A guide to

NEURO DIVERSITY

in youth organisations

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TABLE OF CONTENTS

1. INTRODUCTION

1.2. QUESTIONING NORMALCY: WHAT *IS* NORMAL?

Let's talk about normalcy. Have you ever wondered why we view certain things as normal and others not? We all know that each society has its own set of norms, through which one can define what is "normal" and what is "abnormal". We instinctively operate on the set of norms we grow up with – from social interactions to decisions regarding how we should live our lives.

However, the concept of the "normal" is much newer than many people might assume. It only entered the English language in the 1840s, a time when society was rapidly changing due **to industrialization and the rise of the middle class.** Before this period, the closest idea to "normal" was the classical notion of the **"Ideal."** However, the Ideal was seen as something divine, **an unattainable perfection** belonging to the gods. It was **not expected that ordinary humans** could or should strive to achieve it.

In contrast, our modern understanding of "normal" is not just a way to describe what is common or typical; it is also **prescriptive**, meaning that it tells people how they should be. This shift in meaning marked a significant change in how society views human differences. Disability theorists often highlight that what we now call "normal" is actually **an ideal** that very few people achieve, yet it has become the standard by which everyone is judged.

So how did we get from the concept of the **Ideal**, a perfection only belonging to gods, to the concept of the **normal**, a specific framework that we as humans are supposed to fit?

THE BIRTH OF THE AVERAGE MAN

The concept of the norm emerged alongside the use of statistics as a method for governance in the 19th century. A key figure in this process was the French statistician Adolphe Quetelet. He introduced the idea of **averaging human traits**, among which height and weight, to determine what he called the **"average man.**" This idea was not limited to physical characteristics; it extended to moral and social behaviors, creating **a standard** that was **used to justify the social and economic power of the rising middle class**.

A TOOL IN SERVICE OF THE DOMINANT CLASS

Quetelet's work laid the groundwork for a broader societal shift. The idea of the "average man" became a powerful tool for **reinforcing the values and norms of the dominant class.** As society increasingly valued progress, industrial efficiency, and economic growth, the norm became a way to promote the idea that people should strive to fit into a specific mold. Those who deviated from this average were often seen as **inferior** or i**n need of improvement**.

A BASIS FOR MODERN THEORIES

The emergence of the norm was deeply connected to the **ideological strengthening of the power of the bourgeoisie**, the middle class that was gaining influence during the industrial era. This new way of thinking about human difference provided the foundation for several influential modern theories, including Marxism, Freudianism, and eugenics. These "Grand Theories" all relied, in different ways, on the idea that human beings could be **measured, categorized, and improved according to the norm.**

THE NORM AND EUGENICS

It's particularly significant that many of the early statisticians happened to also be **eugenicists,** individuals who believed in improving the human race through selective breeding. This connection was not accidental. The same statistical tools used to define the norm were also used to argue that **society should work to reduce deviations from it**. This perspective fueled harmful ideologies and practices aimed at "improving" the human race by eliminating or marginalizing those who did not fit the norm.

NORMAL AS A SOCIAL CONSTRUCT

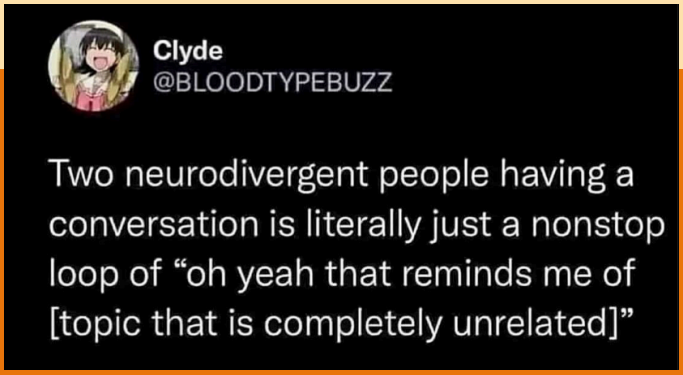
The concept of normalcy as we know it today is not a timeless or universal truth but a relatively recent construct that emerged from specific historical and social contexts. It was shaped by the rise of statistics and the needs of an industrializing society to define, measure, and control human populations. Understanding this history helps to reveal how deeply ingrained ideas about normalcy are in our culture and how they continue to influence the way we think about human difference and disability.

Reflection:

- Has the idea that normalcy is a social construct changed the way you perceive certain things you considered facts? How does that make you feel?
- Have you ever felt pressured to reach certain standards that that did not feel natural to who you are? What were those standards?
- Take a moment to reflect on other things you consider normal and/or facts. Make a list and research them from an intersectional perspective. How many of them are true facts?

Give yourself permission to write freely, even if that means the image resulting is informed by stereotypes. The purpose of this task and this chapter is learning and unlearning, and there is no place for judgement in that!

