information.
- Understand communication may decline under stress or overload.
- Wait patiently without rephrasing questions prematurely.
- Ask patients directly for their perspective rather than assuming.
- Avoid assumptions about shared social knowledge.
- Provide detailed information when needed or requested by neurodivergent people.
- Understand that initiating and asking for adjustments or expressing needs might not be possible for some individuals.

Social environment: Understanding of internal body states

- *Believe patients' reports of sensory experiences or pain.*
- *Avoid assumptions about a patient's wellbeing based on their outward presentation and pay attention to what neurodivergent people say about their pain and symptoms, resist making clinical judgements based solely on outward behaviour and believe patients' self-reported experiences.*
- *Understand needs for proprioceptive input (e.g., stress balls, chewing gum, rocking, jumping) without judgment.*
- *Avoid assumptions about body postures people use.*
- *Use appropriately formal and medically accurate terminology for body systems and symptoms.*
- *Recognise non-verbal pain and other symptom expressions may differ.*
- *Use adapted pain scales, observations and direct questioning for accurate assessment.*
- *Recognise patients may not know when they are hungry, thirsty, in pain, need to use the toilet or are feeling sick (this is called interoception).*
- *Understand that alexithymia (difficulty understand and processing emotions) may affect emotion recognition in patients.*
- *Instruct patients very explicitly to indicate to areas of tenderness or pain during exams.*
- *Recognise that neurodivergent people may have difficulties using language to describe body sensations.*
- *Patients may exhibit atypical pain presentations - pain may therefore be reported as greater or milder or not present (hyposensitivity or hypersensitivity).*
- *Recognise that neurodivergent patients may experience senses more or less intensely.*

Physical Environment

Physical environment (general)

- Use literal, unambiguous wording in signage and instructions.
- Use clear, consistent signage. Examples can be found here <http://www.tomorraccessibility.co.uk/symbols.htm>
- Adjust waiting areas based on feedback (e.g., reduce noise when asked to).
- Use photo name badges or staff photo boards for identification.
- Ensure there is a range of seating options (e.g. individual seats rather than benches, high backed chairs, swivel chairs, to let people turn away from the room).
- Use a visual timetable or schedules for appointments.
- Ensure visual supports are easy to read and understand.
- Ensure a supply of sensory tools like noise-cancelling headphones, headphones, or earplugs.

Physical environment: Sensory: Sound

- Designate accessible quiet areas with minimal background sensory input, including a designed quiet space for conversations.
- Replace audible alarms with silent alternatives.
- Reduce auditory clutter in patient areas (e.g., heating systems, TVs, voices, equipment hum).
- Ensure silent alarms effectively alert staff without distressing patients.
- Use soft furnishings (e.g., carpets, curtains) and sound-absorbing panels.
- Ensure doors close gently to reduce sudden sounds.
- Evaluate all aspects of sound (e.g. pitch, loudness, duration, frequency) not just loudness.

Physical environment: Sensory: Touch

- *Provide extra physical space to avoid proximity discomfort.*
- *Minimise situations requiring close contact with others (where possible).*
- *Identify and accommodate tactile preferences, especially for physical exams.*
- *Obtain informed consent before physical touch.*
- *Avoid casual touch unless consented.*
- *Avoid physical restraint unless absolutely necessary.*
- *Provide a process to accommodate texture preferences for food.*
- *Provide a process to accommodate texture preferences for hygiene and personal care items.*
- *Provide a process to accommodate texture preferences for clothing.*
- *Provide a range of sensory-friendly bedding, furniture, personal care and clothing options.*

Physical environment: Sensory: Light and visual

- *Ensure the environment is tidy and uncluttered.*
- *Ensure lights can be turned off.*
- *Ensure lights can be dimmed or made lower level.*
- *Ensure blinds are available and user adjustable.*
- *Avoid highly stimulating décor, displays and patterns, especially in clinical areas.*
- *Support user control over lighting.*
- *Ensure alternative light sources are available (e.g., desk lamps).*
- *Use warm, yellow, diffused lighting.*
- *Use light shades.*
- *Use high-quality bulbs to prevent flicker and noise.*
- *Ensure flickering or oscillating features (e.g., fans) can be switched off.*
- *Allow patients to use sunglasses indoors without judgement.*

Physical environment: Sensory: Temperature

- *Monitor environmental temperature.*
- *Allow patient led adjustments of environmental temperature.*
- *Adjust room temperature or provide fans as needed.*

Physical environment: Sensory: Smell and taste

- *Identify and eliminate strong smells – consider food, cleaning, or personal products.*
- *Ensure ventilation or open windows.*
- *Use unscented laundry products.*
- *Use unscented cleaning products.*
- *Avoid staff use of perfumes or scented cosmetics.*
- *Close doors to contain odours.*
- *Allow patients to use preferred scents to mask unwanted smells.*
- *Respect sensory preferences for food taste, texture and appearance and avoid food pressure.*
- *Consider taste and texture in medication options.*
- *Offer non-standard medication formulations.*
- *Respect preferences for food separation or colour without judgement.*

Notes



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