1.3. EXPLORING MODELS OF DISABILITY: DISABILITY AS CULTURE AND IDENTITY



@BLOODTYPEBUZZ on Twitter/X through @lifeinanautismworld

There are various models of disability that have been used as a framework – both throughout history and in modern times – to understand and approach disability.

In this chapter I will be focusing on the medical model and how it has been used to cast a negative and tragedy informed perspective over disability and disabled people. I will counter this framework by explaining how the social model defines and understands disability.

I will then focus on the affirmative/ identity model – less talked about in youth work environments – and how it challenges the very core of how disability has been historically perceived – from an illness to be eradicated, an undesirable trait to a part of someone’s identity around which a culture has been developed.

The framework through which I will approach the conversations surrounding disability and neurodivergence is a combination of the social model and the affirmative model, with a focus on presenting disability as culture.

1.3.1. THE MEDICAL MODEL: DISABILITY AS PERSONAL TRAGEDY AND PATHOLOGY

For much of history, disability has been viewed primarily through the lens of the medical model, which perceives disability as a **personal tragedy** and a **pathology**. Within this framework, disability is seen as an **undesirable deviation from the norm**, a defect or illness that resides **within** the individual. The medical model treats disability as a problem to be solved, focusing on diagnosing, treating, and, if possible, curing the condition. This perspective is deeply rooted in the idea that the ultimate goal for people with disabilities is to be "fixed" or made to conform as closely as possible to societal standards of normalcy.

A NARRATIVE OF LOSS AND LIMITATION

The medical model is often reinforced by the broader societal tendency **to pity** or **fear** those with disabilities, often times unconsciously, framing their lives as inherently less valuable or fulfilling. This model tends to other the individual, placing the **burden of disability solely on their shoulders**. The narrative that emerges from this model is one of **loss and limitation**, where the person with a disability is often perceived as **a victim of their circumstances**, and their struggles are seen as unfortunate but inevitable consequences of their condition.

STIGMA AND DISCRIMINATION

This approach can lead to a focus on what individuals with disabilities **cannot do**, rather than on what they **can achieve**. It often results in interventions that prioritize pushing the individual to **fit the norm** over empowerment, seeking to **reduce** or **eliminate** the visible signs of disability rather than addressing the broader social and environmental factors that contribute to the challenges these individuals face. As a result, the medical model can inadvertently **perpetuate stigma and discrimination**, reinforcing the notion that disability is something to be feared, pitied, or eradicated.

EXAMPLES OF UNCONSCIOUS DISCRIMINATION (UNCONSCIOUS ABLEISM)

- asking someone what is "wrong" with them
- saying, "You do not look disabled," as though this is a compliment
- viewing a person with a disability as inspirational for doing typical things, such as having a career
- assuming a physical disability is a product of laziness or lack of exercise
- "inclusion" through creating special accommodations for a disabled person, but failing to integrate the accommodations - and the disabled person - throughout the entire program and activity
- interacting with a disabled person as if their disability is more important than any other part of their identity

adapted from medicalnewstoday.com

Reflection:

- Have you ever thought or interacted with a disabled person in any of the above ways? If yes, think about how the other person reacted or what they said. How do you think they felt? Take a few moments to reflect on what you would do differently in that interaction now as a more educated and informed person.

1.3.2. THE SOCIAL MODEL: REFRAMING DISABILITY AND STRUGGLES

DISABILITY AS SOCIAL CONSTRUCT

In response to the limitations of the medical model, the social model of disability emerged in the latter half of the 20th century, offering a radically different perspective. The social model reframes disability not as an individual deficit but as **a social construct**. According to this model, disability arises from the interaction between individuals with impairments and **a society that is not designed to accommodate their needs**. Rather than seeing the problem as residing within the person, the social model locates the source of disability in s**ocietal barriers**—be they physical, attitudinal, or institutional.

SOCIETAL NORMS ARE DISABLING

The social model encourages us to shift our focus from "fixing" the individual to **"fixing" society**. It calls for a reevaluation of how environments, institutions, and social practices contribute to the marginalization and exclusion of people with disabilities. For example, a wheelchair user is not disabled by their inability to walk, but by the lack of accessible infrastructure such as ramps, elevators, and adequate public transportation. Similarly, someone with a learning disability may be more hindered by rigid educational systems that fail to offer alternative methods of instruction than by the disability itself.

The social model challenges society to recognize that the real "disability" lies not in the individual, but in **the collective failure to accommodate human diversity.** By reframing disability in this way, the social model empowers individuals and communities to demand changes that enable full participation in society.

1.3.4. DISTINGUISING BETWEEN IMPAIRMENT AND DISABILITY

According to Tom Shakespeare, "The distinction between impairment and disability lies at the heart of the social model."

Let's explore that.

IMPAIRMENT is defined in individual and biological terms. (Shakespeare 2006: 43).

DISABILITY

- is defined as a social creation. (Shakespeare 2006: 43).
- linked to the loss of opportunities in society caused by society's failure to break down the barriers (physical and social);
- disablement has nothing to do with the body. (Bunbury 2019: 30).

DISABILITY IS WHAT MAKES IMPAIRMENT A PROBLEM.

1.3.5. THE AFFIRMATIVE (OR IDENTITY) MODEL

DISABILITY AS IDENTITY

Building on the foundations laid by the social model, the affirmative or identity model of disability takes the conversation one step further by positioning disability as a **positive identity** and a **source of culture and community.** This model radically changes how disability is understood and defined: disability is not a condition to be managed or a barrier to be overcome but a part of one's identity. Even further, disability advocates argue that disability is an **identity category** just like ethnicity, race, sexuality, gender identity, etc.

DISABILITY PRIDE

The affirmative model challenges the notion that living with a disability is inherently tragic or undesirable. Instead, it recognizes that many people with disabilities take **pride** in their identity and see their experiences as a source of **strength, creativity, and resilience**. Just as other marginalized groups have developed rich cultural traditions, the disability community has its own languages, norms, histories, and forms of expression that are worthy of recognition and celebration.

DISABILITY AS CULTURE AND COMMUNITY

This model also highlights the importance of disability communities and the shared experiences that unite them. Through these communities, individuals with disabilities can find **solidarity**, **support**, and **a sense of belonging** that counters the isolation often imposed by the medical model. Disability culture encompasses a wide range of expressions, including art, literature, humor, and activism, all of which contribute to a collective identity that is as diverse as it is empowering. Just as other marginalized groups have developed rich cultural traditions, the disability community has its own languages, norms, histories, and forms of expression that are worthy of recognition and celebration.

1.3.6. UNDERSTANDING DISABILITY THROUGH BOTH THE SOCIAL AND AFFIRMATIVE MODELS

While the social model provides a crucial critique of societal structures that disable individuals, and the affirmative model offers a positive reimagining of disability as culture, a comprehensive understanding of disability requires integrating insights from both perspectives. Together, these models provide a more holistic view of disability that encompasses **both** the external barriers imposed by society and the internal experiences of identity and culture.

The social model is essential for **addressing the structural inequalities** that perpetuate the marginalization of people with disabilities. It provides a framework for advocating for policy changes, accessibility improvements, and societal shifts that make the world more inclusive for everyone. By highlighting the role of social barriers in creating disability, this model empowers individuals and communities **to challenge and change the status quo.**

However, the social model alone may not fully capture the richness of the disability experience. This is where the affirmative model comes into play, offering **a complementary perspective** that frames **disability as an identity** and focuses on **its positive aspects**. The affirmative model reminds us that people with disabilities are not just passive recipients of societal change, but **active agents in shaping their own lives and communities**. It celebrates the diversity of the disability experience and encourages the broader society to do the same.

By combining the strengths of both the social and affirmative models, we can develop a more nuanced understanding of disability that recognizes the importance of **both systemic change and cultural pride**. This integrated approach challenges us to create a world where people with disabilities are not only free from discrimination and exclusion but are also empowered to embrace their identities and contribute to the rich tapestry of human diversity.

In conclusion, the journey from the medical model to the social and affirmative models represents a significant evolution in how we understand and engage with disability. Moving from a view of disability as a personal tragedy to one that recognizes the role of societal barriers and the value of disability culture, these models invite us to reconsider our assumptions and work towards a more inclusive and equitable world. By embracing both the social and affirmative models, we can create a society that not only accommodates but also celebrates the full range of human experiences. It allows us to see and respect disability as a part of one's identity and as culture while not invalidating the struggles and difficulties - both caused and reinforced by societal factors and biological factors, such as pain - that may come with being disabled.

Reflection:

Give yourself permission to write freely, even if that means the image resulting is informed by stereotypes. The purpose of this task and this chapter is learning and unlearning, and there is no place for judgement in that!

1.4. WHAT IS NEURODIVERSITY?

A different perspective

Task:

Think for a second about mental illness, mental/ neurological disability and mental health struggles. Try picturing a person exhibiting characteristics associated with these situations. What comes first to mind when you think about mentally disabled people, someone who struggles with mental health or someone who has cognitive and/ or neurological differences? How do they look like? How do they behave? Do you notice anything particular about them? If yes, what exactly? What are their main characteristics? Do they work? What kind of work do they do? What interests do they have? What emotions resurface when you picture that image? Pay attention to the language you use to refer to these people.

Give yourself permission to think freely, even if that means the image resulting is informed by stereotypes. The purpose of this task and this chapter is learning and unlearning, and there is no place for judgement in that!

How many of you thought of someone strange, quirky, maybe childish, with unusual behaviour, unusual hand hand gestures and face movements? Or someone who has a different, lesser, capacity to understand and communicate, struggling, unpredictable, or incapable of making decisions for themselves? Someone who stands out like a sore thumb in any social group and gatherings. Maybe some of you thought of someone dangerous and aggressive and to be avoided. How many of you thought of them with pity and in need of help? How many felt the need to avoid this person? Some might have also thought of terms like "crazy" or "unstable".

This characterisation implies a certain degree of **marginalisation** and **unequal difference** between "the mentally ill" and "the normal people". It is usually informed by our parents' views or the views of other people, media portrayals, such as movies and documentaries, and especially by what is medically considered abnormal and in need of correction. It is an image that gives a definition to normalcy and solidifies its status of power against the image of the mentally different. In order to be normal and healthy we need to be in the way that they are *not*. It is clear that being "normal" and being different in terms of cognition and/ or neurology are not seen or treated with the same degree of validation and respect.

Let's have a look at a different perspective, one which does not operate with such dichotomies.

The term neurodiversity was introduced as an advocacy term by Judy Singer in order to bring **a new perspective on human neurological diversity**, especially on neurological types which fall under psychiatric diagnosis (often also called neurodivergent identities). On her website, Neurodiversity2.blogspot.com, Singer provides a revised definition of Neurodiversity:

Neurodiversity (n):

A biological truism that refers to the limitless variability of human nervous systems on the planet, in which no two can ever be exactly alike due to the influence of environmental factors

Usage

- encompasses ALL Humanity
- is an advocacy term to name the Neurodiversity Movement, a civil rights movement for psycho-medically labelled minorities and their allies
- is a category of the intersectional factors that define advantage or disadvantage that

Misusage:

- Does not mean "Neurological Disability" or "Otherness"
- Is not a diagnosis
- Is not a descriptor of genomes

CHALLENGING TRADITIONAL VIEWS

Neurodiversity, as a concept, has its origins in the autistic self-advocacy movement that began in the late 1990s. The term was intended to highlight the spectrum of neurological differences that exist within the human population. The neurodiversity movement challenges the traditional view of neurological variations as **deficits or disorders**, instead promoting the idea that these variations are a **natural and valuable part of human diversity.** Initially focused on autism, the term has since grown to encompass all human neurological diversity.

At its core, neurodiversity is **an umbrella term** that acknowledges the wide range of neurological differences and how people experience and interact with the world. This concept rejects the idea that there is a single "correct" way for brains to function, embracing instead **a spectrum of cognitive functioning where differences are not just inevitable but essential for the richness of human experience**. Thus, neurodiversity challenges the binary categorization of people as either "normal" or "abnormal,"

THE NEURODIVERSITY MOVEMENT

The neurodiversity movement is a continuously evolving public discourse that advocates for **the rights and recognition of neurodivergent people**. At its heart, the movement seeks to challenge the dominant narrative that pathologizes neurological differences, instead promoting a view of **neurodivergence as a natural and valuable aspect of human diversity**. This movement draws from the principles of disability rights and social justice, arguing that neurodivergent individuals should not be forced to conform to neurotypical standards but **should be supported in living authentic lives**.

Over time, the neurodiversity movement has expanded its focus, incorporating issues such as employment discrimination, access to education, and representation in media. It also emphasizes the importance of self-advocacy, encouraging neurodivergent individuals to **speak for themselves and define their own experiences**. As public awareness of neurodiversity grows, so too does the recognition of the need for systemic change to create a more inclusive society.

COUNTERACTING THE MEDICAL MODEL OF DISABILITY

The neurodiversity paradigm serves as **a counterpoint** to the medical model of disability, which views neurodivergent conditions primarily as disorders to be cured or managed. The medical model emphasizes diagnosis, treatment, and normalization, often at the expense of the individual's autonomy and identity. In contrast, the neurodiversity model advocates for viewing neurological differences through **a social model** of disability, where the focus is on **societal barriers** rather than individual deficits.

This approach argues that many of the challenges faced by neurodivergent individuals are not inherent to their neurological differences but are instead **a result of societal structures that fail to accommodate them**. For example, rigid educational systems, inaccessible workplaces, and pervasive social stigma contribute to the marginalization of neurodivergent people.

Many systems in education and in the workplace are fundamentally based on principles of productivity and loyalty to the system. Here are a few examples such system features:

- The approach focused in constant (growing) productivity and results
- The glorification of overtime and treating working all the time as a value, something to boast about
- The constant push to socialise and engage in small talk, where alone time and saying no to work related social gatherings are seen negatively
- Imposing rigid work systems/ ways to deal with tasks that the employees are expected to follow, to the detriment of accepting and encouraging different approaches to tasks and time management, alternatives which might challenge the norm
- The stigma of asking questions and asking for additional information
- Heavy focus on being a team player to the detriment of the value and skills of independent and autonomous work.

Many neurodivergent people struggle to adapt and function in a healthy way to workplace environments that have similar approaches as above.

Neurodiversity is a perspective that prioritises people over products and results. By shifting the focus from curing neurodivergence to creating a more inclusive society, the neurodiversity movement seeks to empower individuals and promote systemic change.

NEURODIVERSITY AS PART OF HUMAN DIVERSITY

Ultimately, the concept of neurodiversity is about recognizing neurological differences as a fundamental aspect of human diversity. Just as society values diversity in culture, language, and experience, so too should it value the diversity of the human brain. This perspective opposes the traditional binary categorization of people into "normal" and "abnormal," "healthy" and "ill." Instead, it sees neurological variations as part of the rich tapestry of human existence.

By embracing neurodiversity, society can move towards **a more inclusive understanding of what it means to be human**. This shift requires not only changes in attitudes and language but also in policies and practices that support neurodivergent individuals in all areas of life. Neurodiversity invites us to reconsider our definitions of normalcy and **to celebrate the wide range of human potential**.

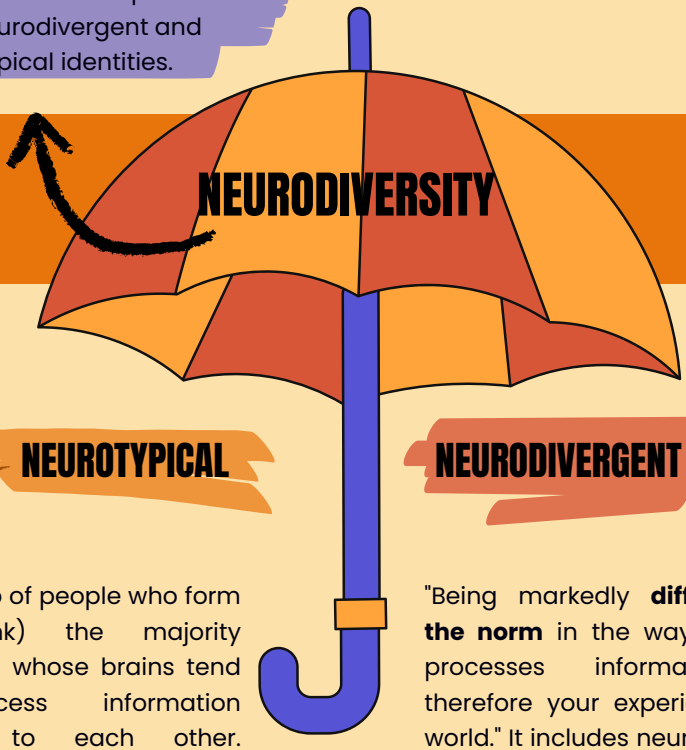
Reflection:

- How does the neurodiversity perspective change the way you see and understand mental health and neurodivergent identities in young people?
- In what ways do you think that the dichotomy between what is socially considered to be the “normal” neurotype and neurodivergent identities is harmful to the latter?
- In which way adopting a neurodiversity perspective could benefit you in the workplace?
- How would a neurodiversity informed system improve the access to education and/or workforce of young people?

NEURODIVERGENT VS NEUROTYPICAL VS NEURODIVERSITY

Let's clear up some confusion

Neurodiversity is an **umbrella term** which encompasses both neurodivergent and neurotypical identities.



NEUROTYPICAL

"The group of people who form (we think) the majority worldwide, whose brains tend to process information similarly to each other. Neurotypical people have an advantage over neurodivergent people in that systems in the world (like our education system) were often designed by people like them, for people like them."

NEURODIVERGENT

"Being markedly **different from the norm** in the way your brain processes information, and therefore your experience of the world." It includes neurotypes such as ADHD, autism, dyslexia, and many more.

ARE NEURODIVERGENT PEOPLE DISABLED?

The question of whether neurodivergent people are disabled is complex and depends on the perspective from which we approach it. According to the social model of disability, neurodivergent people can indeed be considered disabled, but not necessarily because of their neurological differences themselves. Instead, they are disabled by living in a world that is structured around neurotypical norms, which often creates barriers and challenges that make it difficult for them to navigate society.

It's important to recognize that neurodivergence encompasses a wide range of neurotypes, including autism, ADHD, dyslexia, and more. Some neurodivergent individuals may also have intellectual disabilities or mental illnesses, which can further influence how they experience the world and how they are perceived by others. For these individuals, the overlap between neurodivergence and disability might be more pronounced, particularly in contexts where support and accommodations are lacking.

NOT ALL NEURODIVERGENT PEOPLE IDENTIFY AS DISABLED

However, not all neurodivergent people identify as disabled. The relationship between neurodivergence and disability is deeply personal and can vary significantly from one individual to another. Some people may embrace the identity of being disabled as part of their experience, finding community and strength in this identity. Others may prefer to focus on the unique strengths and perspectives that their neurodivergence brings without framing it as a disability.

RESPECT EACH PERSON'S LABELS

It's essential to respect each neurodivergent person's way of referring to themselves. Some may proudly claim both labels—neurodivergent and disabled—while others may identify solely as neurodivergent or choose different terms altogether. The most important thing is to honor each individual's language and self-understanding, recognizing that their experiences and identities are valid and unique.

2. GENERAL CONSIDERATIONS

to keep in mind

2.1. LANGUAGE

TRAITS VS SYMPTOMS

Do not use symptoms when referring to neurodivergent types of behaviours. This is seen as harmful because it implies that being neurodivergent is an ilness or a disease. Being neurodivergent is who we are, it`s an integral part of out identity. It is not something that we have.

Instead, we use traits. By using traits, we are normalizing diversity and complexity in types of behaviours beyond the neurotypical social norms. Using traits humanises us, and perceives our neurodivergency as part of out identity.

IDENTITY-FIRST LANGUAGE VS PERSON FIRST LANGUAGE:

Person-first language is an approach regarding disability which places the person before the disability, with the intent of suggesting that we should see the people and not the disability. While this approach has good intentions, it ultimately treats disability as a negative feature, falling back to the principles of the medical model. In many cases, it also erases a person's disability and their traits.

Most neurodivergent, and generally disabled, people prefer identity first language instead of person-first language. Identity first language is an approach which places disability first. Through this approach, many neurodivergent people reclaim their neurodivergence and/or disability as a part of their identity - with both the positive and disabling traits - and that their disability is not a bad thing that needs to be fixed.

This approach borrows its perspective from both the social model and identity model of disability.

Example of Person-First language:
People with autism

Example of Identity first language:
Autistic people

FUNCTIONING LABELS VS SUPPORT NEEDS

Functioning labels are words that try and show different "types" of neurodivergent identities, usually associated with autism, such as:

"High functioning", "Low functioning", "Mild autism", "Moderate autism", "Severe autism", "Classic Autism", "Asperger's Syndrome".

We do not use functioning labels when referring to a neurodivergent person because they center the experience of neurotypical people in relation to neurodivergent people. Functioning labels don not help neurodivergent people get what we need, because they don't show how neurodivergent people need help with different things. Instead, we use terms associated with Support Needs. Support needs are things neurodivergent people need help with. Different neurodivergent people need help with different things. Some people need more support, and some people need less support. Some people might have more support needs sometimes, and less support needs other times. The words "support needs" mean we need help, and don't judge us for needing help.

Asperger's Syndrome is (often shortened to Asperger's) is no longer used as a diagnostic term for autism and is considered controversial due to the history of Hans Asperger, who Asperger syndrome was named after and who was complicit with the Nazis.

Historically, Asperger syndrome was used as a diagnostic term for some autistic people who did not also have a diagnosis of a learning disability. Broadly, it is now agreed that what was referred to as Asperger syndrome is part of the autism spectrum and there is no need for a separate term.

RESPECT EACH PERSON'S LABELS

Some terms are being recognised within the disability movements as being appropriate, highlighting that some outdated terms in the mainstream are harmful. Let's take for example the term "differently-abled" vs "disabled". Many (mostly non-disabled) people argue that we should not refer to a person as disabled as this erases their personhood. However, just like it is the case with person-first language, this perspective treats disability as a bad and offensive word, when in reality, "differently-abled" reinforces the idea of a "normal" default. Calling a disabled person "differently abled" puts the responsibility on the disabled person to develop the abilities needed to function in an inaccessible society, rather than putting the responsibility on the society to become accessible for disabled people. [1] Terms like "differently abled" and "special needs" center non-disabled people. [2]

However, some people might refer to themselves by using certain old terminology or terminology considered inappropriate nowadays. What is important to keep in mind here is that each person has the right to refer to themselves in whatever way they find most fitting, even if that might go against what is currently considered as appropriate. In this situation, you should always respect each person's own way of referring to themselves and use that accordingly, while when you are speaking to the majority of disabled people or in reference to them, [3] use the language generally accepted as appropriate by said community.

[1, 2, 3] inspired and adaped from @jeremyandrewdavis

2.2. LET'S LEARN SOME IMPORTANT TERMINOLOGY!

Allistic - A non-autistic person

Neurotype - A type of brain in terms of cognitive functioning, executive functioning, how a person interprets and responds to the world around them.

Stimming (or stim) - Activities carried out by neurodivergent people to soothe or calm themselves to regulate and stabilise their emotions and nervous system. These activities can involve flapping, dancing, making noises, humming, movement and sound of any kind.

Stim tools - Also known as "stim toys", they are devices used by neurodivergent people to stim.

Safe foods - Safe food is a food that some neurodivergent people eat a lot and feels safe. Eating a safe food can often feel comforting.

Masking - When neurodivergent people 'mask' they may hide or disguise certain traits in order to conform and adapt to the expectations of a neurotypical society. Masking is more common in girls than boys, but many neurodivergent people 'mask' at some point. Masking can be seen as a coping strategy, but it can have a significant and detrimental impact, resulting in stress, anxiety and depression.
(adapted from
https://nhsdorset.nhs.uk/neurodiversity/about/language/)

Executive functioning - A series of brain functions managed by the frontal lobe including memory, learning, decision making, organisation and time management.
www.inclusiveemployers.co.uk

5 PRINCIPLES of Accessibility TO REMEMBER

1

EVERYTHING WE DO IN OUR YOUTH WORK SHOULD BE DONE WITH ACCESSIBILITY IN MIND.

Accessibility is not an afterthought, but a priority.
In any stage of the process you should ask yourself: Is it accessible?

2

ALWAYS THINK ACTIVELY HOW TO CREATE ACCOMMODATIONS.

Ask yourself: If an aspect isn't up to accessibility standards, what can we do to compensate/ fix the situation?

3

ACCESSIBILITY IS NOT JUST FOR PARTICIPANTS, BUT ALSO FOR THE TEAM.

Everyone, including the preparatory team, has got certain needs that help them navigate the process better and have a comfortable and fulfilling experience. Making sure we're communicating our needs and that we hear and listen to each other is an essential tool in building strong and effective teams.

5 PRINCIPLES of Accessibility TO REMEMBER

4

ACCESSIBILITY AND CREATING ACCOMMODATIONS ISN'T A PERFECT PROCESS.

Accept the fact that you might make mistakes. When this happens, don't focus on the mistake, but strive to find solution in correcting it.
The point is to provide as many accommodations required as possible while having in mind the needs of the participants and the team. To be seen and heard is already half of the process.

5

IF YOU ARE UNSURE ABOUT HOW TO PROCEED IN ACCOMMODATING SOMEONE, DON'T BE AFRAID TO ASK!

Inquiring about someone's needs isn't offensive or insensitive, and neither is admitting you are unsure how to accommodate them. When asking, be honest and respectful - For example:

"Could you please tell me more about your needs/ about x need so I could find the most suitable way to accommodate you?" or

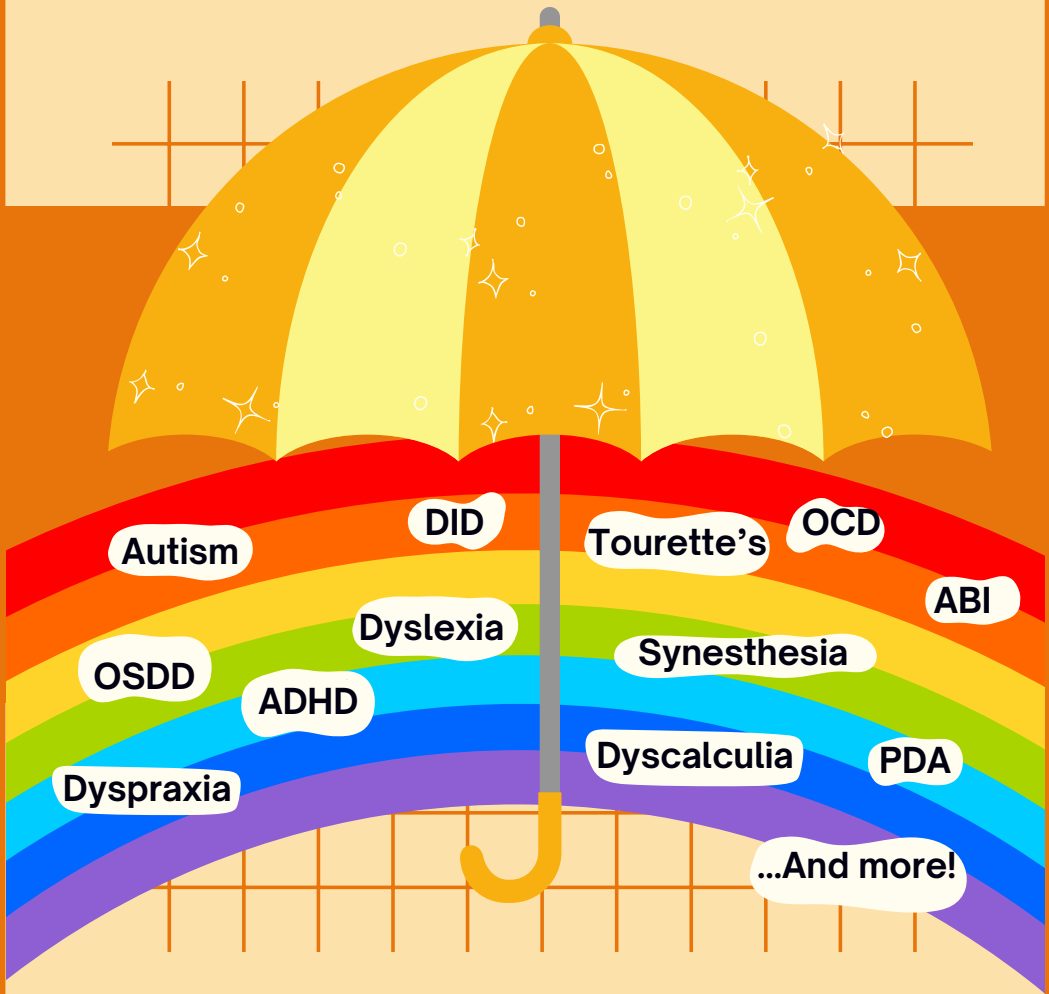
"I'm not very sure what the best way to accommodate you might be. These are the options I thought of. What do you think? Do you have another way in mind that works better for you?"

In this way, you are also including the person in question in the process of finding appropriate accommodations. This allows you to create the safe space for people to open up and communicate their needs in the future.

2.1. ...SOME TYPES OF NEURODIVERGENT IDENTITIES

& common traits associated with them

NEURODIVERGENT IS AN
Umbrella term



TRAITS

Things to remember

- Not all neurodivergent people will have all of the traits listed below
- The traits of neurodivergent neurotypes are a spectrum, creating a diversity of possibilities
- Every neurodivergent person displays different traits during different circumstances at varying degrees
- Some of these traits are actually the result of other traits or comorbidities mixed with other factors
- The a person's neurodivergence is not confirmed or denied by how many traits they have from this list

SOME NEURODIVERGENT TRAITS

- need for sameness/ consistency
- stimming
- eye contact can be painful
- excessive eye contact
- bluntness
- photographic memory
- connection based thinking/ information processing
- difficulty with memory
- difficulty with understanding and interpeating timelines
- detail-oriented
- difficulty in understanding and applying instructions

SOME NEURODIVERGENT TRAITS

- Sensory sensitivity
- impulsive speech
- emotional dysregulation
- rejection sensitivity dysphoria
- time blindness
- auditory processing disorder
- meltdowns and shutdowns
- rigid thinking
- special interests
- doesn`t read social cues well
- cannot switch from one task to another on command
- doesn`t interpret meanings well (others muct be direct)
- situational mutism
- nonspeaking, semiverbal, hyperverbal
- echolalia
- lack of facial expressions
- difficulty in knowing when it`s our turn to speak, may interrupt
- hyperactivity
- food sensitivity

...SOME EXAMPLES OF ACCOMMODATIONS IN YOUTH ORGANISATIONS *& activities*

STIM TOOLS

Stim tools are a great way to accommodate a neurodivergent person. In the workplace, stimming is often seen as distracting or unprofessional. However, for neurodivergent individuals, “stimming is often essential for managing sensory or emotional overload and for maintaining focus or calm in certain environments.” Providing free stim tools in the youth centers and organisations not only offers the neurodivergent person with tools to stim, but it also creates a safe and accepting space.

https://enna.org/what-managers-need-to-know-about-stimming-in-the-workplace-a-comprehensive-guide/

BODY DOUBLING

Body doubling is often used by ADHD people (who tend to struggle with repetitive tasks, task initiation, and managing time), although it is used by people with other neurodivergent types. “When someone with ADHD works on tasks or chores alongside another person, this is a practice called “body doubling”. The body double’s job is to help anchor the person with ADHD to the present moment, reducing the risk of distraction and holding them accountable to their task. Two or more people can also work on tasks together on video chat, known as virtual body doubling.”

https://caddac.ca/how-to-boost-productivity-with-body-doubling/#:~:text=When%20someone%20with%20ADHD%20works,them%20accountable%20to%20their%20task.

https://www.nyu.edu/about/news-publications/news/2023/october/N-38.html

QUIET ROOM

A quiet room, or a sensory room, is a private room set up to minimise overwhelming sensory stimuli. Public spaces are often filled with bright lights, loud sounds, and a cacophony of smells, physical sensations, and social pressures. Quiet rooms offer a soothing escape from these overstimulating public spaces.

An existing room, office, or other small space can become a sensory room with just a few minor changes"

When preparing a quiet room, there are a few things you need to take into account:

Lighting: avoid overhead lighting or any strong lighting. Use instead floor or table lamps, yellow/ warm lightbulbs, or anything similar.

Sound: since the purpose of a quiet room is to soothe overstimulation, it should be placed in a quiet environment, with little auditory inputs. Avoid a noisy setting, such as having loud conversations, music, or any noisy activities. If possible, provide earplugs.

Smell: sometimes scents can cause headaches, nausea, or discomfort. Avoid perfumes, scented candles, room fresheners, and food. You can make sure the room stays scent-free by adding a sign on the door requesting no scents to be worn in the room and no food allowed.

Culture: make positive sensory stimulating and self-soothing activities available. Provide things like stim tools, colouring books, optional colour coded stickers.

taken from
https://opal.latrobe.edu.au/articles/educational_resource/Neurodiversity_toolkit/13322981?file=25667627